

# Victorian Service Coordination Practice Manual



A STATEWIDE PRIMARY CARE PARTNERSHIPS INITIATIVE

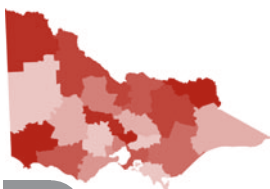
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# Foreword

Since 2000, Primary Care Partnerships (PCPs) across the state have committed many resources and time to develop local protocols, practices, processes and systems to embed Service Coordination in agencies practices. In 2005 the Statewide PCP Chairs Working Group began talking about the need to develop and implement a statewide protocol that builds from the work already done within PCPs. In December 2005, the Primary Health Branch responded to the call from the 31 Primary Care Partnerships in Victoria to enable the development of a statewide protocol for Service Coordination.

The Primary Health Branch agreed that the Statewide PCP Chairs Working Group would coordinate this project and that this would be developed recognising the work already done, highlight best known practice and create a new Service Coordination manual that would be relevant statewide. A Working Group led this work to its completion and has delivered a document that provides a way forward and outlines:

- An agreed minimal standard across the State for how agencies work together to improve consumer care.
- Common concepts and language to ensure improved Service Coordination across sectors.
- An improved approach that enables organisations to be fully engaged in the principles behind Service Coordination.
- An agreed statewide platform that will make possible further development of the Better Access to Services Strategy (BATS) across sectors.

The level of input from the various staff on the ground, consumers and carers has meant that significant ground work had already been laid for us to build on for the future. This document is the result of a very lengthy consultation with the field over 9 months filtered through a statewide Steering Committee and includes two extra resources. The *Good Practice Guide for Practitioners* providing a short summary guide of the manual that can be used by practitioners and the *Continuous Improvement Framework* that will enable organisations and/or PCPs to monitor implementation of Service Coordination.

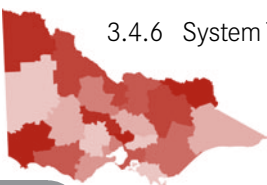
I deeply appreciate the enormous contributions made by many people over the life of the project. Each person provided a wealth of information and input into the development of the final manual. With over 800 agencies directly involved in PCPs and the many program areas within DHS this was not ever going to be an easy task. However, this document has been developed out of the true spirit of partnerships where individuals, agencies and program areas all remained focused on the importance of collaborating, acknowledging different needs and being genuinely prepared to work with each other to finish with a product that will ensure a better response by services to consumers and the community.

Thank you to the Primary Health Branch for funding this work, to the 31 PCPs for engagement in the process, to the many programs across DHS contributing to the many drafts, to Juliet and Ro for listening to so many views and being able to synthesise these into a readable and useful resource and to the Steering Committee for guiding the project. This manual is a significant piece of work that is part of ensuring service integration for existing consumers and future consumers of all of our services.

Clare Amies  
Chair of the Statewide PCP Chairs Working Group

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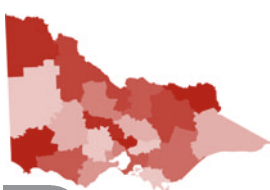
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# Navigating the Manual

This Manual has been developed as a reference guide for managers responsible for leading and managing Service Coordination and for practitioners involved in the implementation of Service Coordination. The Manual is set out in five parts.

- Part 1. Manual Introduction**, provides introductory information for Manual users.
- Part 2. Service Coordination in Victoria**, provides an overview of Service Coordination within Victoria including information about the objectives, principles, and elements, and a flowchart of the consumer pathway through Service Coordination.
- Part 3. Victoria's Service Coordination Practice Standards**, sets out the expected practice for the implementation of Service Coordination across Victoria.
- Part 4. Referral Practice in Victoria**, describes the expected referral practices, processes and systems in Victoria.
- Part 5. Resources and Tools to Support Service Coordination**, provides an overview of the key resources and tools which have been developed to support Service Coordination, including the Human Services Directory (HSD), the Service Coordination Tool Templates (SCTT), electronic referral systems and training packages.

- If you are new to Service Coordination or wish to review background information and the associated context, **please start at Part 2, Service Coordination in Victoria.**
- If you wish to gain a better understanding of the Service Coordination Practice Standards, **please go to Part 3, Victoria's Service Coordination Practice Standards.**
- If you are interested in the requirements for making and receiving referrals, **please go to Part 4, Referral Practice in Victoria.**
- If you wish to gain a better understanding of the resources and tools available to support Service Coordination, **please go to Part 5, Resources and Tools to support Service Coordination.**



Part 1

Introduction



# Part 1. Manual Introduction

## 1.1 What is the purpose of this Manual?

The purpose of this Manual is to:

1. Define practices, processes, protocols and systems which support Service Coordination across Victoria, in particular to:
  - Articulate Victoria's Service Coordination vision and practice standards.
  - Document clear expectations for agencies and practitioners.
  - Provide information on systems and other supports available to agencies involved in Service Coordination.
  - Guide the implementation of Service Coordination at an agency level.
  - Provide a resource for managers and practitioners involved in Service Coordination.
2. Provide the basis for monitoring and continuous improvement of Service Coordination across Victoria, enabling individual agencies and Primary Care Partnerships<sup>1</sup> (PCPs) to:
  - Compare existing practice against statewide practice standards.
  - Ensure Service Coordination is conducted in accordance with the statewide vision and practice, and the Department of Human Services (DHS) *Better Access to Services: A Policy and Operational Framework*.

The Victorian Service Coordination Practice Manual replaces all local and regional Service Coordination Practices, Processes, Protocols and Systems (PPPS) manuals (16 different manuals were in existence in May 2006). However, PCPs can develop local Protocols to complement the Victorian Service Coordination Practice Manual. For example a Protocol could be developed to define and document agreed practice for electronic referral, consumer pathways for chronic disease management or specific requirements for Cultural and Linguistically Diverse (CALD) groups.

## 1.2 Who is this Manual for?

This Manual has been designed as a reference guide for managers responsible for leading and managing Service Coordination and for practitioners involved in the implementation of Service Coordination.

This Manual complements a range of statewide resources including the:

- *Better Access to Services: A Policy and Operational Framework*,
- Self paced training module *Service Coordination: What? Why? How?*
- *Service Coordination Orientation Training Package*, and
- *Service Access Models: A Way Forward Resource Guide for Community Health Services*.

These resources can be found at [www.health.vic.gov.au/pcps/coordination](http://www.health.vic.gov.au/pcps/coordination). In addition, two key resources have been developed to complement this Manual, they are the:

- *Good Practice Guide for Practitioners*.
- *Continuous Improvement Framework*.

Copies of these documents can be downloaded from [www.health.vic.gov.au/pcps/publications](http://www.health.vic.gov.au/pcps/publications).

<sup>1</sup> A Primary Care Partnership or PCP is a group of primary care agencies that have formed voluntary alliances to work together to improve health and wellbeing in their local communities.

### 1.3 Which programs and services are engaged in Service Coordination?

A broad range of programs and services are engaged in Service Coordination across Victoria, including:

- Aboriginal Community Controlled Health Organisations.
- Aged Care Services.
- Alcohol and Drug Services.
- Nursing Services including Community Nursing, Bush Nursing and School Nursing Services.
- Carer Services.
- Community Drug Treatment Services.
- Community Health Services.
- Disability Services.
- Ethno-specific Services.
- General Practice and Divisions of General Practice.
- Hospitals.
- Home and Community Care Services.
- Local Government.
- Mental Health Services.
- Palliative Care Services.
- Psychiatric Disability Rehabilitation Support Services.
- Public Dental Health Services.
- Statewide health and community service organisations and peak bodies.
- Women's Health Services.

Up-to-date information about the scope and nature of DHS program involvement in Service Coordination can be found at [www.health.vic.gov.au/pcps/publications](http://www.health.vic.gov.au/pcps/publications).

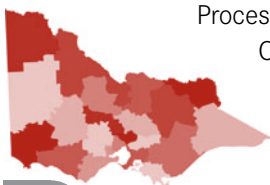
### 1.4 How was the Manual developed?

This Manual was developed as part of the Statewide Service Coordination Practice Manual Project conducted in 2006. The project was an initiative of the Statewide Primary Care Partnership Chairs Working Group and was funded by the Department of Human Services Primary Health Branch.

The Victorian Service Coordination Practice Manual is based on:

- The document *Better Access to Services: A Policy and Operational Framework*.
- A review of the scope and content of the 16 Service Coordination PPPS manuals in use in June 2006.
- Feedback from a range of regional and stakeholder consultations, undertaken in June and July 2006.
- Feedback on draft materials distributed to the sector in August, September and November 2006.
- Input from General Practice Divisions Victoria (GPDV) and the Royal District Nursing Service (RDNS) through Working Groups which were established to support the project.
- Input from a range of DHS programs via an Internal Reference Group established to provide feedback on draft materials (a list of the participating program areas can be found at the back of this Manual).
- Guidance and direction from the Project Steering Committee and Project Management Group (a list of Steering Committee and Management Group members can be found at the back of this Manual).

The significant work by PCPs and agencies over the past four years to develop regional or local Practice, Process, Protocols and Systems (PPPS) manuals, forms the cornerstone of the Victorian Service Coordination Practice Manual.



## 1.5 Terminology

Service Coordination embraces a range of DHS program areas and practitioners including Nurses, Allied Health Professionals, Case Managers, Counsellors, Welfare Workers, Community Care Workers, Front of House Staff etc. In addition, General Practitioners and Divisions of General Practice play an important part in Service Coordination and are partners in PCPs.

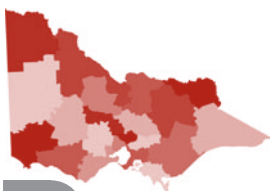
The terminology used by the various program areas and practitioners differs significantly, for example the terms consumer, client and patient can be used to describe an individual receiving care concurrently from a General Practitioner, Alcohol and Drug Counsellor, Social Worker, Podiatrist and Community Care Worker. For the purpose of this Manual when the following terms are used, they should be interpreted as encompassing the related terms.

<b>Agency</b>	Community service organisation, service provider, non government organisation, local government, primary care agency, member agencies of PCPs.
<b>Consumer</b>	Patient, Client, Carer, Family.
<b>General Practice</b>	General practice provides General Practitioner services and may include practice nurse and other allied health/medical specialist services.
<b>General Practitioner</b>	General Practitioner (GP), Doctor.
<b>Practitioner</b>	Health Professional, Nurse, Allied Health Professional, Case Manager, Carer Support Coordinator, Counsellor, Welfare Worker, Community Care Worker, and Service Provider etc.

## 1.6 Acronyms

The following acronyms are used in this Manual

<b>BATS</b>	Better Access to Services.
<b>CALD</b>	Culturally and Linguistically Diverse.
<b>DHS</b>	Department of Human Services.
<b>GP</b>	General Practitioner.
<b>GPDV</b>	General Practice Divisions Victoria.
<b>HSD</b>	Human Services Directory.
<b>INI</b>	Initial Needs Identification.
<b>IT</b>	Information Technology.
<b>MBS</b>	Medicare Benefits Schedule.
<b>PCP</b>	Primary Care Partnership.
<b>PPPS</b>	Practices, Processes, Protocols and Systems.
<b>RDNS</b>	Royal District Nursing Service.
<b>SCTT</b>	Service Coordination Tool Templates.



Part 2

## Service Coordination in Victoria



## Part 2. Service Coordination in Victoria

### 2.1 What is Service Coordination?

Service Coordination is a statewide vision to align practices, processes, protocols and systems through functional integration. Achieving functional integration enables agencies 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. Service Coordination places consumers at the centre of service delivery, to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes.<sup>2</sup>

Victoria's Service Coordination vision is detailed in the Department of Human Services *Better Access to Services: A Policy and Operational Framework* (often referred to as BATS or the BATS Strategy). A copy can be obtained from [www.health.vic.gov.au/pcps/publications](http://www.health.vic.gov.au/pcps/publications).

Further information about Service Coordination and the benefits of Service Coordination can be found in the:

- Self paced training module *Service Coordination: What? Why? How?* which can be viewed at [www.health.vic.gov.au/pcps/publications](http://www.health.vic.gov.au/pcps/publications).
- Australian Institute of Primary Care report on the evaluation of the Primary Care Partnership strategy which can be downloaded at [www.health.vic.gov.au/pcps/evaluation/index](http://www.health.vic.gov.au/pcps/evaluation/index).
- KPMG report which looked at the impact of Service Coordination on five community health services and three local government HACC providers which can be downloaded from [www.health.vic.gov.au/pcps/coordination/pcpimp](http://www.health.vic.gov.au/pcps/coordination/pcpimp).

### 2.2 What principles underpin Service Coordination?

Service Coordination is underpinned by the following principles:<sup>3</sup>

- 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.

### 2.3 What are the elements of Service Coordination?

The Service Coordination elements are:

#### *Initial Contact*

Initial Contact is the first point of 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 Initial Needs Identification.

<sup>2</sup> Better Access to Services: A Policy and Operational Framework, p. 1, DHS June 2001.

<sup>3</sup> Better Access to Services: A Policy and Operational Framework, pp. 9-13, DHS June 2001.

*Initial Needs Identification*

Initial Needs Identification (INI) 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’s needs.

*Assessment*

Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer. 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. The *Better Access to Services: A Policy and Operational Framework* identifies three types of Assessment: Service Specific, Specialist and Comprehensive.

*Care Planning*

Care Planning is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, re-assessment and monitoring. Care planning involves the judgement/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.

*Referral*

Referral is integral to working with many consumers and in particular those with complex needs and a chronic disease. Referral is a function of Service Coordination, and can occur at, or out of, any of the elements of Service Coordination. Referral is defined as the transmission (physically or by other means) of personal and/or health information relating to an individual from one agency to another agency/agencies with the individual’s consent and for the purpose of further assessment, care or treatment.

**2.4 How do the elements of Service Coordination fit together?**

Diagram 1 illustrates how the elements of Service Coordination fit together and the linkages with supporting resources and tools.

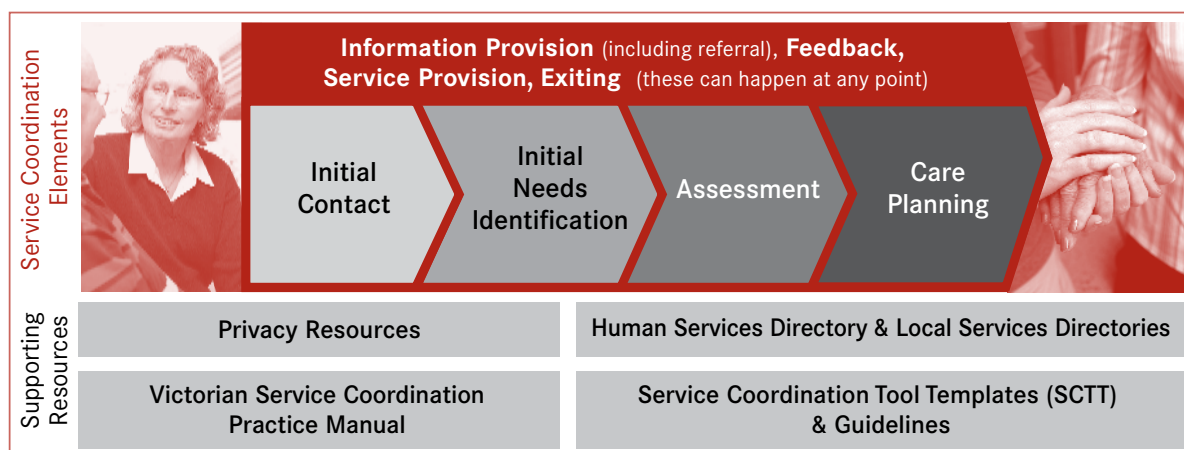
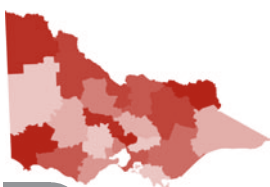


Diagram 1. Service Coordination Elements and Supporting Resources



## 2.5 The consumer pathway through Service Coordination

Diagram 2 illustrates the consumer's pathway through the elements of Service Coordination. This diagram is also provided as a pull-out poster at the back of this manual.

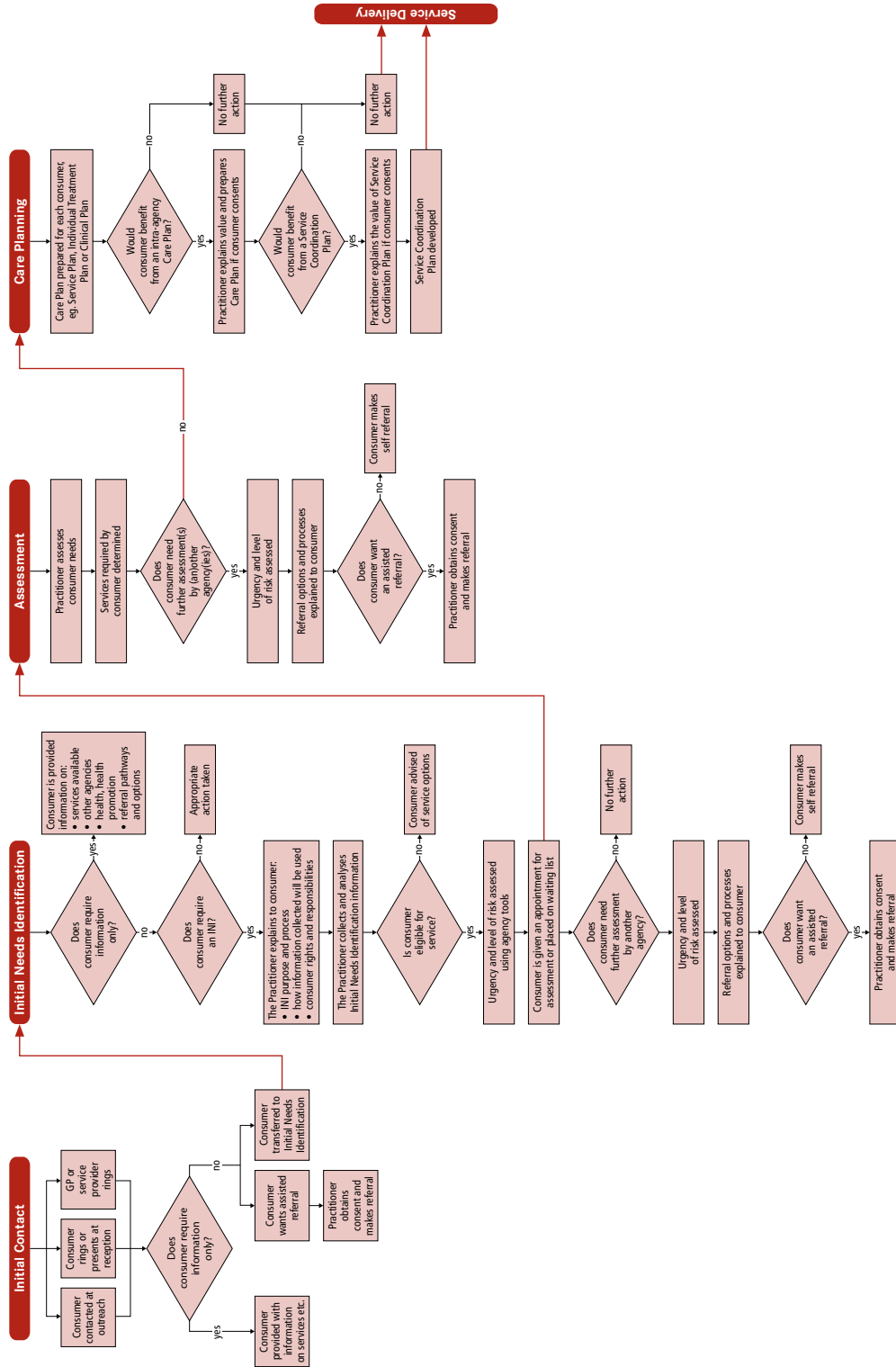


Diagram 2. Consumer Pathway through Victoria's Service Coordination Model

## 2.6 What is expected of agencies involved in Service Coordination?

Different agencies and program areas will have differing roles in the implementation of Service Coordination. The nature and level of involvement by agencies will depend on program requirements, size, service profile, funding, target groups and resources. Agencies like Councils and Community Health Services are likely to be involved in all aspects of Service Coordination.

It is important that consumers and carers across Victoria can access all elements of Service Coordination in a timely and seamless way. Therefore if your agency does not deliver all elements of Service Coordination (for example your agency may not provide INI or develop Service Coordination Plans), it is important that practitioners know where consumers can be referred to for these services.

If you are interested in implementing Service Coordination, the PCPs are there to support you. If you do not know which PCP you belong to, information about all the PCPs can be found at [www.health.vic.gov.au/pcps/](http://www.health.vic.gov.au/pcps/) webpages.

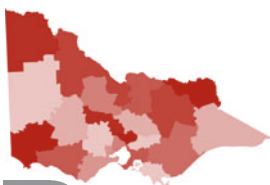
You can find out how different programs are implementing Service Coordination by clicking on the following link and scrolling down to Service coordination – program update [www.health.vic.gov.au/pcps/publications/servcord](http://www.health.vic.gov.au/pcps/publications/servcord).

## 2.7 Where do GPs and General Practice fit in Service Coordination?

General Practitioners, general practice and Divisions of General Practice are essential participants in Service Coordination. GPs and general practice are not mandated to comply with DHS program requirements for Service Coordination. However, GPs work closely with practitioners and Service Coordination agencies by providing “comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health”.<sup>4</sup>

General Practitioners can access reimbursement through the Medicare Benefit Schedule (MBS) and payments through the Practice Incentives Program to undertake particular comprehensive health assessments, health checks, care plans, medication reviews and cycles of care. Your local Division of General Practice is an excellent source of information about the complexities and changing nature of MBS items and incentive payments. You can also search the MBS Online at [www.health.gov.au](http://www.health.gov.au).

The main Service Coordination interface between GPs and agencies is in the areas of referral (and referral feedback) and collaboration around inter-agency care planning.



<sup>4</sup> Royal Australian College of General Practitioners (RACGP) Council 2001.

Part 3

Victoria's Service Coordination  
Practice Standards



## Part 3. Victoria's Service Coordination Practice Standards

### 3.1 Victorian Service Coordination Practice Standards

The Victorian Service Coordination Practice Standards set out agreed process objectives, consumer outcomes, good practice indicators, and systems tools for practitioners involved in Service Coordination across Victoria. The aim of the Service Coordination Practice Standards is to provide:

- a shared vision for the delivery of quality Service Coordination across Victoria,
- a basis for agencies to compare existing practice against the Victorian Practice Standards to identify areas for improvement, and
- a monitoring tool to ensure the Service Coordination Practice Standards are being implemented by agencies across Victoria.

The Service Coordination Practice Standards are set out as follows:

- Process Objectives.
- Consumer Outcomes and Good Practice Indicators.
- Consumer Pathway.
- System Tools.

The Service Coordination Practice Standards set out in this section of the Manual cover:

- Initial Contact.
- Initial Needs Identification.
- Assessment.
- Care Planning.

The Practice Standards for Referral can be found in section 4 of this Manual.

### 3.2 Practice Standards: All elements of Service Coordination

This section provides an overview of the process objectives, consumer outcomes and Good Practice Indicators which are common across all elements of Service Coordination.

#### 3.2.1 Process Objectives – All elements of Service Coordination

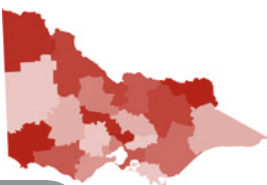
To ensure each consumer has access to effectively and efficiently managed and resourced Initial Contact, Initial Needs Identification, Assessment, Care Planning, Referral and Service Delivery.

### 3.2.2 Consumer Outcomes and Good Practice Indicators – All elements of Service Coordination

Consumer Outcomes	Good Practice Indicators
<p>Consumers experience a timely, coordinated, planned, non-discriminatory, culturally sensitive and reliable service.</p> <p>Consumers can be certain that their information is collected, stored, shared and updated in accordance with the Health Records Act and other privacy requirements.<sup>5</sup></p>	The practitioner provides consumers with relevant information using the Human Services Directory and/or other relevant service directories.
	The practitioner empowers the consumer through the provision of information, decision making support and assistance to access : <ul style="list-style-type: none"> <li>■ Initial Needs Identification</li> <li>■ Assessment</li> <li>■ Care Planning</li> <li>■ Referral</li> <li>■ Service Delivery.</li> </ul>
	The practitioner collects information in a sensitive manner, with particular regard to: cultural requirements, language issues, special communication needs, privacy and confidentiality, and anonymity where practical.
	The practitioner only collects the relevant information required: <ul style="list-style-type: none"> <li>■ for good practice clinical care,</li> <li>■ to meet minimum data set requirements, and</li> <li>■ for making referrals.</li> </ul>
	The practitioner provides the consumer with a copy of the brochure: <i>Your Information: it's Private</i> or relevant agency information.
	The practitioner obtains informed consent before undertaking a referral to another agency for INI, Assessment, Care Planning and/or service(s).
	The practitioner makes referrals without consent, in accordance with the Health Records Act and other requirements such as Duty of Care and Mandatory Reporting.
	The agency has clear written policies, procedures and work instructions for Service Coordination.
	The agency has structures and systems in place to facilitate streamlined access to Initial Contact, INI, Assessment, Care Planning, Referral and Service Delivery.
	The agency has clear procedures and processes for obtaining and documenting consumer consent and complying with privacy requirements.
	The agency ensures information collected and documented on the Service Coordination Tool Templates is consistent with the Department of Human Services' <i>Service Coordination Tool Templates 2006 user guide</i> and <i>Service Coordination Tool Templates 2006 reference guide</i> .
	The agency has appropriately skilled practitioners available to assist consumers.
	The agency ensures staff understand their role and the accountability of their work.
	The agency has a clearly defined and understood procedure for effectively managing consumers in crisis or emergency situations, including the provision of information regarding after hours services.
	The agency monitors the elements of Service Coordination and regularly evaluates whether it is meeting its objectives.
	The agency is responsible for maintaining up-to-date information about services, eligibility criteria, priority for service and waiting times in service directories such as the Human Services Directory and/or other relevant service directories.
	The agency participates in PCP groups and forums to ensure the continuous improvement of Service Coordination.
The agency has integrated Service Coordination performance into consumer feedback systems eg. consumer satisfaction surveys.	

<sup>5</sup> Privacy and consent are key issues to be considered in all elements of Service Coordination and referral. Agencies are encouraged to visit the following websites to ensure they are meeting the relevant privacy and consent requirements:

- [www.health.vic.gov.au/pcps/publications/index](http://www.health.vic.gov.au/pcps/publications/index)
- [www.betterhealth.vic.gov.au](http://www.betterhealth.vic.gov.au)
- [www.dhs.vic.gov.au](http://www.dhs.vic.gov.au)



### 3.3 Practice Standards: Initial Contact

#### 3.3.1 What is Initial Contact?

**Initial Contact** is the point a consumer or carer makes his or her first contact with the service system and will most commonly include:

- the provision of service information eg. services available, eligibility criteria and intake processes,
- the provision of other information such as health promotion literature, and/or
- direct access to services via an INI.

Consumers initiate Initial Contact most commonly by telephone or in person but possibly through a friend, relative, or via electronic media such as websites and service directories.

Initial Contact ends when a consumer requires information that is supported by advice and when a process of inquiry begins ie. the INI process has commenced.

All agencies provide some Initial Contact. Importantly, formalising the role of Initial Contact has meant a change to the responsibilities and practice of many front of house staff and practitioners.

#### 3.3.2 Where does Initial Contact fit into Service Coordination?

Initial Contact is the first stage of Service Coordination, and the entry point into other elements of Service Coordination including INI and Assessment.

Referral to external agencies may also occur out of Initial Contact.

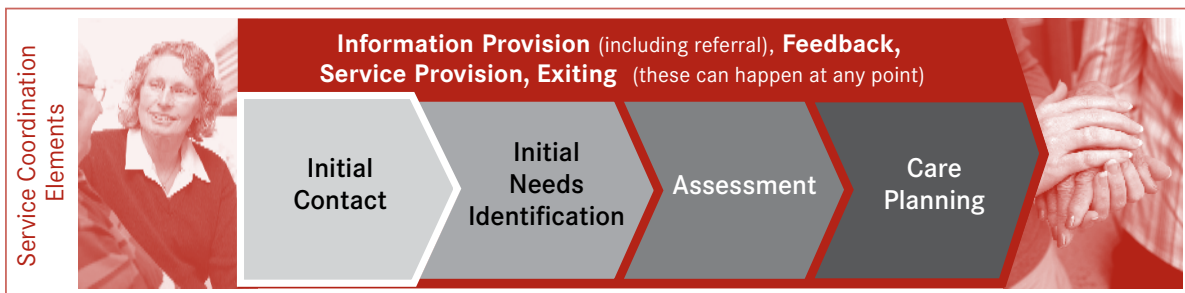


Diagram 3. Initial Contact

#### 3.3.3 Which staff are involved in Initial Contact?

Initial Contact happens differently in every agency. For example:

- In some agencies Initial Contact will be carried out by Reception or Front of House staff, in other agencies it may be undertaken by a Duty Worker or Information Officer. Elsewhere it may be the responsibility of the Service Coordinator (or Intake Worker). Outreach Workers also provide an important point of Initial Contact.
- Initial Contact and INI may be carried out by a single staff member at the one time, such as the Service Coordinator (or a Duty Worker). In other agencies Initial Contact may be the responsibility of a range of different staff, and Initial Contact and INI may be completed over a number of days.

Across the service system Initial Contact may be undertaken by one or more of the following staff:

- Front of House or Reception Staff.
- Service Coordination Workers (sometimes referred to as Intake Workers).
- Duty Workers.
- Triage Staff.
- Outreach Workers.
- Information Workers.

- Individual practitioners (where consumers contact them directly such as in some community health services).
- Volunteers in Neighborhood Houses and Community Centres.

### 3.3.4 What is expected from agencies providing Initial Contact?

This section sets out the Victorian Practice Standards for 'Initial Contact'. There is no right or wrong way to implement Initial Contact, however, agencies are expected to meet the practice standards outlined in this Manual.

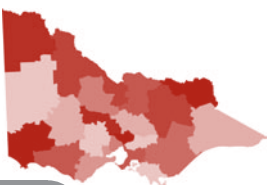
#### 3.3.4.1 Process Objectives – Initial Contact

To ensure that each consumer's access to the service system and the range of services required, is supported by:

- multiple entry points,
- accurate and reliable service information,
- competent staff,
- an understanding of the INI, Assessment, Care Planning and Referral processes,
- information about a consumer's rights and responsibilities,
- culturally sensitive practice, and
- access to INI, Assessment, Care Planning, Referral or Service Delivery.

#### 3.3.4.2 Consumer Outcomes and Good Practice Indicators – Initial Contact

Consumer Outcomes	Good Practice Indicators
Consumers are informed about: <ul style="list-style-type: none"> <li>■ the services available and eligibility criteria,</li> <li>■ entry and INI processes,</li> <li>■ their rights and responsibilities in relation to accessing services.</li> </ul> Consumers are empowered to make informed choices and self-referrals, through the provision of information and/or assistance. Consumers have streamlined access to INI, assessment and referrals.	The front of house staff / practitioner provides information in a manner, which empowers the consumer to make informed choices. This may involve the use of interpreters, translated material and culturally sensitive practice.
	The front of house staff / practitioner explains the INI and Assessment processes including timeframes to the consumer.
	The front of house staff / practitioner, when appropriate, facilitates: <ul style="list-style-type: none"> <li>■ access to INI, Assessment, Referral or Service Delivery and/or</li> <li>■ referrals where a consumer asks for assistance or cannot make a self-referral.</li> </ul>
	The agency provides access to accurate service information within no more than 1 working day of a consumer making Initial Contact.
	The agency is an entry point to the full suite of services offered by the service system. As such the agency will provide consumers with the information and assistance they need to navigate the service system.
	The agency collects some data/information at Initial Contact for the purpose of planning and health promotion, including the: <ul style="list-style-type: none"> <li>■ number and nature of enquiries, and</li> <li>■ level of unmet need.</li> </ul>



### 3.3.5 Consumer Pathway through Initial Contact

The consumer pathway through initial contact is set out in Diagram 4.

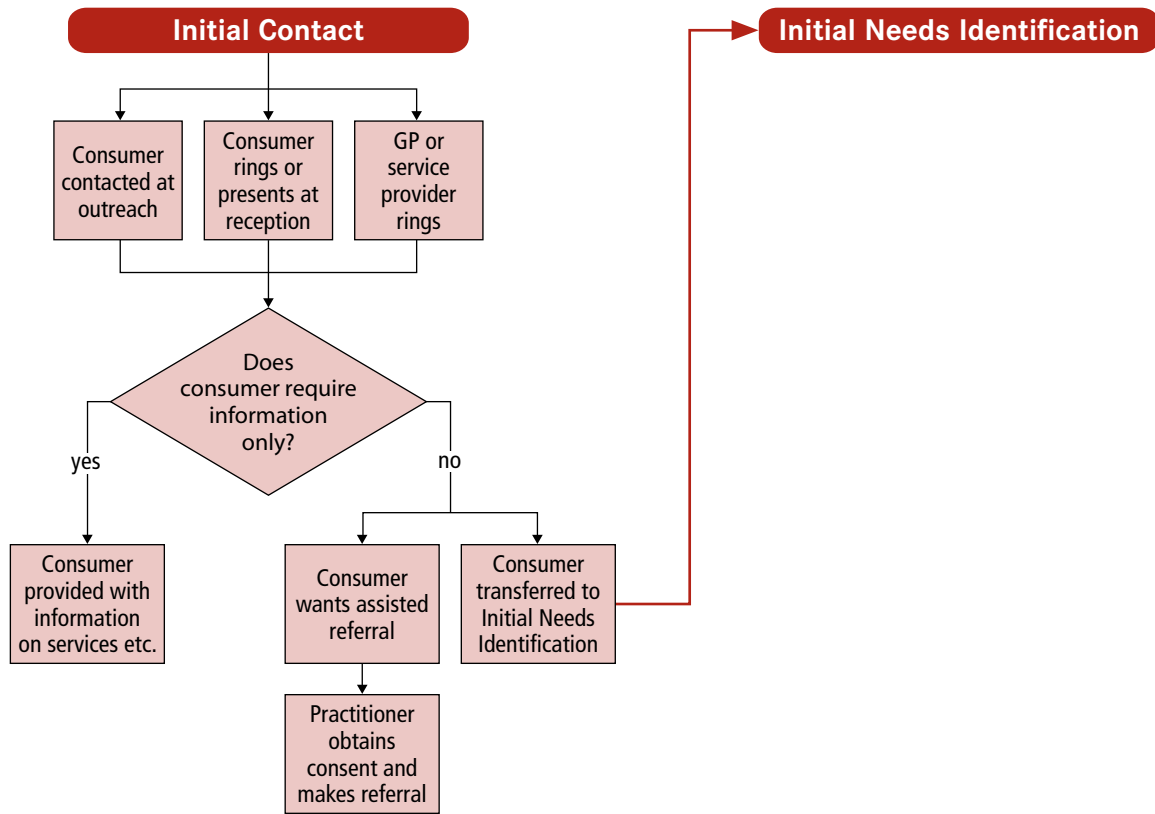


Diagram 4. Consumer Pathway through Initial Contact

### 3.3.6 Systems Tools – Initial Contact

- The statewide Human Services Directory has been designed to support Initial Contact. The Human Services Directory can be found at [www.humanservicesdirectory.vic.gov.au](http://www.humanservicesdirectory.vic.gov.au). Your PCP, program area, agency or local Council may also have service directories which can support Initial Contact.
- DHS Service Coordination Tool Templates: Consumer Information Template.
- *Service Coordination Tool Templates 2006 user guide* and *Service Coordination Tool Templates 2006 reference guide*.

### 3.4 Practice Standards: Initial Needs Identification

#### 3.4.1 What is Initial Needs Identification?

**Initial Needs Identification** (sometimes referred to as I.N.I. or INI) is an initial screening 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's needs.

The practitioner undertaking INI looks beyond the presenting issues to what underlying issues may exist. INI is sometimes referred to as triage or service screening.

Initial Needs Identification allows for the consumer's health and wellbeing needs and health promotion opportunities to be broadly identified, 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 service supports and resources.

#### 3.4.2 Where does Initial Needs Identification fit into Service Coordination?

Consumers usually progress from Initial Contact to INI. Staff undertaking an INI, explore a broad range of needs, not just those needs that can be met by the agency.

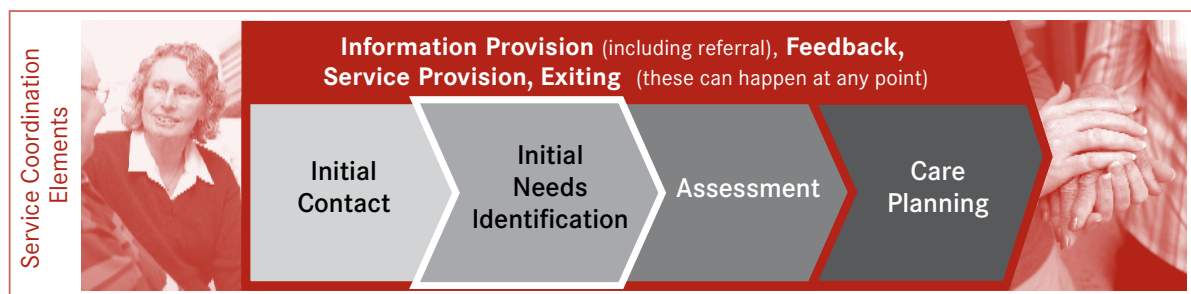


Diagram 5. Initial Needs Identification

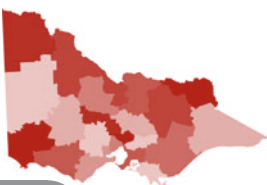
#### 3.4.3 Which staff are involved in Initial Needs Identification?

Initial Needs Identification is usually carried out by a skilled practitioner, preferably with a health or welfare qualification. Decisions made by staff undertaking INI require a broad understanding of the service system, advanced interviewing skills, and high level interpersonal skills including the ability to develop rapport with consumers.

Practitioners should have easy access to agency decision support tools, the Human Services Directory and/or other relevant service directories.

Initial Needs Identification happens differently in every agency and across programs. For example:

- Initial Needs Identification may be undertaken by a dedicated Service Coordination Worker (or Intake and Duty Worker) in one agency and by individual practitioners in another agency.
- Initial Contact and INI may be done by one staff member all at the same time, or by different practitioners and over a period of days.
- Initial Needs Identification and Assessment may occur together and at the same time in one agency, and by separate practitioners over a period of time in another agency.
- Certain workers (such as an Outreach Worker) may be responsible for Initial Contact, Initial Needs Identification and Assessment. These activities may happen all at once, or over time.



Initial Needs Identification may be conducted by one or more of the following staff:

- Service Coordination Workers (often referred to as Intake Workers).
- Duty Workers.
- Care Coordinators.
- Triage Nurses.
- Assessment Officers/Nurses.
- Outreach Workers.
- Individual Practitioners (in particular, where consumers contact them directly to make appointments, as happens in some Community Health Services) such as a Physiotherapist, Alcohol and Drug Counselor, Care Coordinator in an Emergency Department.
- Case Managers.

Victoria is committed to ensuring that all consumers can easily access an INI when required. If your agency does not provide this service, it is important that your practitioners know where consumers can be referred to for an INI.

### 3.4.4 What is expected from agencies providing Initial Needs Identification?

This section sets out the Victorian Practice Standards for 'Initial Needs Identification'. There is no right or wrong way to implement INI however it is expected that all agencies undertaking this role will meet the practice standards set out below.

#### 3.4.4.1 Process Objectives – Initial Needs Identification

To ensure that each consumer has access to initial screening for health promotion opportunities, service requirements and risk, and culturally sensitive and streamlined access to appropriate assessment(s), care planning and service(s).

#### 3.4.4.2 Consumer Outcomes and Good Practice Indicators – Initial Needs Identification

Consumer Outcomes	Good Practice Indicators
Consumers are informed about: <ul style="list-style-type: none"> <li>■ the INI process,</li> <li>■ why information is being collected and how that information will be used,</li> <li>■ the screening process and how risk and priority are determined,</li> <li>■ their rights and responsibilities including access to their health records,</li> <li>■ the implications of providing and not providing information, and</li> <li>■ consent requirements.</li> </ul> Consumers are supported and empowered to participate in the INI process, through the provision of information, decision making support and/or direct assistance such as an assisted referral.           Consumers have access to appropriate assessments and referrals.	The practitioner explains to the consumer the rationale for collecting information and how that information will be used to screen for broader needs.
	The practitioner discusses with the consumer possible choices for support, including those provided by other agencies. This may involve the use of interpreters, translated material and culturally sensitive practice.
	The practitioner assists the consumer to identify and define their issues and needs including opportunities for health promotion through the INI process.
	The practitioner ensures the consumer is fully informed of the processes for decision-making and is encouraged and supported to actively participate in those processes.
	The practitioner uses appropriate risk assessment tools to determine the consumer's needs, level of risk and priority of access to assessment, care planning and services.
	The practitioner discusses options about alternative services with each consumer who is not eligible for service and wherever possible refers the consumer on to a service(s) which meets their needs.
	The agency conducts an INI within no more than 7 working days of Initial Contact or of receiving a referral identified as 'low' or 'routine' from Initial Contact.
	The agency conducts an INI within no more than 2 working days of Initial Contact or of receiving a referral identified as 'urgent' from Initial Contact.
The agency has in place a process for consumers who require 'urgent services' and who cannot wait for a formal assessment process to be completed.	

### 3.4.5 Consumer Pathway through Initial Needs Identification

The consumer pathway through the Initial Needs Identification (INI) process is set out in Diagram 6.

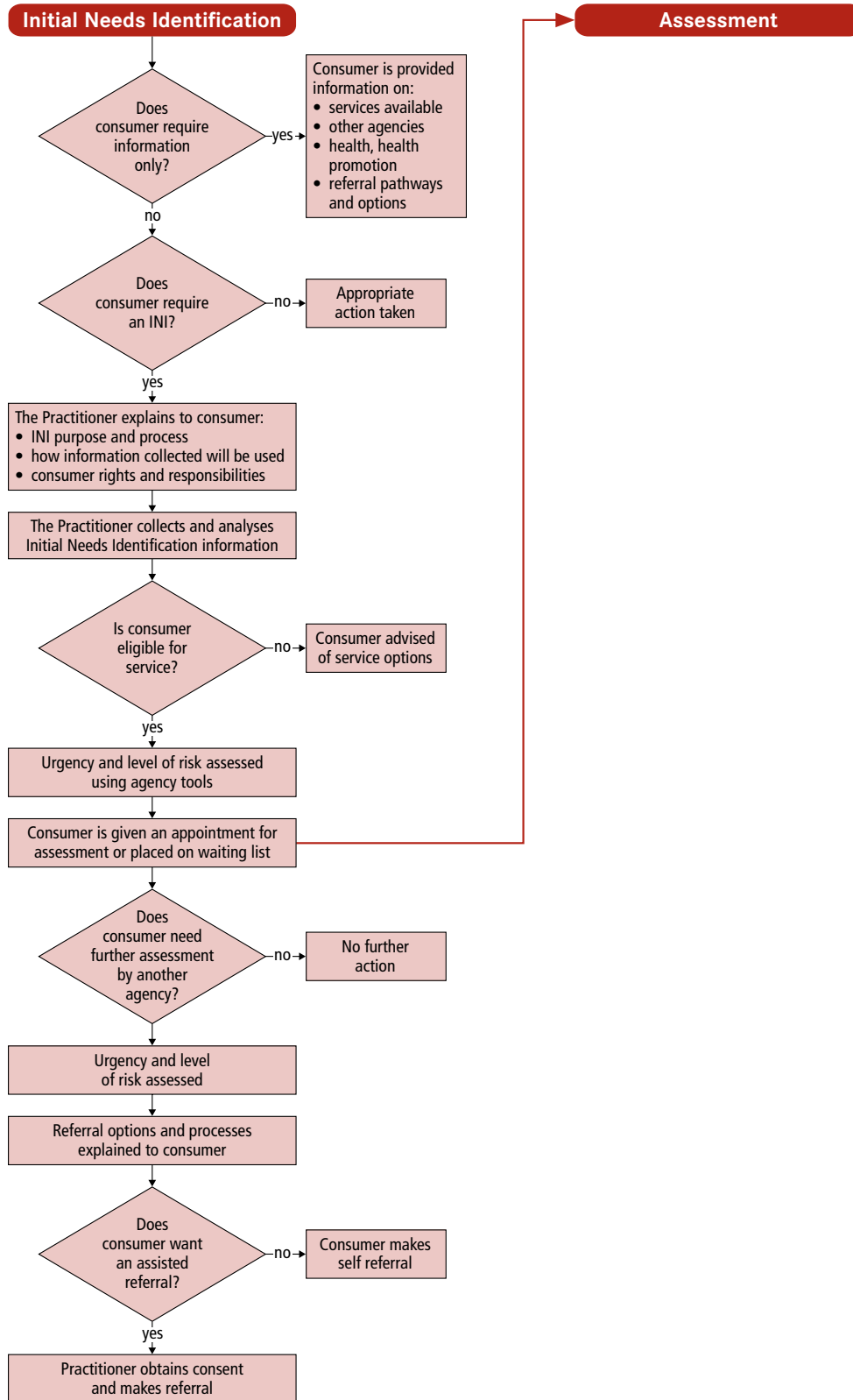
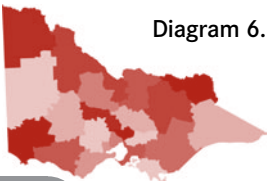


Diagram 6. Consumer Pathway through Initial Needs Identification



### 3.4.6 System Tools – Initial Needs Identification

- DHS Service Coordination Tool Templates.
- *Service Coordination Tool Templates 2006 user guide* and *Service Coordination Tool Templates 2006 reference guide*.
- Agency: Eligibility Criteria, and Priority Access Policy.
- The Human Services Directory and/or other relevant service directories.

### 3.5 Practice Standards: Assessment

#### 3.5.1 What is Assessment?

**Assessment** is a decision-making methodology that collects, weighs and interprets relevant information about the consumer. 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.

Assessment is a process by which a skilled practitioner investigates in detail the specific needs of a consumer. A consumer may require more than one assessment as specific disciplines collect and interpret particular information to inform the recommended treatment or care plan for the consumer.

Each agency should have assessment tools in place which meet consumer, service, agency, reporting and program requirements.

#### 3.5.2 Where does Assessment fit into Service Coordination?

Assessment builds on the information gathered through Initial Contact, INI and other relevant assessments. Assessment is completed by a qualified practitioner to:

- set care goals,
- determine services required,
- develop a care plan, and
- make appropriate referrals with the consumer’s consent.

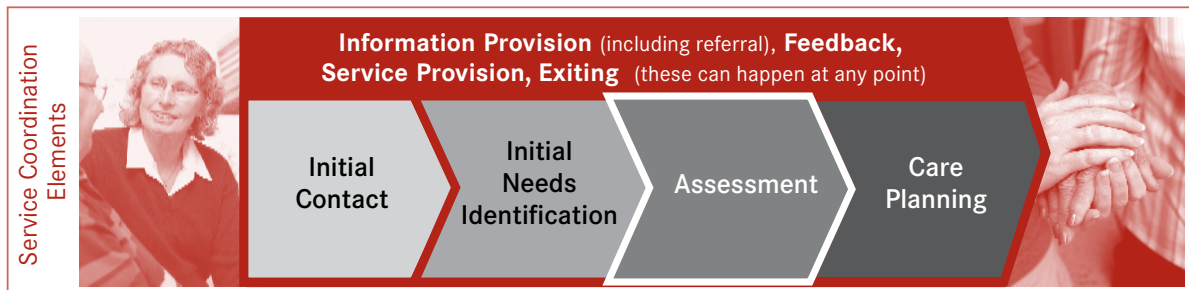


Diagram 7. Assessment

The *Better Access to Services Policy and Operational Framework* identifies three types of Assessment, they are:

#### *Service Specific Assessment*

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

#### *Specialist Assessment*

Specialist Assessment is a face-to-face interaction with a consumer and is undertaken when the presenting issue clearly requires a specialist service response. It occurs where a specialist need is identified following INI.

#### *Comprehensive Assessment*

A Comprehensive Assessment is 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.



Further information about the three types of assessment can be found in the *Better Access to Services Policy and Operational Framework*, a copy of which can be downloaded from [www.health.vic.gov.au/pcps/publications](http://www.health.vic.gov.au/pcps/publications).

Most DHS program areas have developed Assessment Frameworks, Guidelines, Templates and Tools to support assessment.

### 3.5.3 Which staff are involved in Assessment?

Assessments can only be carried out by trained practitioners with expertise in this particular area of service delivery. Decisions made by staff undertaking assessments require a broad understanding of the service system, advanced interviewing skills, and high level interpersonal skills including the ability to develop rapport with consumers.

The transition from INI to Assessment happens differently in every agency and across program areas, and at times the transition is blurred. For example an INI and Assessment may be carried out by one staff member all at the same time, or by different staff and over a period of days. Staff involved in undertaking assessments will be required to have appropriate qualifications, skills and knowledge.

General Practitioners can access reimbursement through the MBS and payment through the Practice Incentives Program to undertake particular comprehensive health assessments and health checks.

### 3.5.4 What is expected from agencies providing Assessment?

This section sets out Victoria’s Practice Standards for ‘Assessment’. There is no right or wrong way to undertake an assessment, however, agencies are expected to meet the practice standards outlined below.

#### 3.5.4.1 Process Objectives – Assessment

To ensure that each consumer has access to appropriate assessments to meet their needs and service requirements.

#### 3.5.4.2 Consumer Outcomes and Good Practice Indicators – Assessment

Consumer Outcomes	Good Practice Indicators
Consumers are informed about: <ul style="list-style-type: none"> <li>■ the assessment process,</li> <li>■ why information is being collected and how that information will be used,</li> <li>■ their rights and responsibilities including access to their health records,</li> <li>■ the implications of providing and not providing information, and</li> <li>■ consent requirements.</li> </ul> Consumers are supported and empowered to participate in the assessment process. Consumers have direct access to assessments and referrals.	The practitioner explains to the consumer the rationale for collecting information and how that information will be used to assess their needs.
	The practitioner discusses with the consumer possible choices for support, including those provided by other agencies. This may involve the use of interpreters, translated material and culturally sensitive practice.
	The practitioner in collaboration with the consumer and their carer (if appropriate) identifies the full range of consumer issues and needs including opportunities for health promotion and opportunities for self management through the assessment process.
	The practitioner ensures the consumer is fully informed of the processes for decision-making and is encouraged and supported to actively participate in those processes.
	The practitioner uses appropriate assessment tools to determine the consumer’s needs, level of risk and priority of access to services or further referrals.
	The practitioner discusses options about alternative services with consumers who are not eligible for service and wherever possible refers the consumer on to a service(s) which meets their needs.
	The agency has in place an assessment process which meets accepted discipline specific practice and program requirements.
	The agency has in place a process for consumers who require ‘urgent services’ and who cannot wait for a formal assessment process to be completed.

### 3.5.5 Consumer Pathway through Assessment

The consumer pathway through the assessment process is set out in Diagram 8.

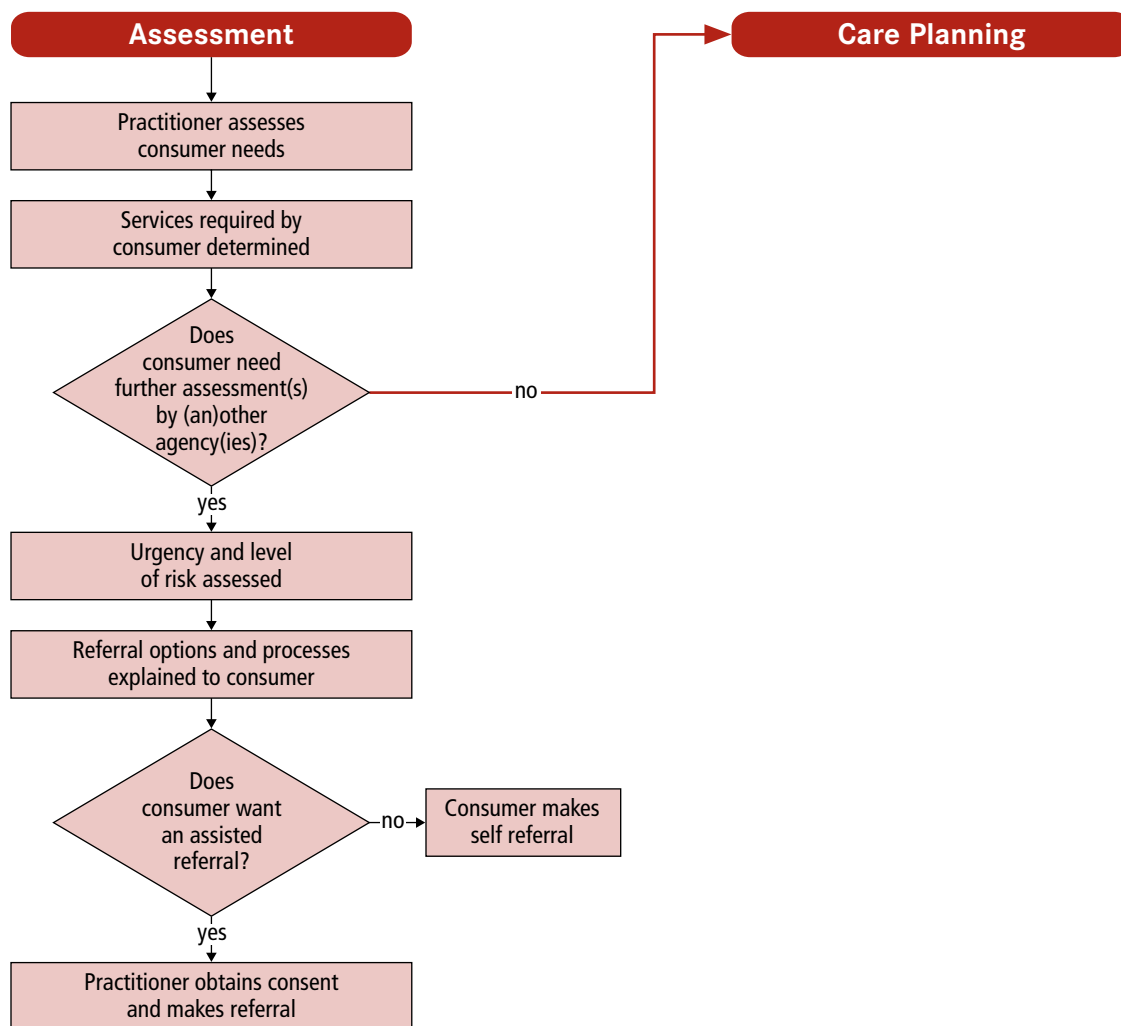
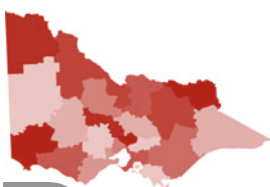


Diagram 8. Consumer Pathway through Assessment

### 3.5.6 System Tools – Assessment

- Program Guidelines, Requirements and Templates.
- Agency or service specific assessment policies, work instructions and tools.
- DHS Service Coordination Tool Templates.
- *Service Coordination Tool Templates 2006 user guide* and *Service Coordination Tool Templates 2006 reference guide*.
- The Human Services Directory and/or other relevant service directories.



### 3.6 Practice Standards: Care Planning

Care planning is a complex area, and the practice experience in Victoria will undergo significant development over the next 2 years, through the implementation of the Chronic Disease Management Program<sup>6</sup> and other policy directions which have prompted a focus on care planning.

The information presented in this section of the Manual has been drawn from the *Better Access to Services: A Policy and Operational Framework* and emerging good practice in Victoria. As evidence and good practice learnings from the Chronic Disease Management Program and other initiatives become available, the care planning practice standards contained in this Manual will be refined and further developed.

#### 3.6.1 What is Care Planning?

**Care Planning** is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting. Care planning involves the judgement/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, such as those consumers with a chronic disease.

Care Planning is dynamic and can occur at a number of levels.

A consumer accessing one service within an agency may have a **service specific care plan**. Service specific care plans are usually developed and documented using program or agency tools, and may be referred to as a Consumer Care Plan, an Individual Treatment Plan, a Self Management Plan, a Personal Action Plan, a Clinical Plan, or a Service Plan. Some examples of service specific care plans are listed below:

- A Drug and Alcohol Counsellor may develop an Individual Treatment Plan with a consumer which sets out agreed goals and service responses related to the consumer's alcohol dependency.
- A HACC Assessment Officer may develop a Care Plan with a consumer which details the services to be provided (days of the week, hours of service), Occupational Health and Safety requirements and service fees.
- A General Practitioner may develop a Management Plan with a consumer to provide structured care around the management of a chronic disease.

A consumer accessing more than one service from an agency, or receiving services from a number of practitioners from within the one agency, may require an *intra-agency care plan*. Intra-agency care plans are typically developed in agencies which provide a range of services such as Community Health and Hospitals. For example, an intra-agency care plan may be developed for a consumer with Diabetes, who is receiving services at the local Community Health Centre from the Podiatrist, Diabetes Nurse Educator and Dietitian. Some agencies use the Service Coordination Plan to document intra-agency care plans.

An intra-agency care plan is usually developed to:

- coordinate internal service provision,
- facilitate communication of agreed strategies and service interventions between the practitioners,
- articulate shared goals and outcomes,
- outline the roles and responsibilities of each practitioner, and
- identify the practitioner responsible for care coordination and/or case management.

<sup>6</sup> Funding has been provided to all PCPs by the Department of Human Services as part of its Integrated Chronic Disease Management (ICDM) initiative). Further information can be obtained from [www.health.vic.gov.au/communityhealth/publications/cdm\\_guidelines.htm](http://www.health.vic.gov.au/communityhealth/publications/cdm_guidelines.htm)

Where a consumer has complex or multiple needs and requires the services of more than one agency (eg. the consumer has a chronic disease), an **inter-agency care plan** should be developed. In this instance, care planning ensures that the needs of a consumer are discussed with them, their carer and other relevant practitioners such as their GP, in the context of possible options and subsequently worked through to an agreed strategy.

Where inter-agency care planning for a consumer with complex or multiple needs is led by a PCP member agency, the Service Coordination Plan should be used.

### 3.6.2 Where does Care Planning fit into Service Coordination?

A consumer may have a number of care plans. For example, a consumer with Diabetes may have a service specific care plan with the podiatrist, an intra-agency care plan to coordinate the services provided by the podiatrist, Diabetes Nurse Educator and Dietician. If the consumer is also receiving services from another agency/s and their GP, they should have an inter-agency care plan such as a Service Coordination Plan.

Care planning at all levels encompasses care coordination, case management, referral, feedback, review<sup>7</sup>, re-assessment<sup>8</sup>, monitoring and exiting.

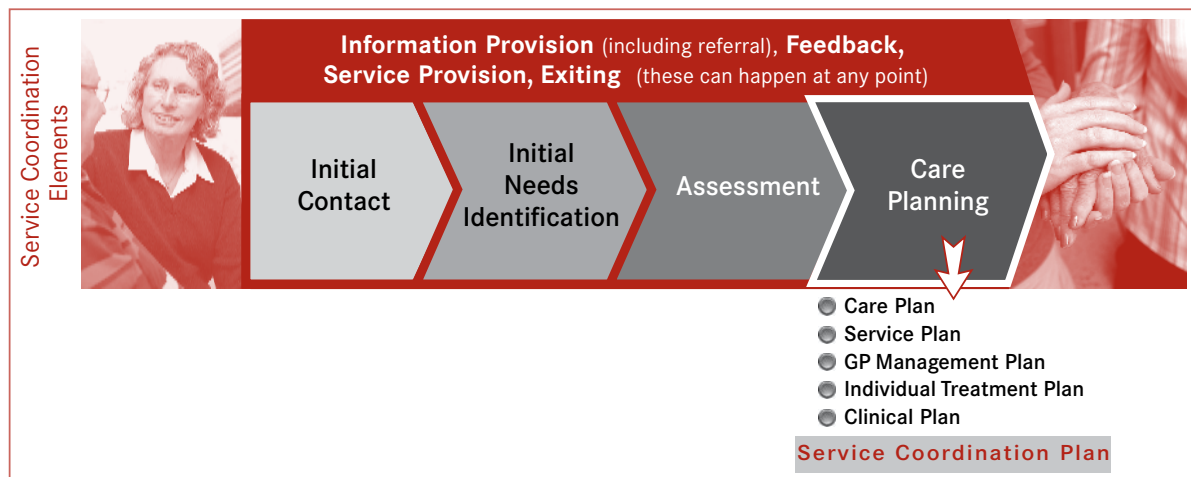


Diagram 9. Care Planning

The *Better Access to Services: A Policy and Operational Framework* identifies the following key features of care planning in Victoria:

- Nomination of a key worker/case coordinator/case manager for the consumer (one contact person instead of several) to promote effective communication. The key worker/care coordinator/case manager role is responsible for ensuring that the care plan is implemented, review dates are set, re-assessments are initiated where appropriate, and feedback is provided to a referring agency.
- Incorporation of the continuum of care management for consumers, including case management, where a consumer requires multiple services or has complex or multiple needs.
- Acknowledgement of the potential contribution of self management to effective care.

<sup>7</sup> Formal follow up of a consumer, usually on a date specified in the care plan, or due to a sudden change in the consumer's situation, where the suitability of the care plan in meeting the needs of the consumer is considered.

<sup>8</sup> 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 re-assessment process should mirror the original assessment in order to maximise identification of changes in the consumer. The outcome of re-assessment is a new care plan.

- Provision of effective monitoring (both formal and informal) of consumers' health and wellbeing and formal evaluation of the effectiveness of services being delivered eg. regular reviews.
- The requirement that referral information is received and acted upon by the practitioner to whom the referral is made, and that feedback is provided to the referrer.
- Maximising the opportunities inherent in the Federal government's MBS items, as this facilitates collaborative care planning with GPs.
- Use of the Service Coordination Plan Template for consumers with complex or multiple needs who require the services of more than one agency.

### 3.6.3 Which staff are involved in Care Planning?

Care Planning should be done by trained practitioners with the skills and competence to:

- engage and empower the consumer (and their family/carers if appropriate),
- draw together existing information such as assessments and care plans,
- develop and document a service specific care plan, intra-agency care plan and/or a Service Coordination Plan,
- implement the care plan including reviews and re-assessments as required,
- monitor the care plan,
- undertake care coordination,
- liaise and communicate with all key stakeholders including GPs,
- discuss exit options and procedures,
- provide feedback to referrers and other stakeholders eg. GPs, and
- ensure documentation and processes meet the requirements of the Health Records Act and other privacy legislation.

### 3.6.4 How can GPs be involved in Care Planning?

The involvement of General Practitioners in care planning for people with complex or multiple needs and/or chronic diseases is essential. The ways GPs can be involved in care planning are governed by the MBS Guidelines and general practice tools which have been developed to meet MBS rules. Importantly, GPs can be involved in care planning led by agencies, and/or they can lead care planning which involves other practitioners.

If a consumer has a chronic disease, or complex or multiple needs, practitioners should consider checking (with consent) if a consumer's GP has completed a GP Management Plan and/or Team Care Arrangements (TCA). If not, it might be appropriate to check if the GP is interested in initiating a TCA with a multi-disciplinary team.

Further information about how GPs can be involved in care planning can be obtained from your PCP, local Division of General Practice or from [www.health.gov.au/mbs/](http://www.health.gov.au/mbs/).

### 3.6.5 What is expected from agencies providing Care Planning?

This section sets out the Victorian Practice Standards for 'Care Planning' for consumers with complex or multiple needs who require the services of more than one agency.<sup>9</sup> There is no right or wrong way to conduct care planning however it is expected that agencies will meet the requirements set out below.

<sup>9</sup> Service specific care planning and intra-agency care planning should be guided by program or agency requirements and tools.

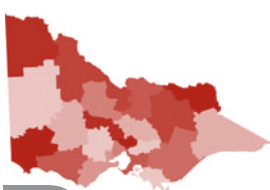
### 3.6.5.1 Process Objectives – Care Planning

To ensure that consumers with complex or multiple needs (who are receiving services from more than one agency) have access to care coordination, which:

- takes into account social, emotional, and health needs (not just the presenting issues),
- is based on documented needs, goals and actions,
- is consumer centred,
- encourages and empowers self management,
- has built in monitoring process and review dates, and
- is underpinned by communication between stakeholders.

### 3.6.5.2 Consumer Outcomes and Good Practice Indicators – Care Planning

Consumer Outcomes	Good Practice Indicators
<p>Consumers are informed about:</p> <ul style="list-style-type: none"> <li>■ the value of care planning, a Service Coordination Plan and care coordination,</li> <li>■ care planning options and processes,</li> <li>■ roles and responsibilities of the practitioners including the practitioner who will be fulfilling the key worker role,</li> <li>■ privacy, confidentiality and consent procedures and their right in relation to these procedures.</li> </ul> <p>Consumers (and when relevant, family members and carers) are empowered to participate in the development, implementation, monitoring and review of their service specific care plan, intra-agency care plan or Service Coordination Plan.</p> <p>Consumers have direct access to care planning and care management processes.</p>	<p>The practitioner explains to the consumer (and their carer if appropriate) the value of a service specific care plan, an intra-agency care plan and a Service Coordination Plan. This may involve the use of interpreters, translated material and culturally sensitive practice.</p>
	<p>The practitioner checks whether a Team Care Arrangement or a GP Management Plan is in place for a consumer with a chronic disease and/or complex or multiple needs.</p>
	<p>The practitioner ensures that the consumer and their carer are empowered to actively participate in all care planning processes.</p>
	<p>The practitioner initiates (with consent) the development of a Service Coordination Plan for consumers with complex needs and inter-agency involvement.</p>
	<p>The practitioner liaises with other relevant agencies and the consumer’s GP to develop, monitor and review the Service Coordination Plan.</p>
	<p>The practitioner informs the consumer (and his/her family/carer) of the roles and responsibilities of all stakeholders including the key worker.</p>
	<p>The practitioner documents needs, goals and actions for consumers with complex or multiple needs and inter-agency involvement in a Service Coordination Plan. A copy of the Service Coordination Plan which includes a review date is provided to the consumer and other relevant stakeholders such as the consumer’s GP.</p>
	<p>The agency is involved in an agreed process to nominate a key worker for consumers who have a Service Coordination Plan.</p>
	<p>The agency ensures that the key worker role is allocated and performed.</p>
	<p>The agency has in place a process for monitoring and reviewing consumer needs and updating care plans when a consumer’s/carer’s needs change.</p>
	<p>The agency has in place a process for exit or discharge and re-entry if required.</p>
	<p>The agency has in place a process for consumers who require ‘urgent services’ and who cannot wait for a formal assessment or care planning processes to be completed.</p>



### 3.6.6 Consumer Pathway through Care Planning

The consumer pathway through Care Planning is set out in Diagram 10.

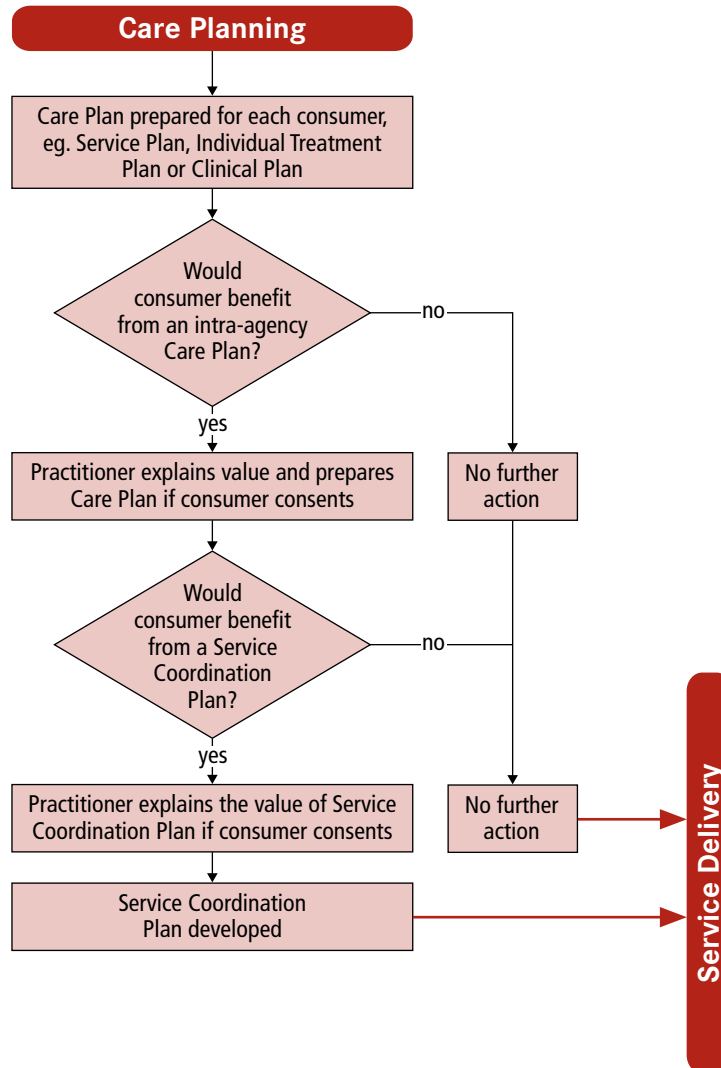
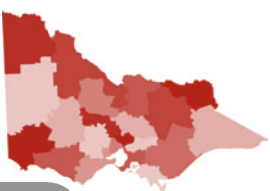


Diagram 10. Consumer Pathway through Care Planning

### 3.6.7 System Tools – Care Planning

- Agency or program Care Planning Guidelines and tools.
- Service Coordination Plan Template.
- *Service Coordination Tool Templates 2006 user guide* and *Service Coordination Tool Templates 2006 reference guide*.
- Agency: Eligibility Criteria, and Priority Access Policy.
- The Human Services Directory and/or other relevant service directories.
- The MBS.



Part 4

Referral Practice in Victoria



## Part 4. Referral Practice in Victoria

### 4.1 What is Referral?

Referral describes the transmission of personal and/or health information relating to an individual from one agency to another agency with the individual's consent and for the purpose of further assessment, care or treatment.

Referrals are made from all elements of Service Coordination. For example:

- A staff member involved in Initial Contact may refer a consumer on to another, or more appropriate, service.
- An INI practitioner may identify referrals as part of their screening role.
- Practitioners may identify further assessments and treatments required to meet a consumer's needs as part of the assessment process.
- Referrals often occur out of care planning.

As the needs of consumers change, further referrals may be required.

The Service Coordination Tool Templates were developed to support inter-agency referral. Practitioners should complete the SCTT in accordance with agency practice and the DHS *Service Coordination Tool Templates 2006 user guide* and *Service Coordination Tool Templates 2006 reference guide*.

While it is a requirement that referrals are made using the SCTT, practitioners are not required to complete all the SCTT Profiles before they make a referral. In most instances practitioners making a referral will complete the Consumer Information Template and the Summary and Referral Template and include other Templates or information when relevant.

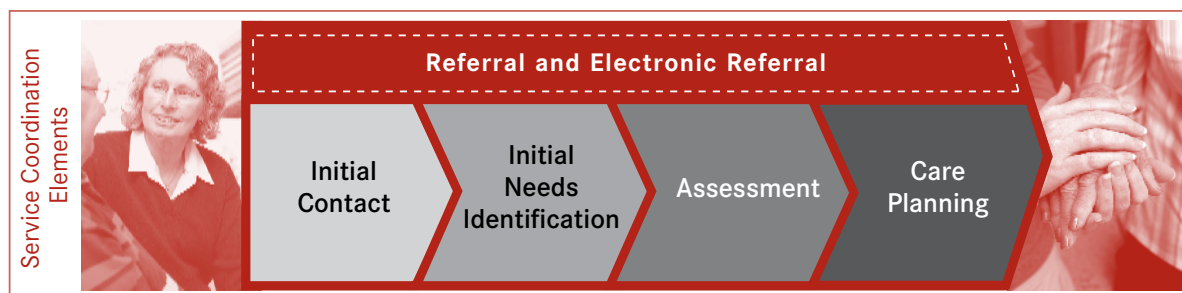
At times a practitioner may need to make an immediate referral such as when a consumer is in crisis, and follow this up with a more detailed referral using the SCTT.

Practitioners collect information from consumers for a variety of reasons (eg. to identify needs, to make a good quality referral, to undertake an assessment, to provide a service, for effective care planning, to meet data collection requirements, to meet program requirements, to ensure quality of service etc). However, practitioners should not collect information that is not relevant for their agency's practice. For example, collect another agency's minimum data set requirements.

### 4.2 Where does Referral fit into Service Coordination?

Referral may occur out of any or all of the elements of Service Coordination. A consumer may be referred for any of the following:

- Information eg. services available, health promotion, chronic disease management.
- Health Promotion activities, including groups and preventative support.
- Initial Needs Identification.
- Assessment or further Assessment.
- Service provision or treatment.
- The development of a Service Coordination Plan.
- Re-assessment, monitoring and review.



**Diagram 11. Referral**

There are two main types of referral.

#### *Self referral*

This is where a consumer takes responsibility for contacting another agency to make a referral on their own behalf. Where a consumer chooses to make a self referral, practitioners should support this choice by providing:

- information ie. agency contact details,
- advice and decision making support, and
- a copy of completed SCTT (if appropriate).

#### *Assisted referral*

This is where practitioners within the service system make a referral on behalf of a consumer. An assisted referral is usually made when a consumer chooses/wants to access this support and requires consumer consent. A practitioner making an assisted referral should use the SCTT. In some situations a practitioner may make an immediate referral such as when a consumer is in crisis (for example attempted suicide, serious self-harm, behaviour endangering self or others, threats of violence etc) and follow this up with a more detailed referral using the SCTT. In some circumstances a referral can be made without consumer consent, such as referrals to statutory services ie. Child Protection or specialist services ie. Mental Health, or where an immediate referral is in the best interests of the consumer.

### **4.3 Which staff are involved in Referral?**

All practitioners involved in Service Coordination and/or service delivery will make or receive referrals at some time. Therefore it is important that all practitioners are familiar with the Referral Practice Standards and their agency practice which governs how referrals between agencies will occur.

There are four key requirements for all practitioners making inter-agency referrals. They must:

- Make referrals in accordance with agency guidelines, policies, procedures and work instructions.
- Adhere to Victoria's Service Coordination Practice Standards.
- Use the SCTT. Some agencies also use the SCTT for making internal referrals.
- Meet the privacy and consent requirements.

A GP's main contact with agencies will be through referrals and collaboration on inter-agency care planning. General Practitioners are encouraged to use the Victorian Statewide Referral Form embedded in most GP Clinical Software, when making referrals to agencies. The Victorian Statewide Referral Form has many benefits for GPs and their patients, in particular:

- The multitude of agency specific referral forms are replaced by a single statewide referral form.
  - Referral processes are simplified using existing GP Clinical software.
  - Quality inter-professional communication is supported.

Further information about the Victorian Statewide Referral Form can be found at [www.health.vic.gov.au/pcps/publications/servcord](http://www.health.vic.gov.au/pcps/publications/servcord) or accessed via the GP's local Division of General Practice.

Feedback is a critical component of the Referral process. General Practitioners value feedback, and are particularly interested in receiving information that they need to act on, or be aware of, when they next see the consumer.

Your agency should have in place policies, procedures, tools and systems to support feedback to GPs and other referring agencies. In addition to acknowledging a referral that has been received, agencies are expected to provide feedback to referring agencies and the consumers GP about the referral outcomes. That is, relevant assessment findings, services or interventions which will be provided, care planning goals etc.

## 4.4 What is expected from agencies making and receiving Referrals?

This section sets out Victoria's Practice Standards for 'Referral'. There is no right or wrong way to implement referral, however it is expected that all agencies will meet the practice standards outlined in this Manual.

### 4.4.1 Process Objectives – Referral

The referral process aims to:

- Assist consumers in a seamless and timely manner by streamlining access to appropriate services through self referral or assisted referral.
- Empower consumers to participate in decisions about their care.
- Respect consumers' rights and privacy.
- Facilitate choice and understanding.
- Enable referrals to be conducted efficiently and effectively.
- Minimise risk and meet duty of care requirements.

Agencies will:

- Work in partnership.
- Take responsibility for agreed roles and tasks in a timely manner.
- Meet moral, ethical and legal obligations.
- Refer consumers, to the right service, at the right time, and right place.
- Aim to meet consumer needs and goals in respect to their quality of life.
- Operate in accordance with consent gained.
- Communicate statutory and duty of care arrangements.
- Operate within a quality and continuous improvement framework.

The *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide* suggest the following priorities for processing incoming referrals:

- **Low**, meaning 'hold over during peak demand'.
- **Routine**, meaning 'attend in date order'. This may include the consumer being placed on a waiting list.
- **Urgent**, meaning the referral 'cannot wait'. It is good practice to contact an agency prior to sending an urgent referral, to ensure the referral can be handled in a timely manner.

The Good Practice Indicators set out the expected response times for sending and actioning referrals. The phrase 'within no more than' is used because many agencies and program areas will send and action referrals within shorter timeframes.

#### 4.4.2 Consumer Outcomes and Good Practice Indicators – Referral

Consumer Outcomes	Good Practice Indicators
<p>Consumers are referred at the right time, to the right service to maximise health and well-being outcomes/ quality of life.</p> <p>Consumers are involved in decision making about their care and referrals.</p>	<p>The practitioner making a referral explains referral options and processes to the consumer. This may involve:</p> <ul style="list-style-type: none"> <li>■ assisting the consumer to identify their issues and define their needs,</li> <li>■ using interpreters, translated materials and culturally sensitive practice,</li> <li>■ sourcing information from the Human Services Directory and/or other relevant service directories, or calling the service/s directly,</li> <li>■ explaining waiting times and service limitations,</li> <li>■ discussing the pros and cons of self referral.</li> <li>■ offering to assist the consumer by making the referral on their behalf (particularly if the consumer finds their options confusing, distressing or frustrating),</li> <li>■ facilitating referrals and/or assisting with navigation and negotiation of the service system when appropriate,</li> <li>■ explaining the use of information for the purpose of referral and explaining options,</li> <li>■ providing the consumer with information about their rights including the option of sharing all, or some, information, and</li> <li>■ assisting the consumer to make an informed choice.</li> </ul>
	<p>The practitioner supports the consumer to make a self referral if they choose to do so, and may support the consumer by providing:</p> <ul style="list-style-type: none"> <li>■ information ie. agency contact details,</li> <li>■ advice and decision making support, and</li> <li>■ a copy of completed SCTT (if appropriate).</li> </ul>
	<p>The Practitioner making a referral:</p> <ul style="list-style-type: none"> <li>■ offers the consumer a copy of the <i>Your Information – it's Private</i> brochure or relevant agency information,</li> <li>■ completes the relevant sections of the SCTT,</li> <li>■ makes an assessment of risks faced by the consumer and/or staff,</li> <li>■ prioritises the referral as low, routine or urgent,</li> <li>■ sends referrals in accordance with the privacy requirements,</li> <li>■ transmits referrals using the electronic referral system or through secure fax/post/email,</li> <li>■ contacts the agency or practitioner receiving the referral (if appropriate) for the purpose of prioritising the referral, providing additional consumer information or to discuss assessment, care planning or service delivery options.</li> <li>■ may make an immediate referral ie. over the telephone, when a consumer is in crisis, and follow this up with a more detailed referral using the SCTT.</li> </ul>
	<p>The agency making a referral retains responsibility for the consumer until the referral acknowledgement is received, unless the receiving agency does not respond within the agreed timelines. If the receiving agency does not respond within agreed timelines, follow up by the sending agency is required to ensure the referral was received.</p>
	<p>The agency sending a referral is expected to:</p> <ul style="list-style-type: none"> <li>■ Send 'urgent' referrals within no more than 1 working day of obtaining consumer consent.</li> <li>■ Send 'low' or 'routine' referrals within no more than 7 working days of obtaining consumer consent.</li> <li>■ Send referral information using the SCTT.</li> <li>■ Make immediate referrals (eg. over the phone when a consumer is in crisis), and follow this up with a more detailed referral using the SCTT.</li> </ul>
	<p>The agency receiving a referral is expected to:</p> <ul style="list-style-type: none"> <li>■ Respond to 'urgent' referrals within no more than 2 working days of receipt.</li> <li>■ Respond to 'low' or 'routine' referrals within no more than 7 working days of receipt.</li> <li>■ Transmit a Referral Acknowledgement (to the agency which initiated the referral) within no more than 7 working days of receiving the referral stating the referral has been received, and either the estimated date of consumer assessment or the reason why the referral is not proceeding.</li> <li>■ Transmit information about the Referral Outcome (to the agency which initiated the referral) within no more than 14 working days of the consumer/carer being assessed.</li> </ul>

## 4.5 Consumer Pathway through Referral

The consumer pathway through Referral is set out in Diagram 12.

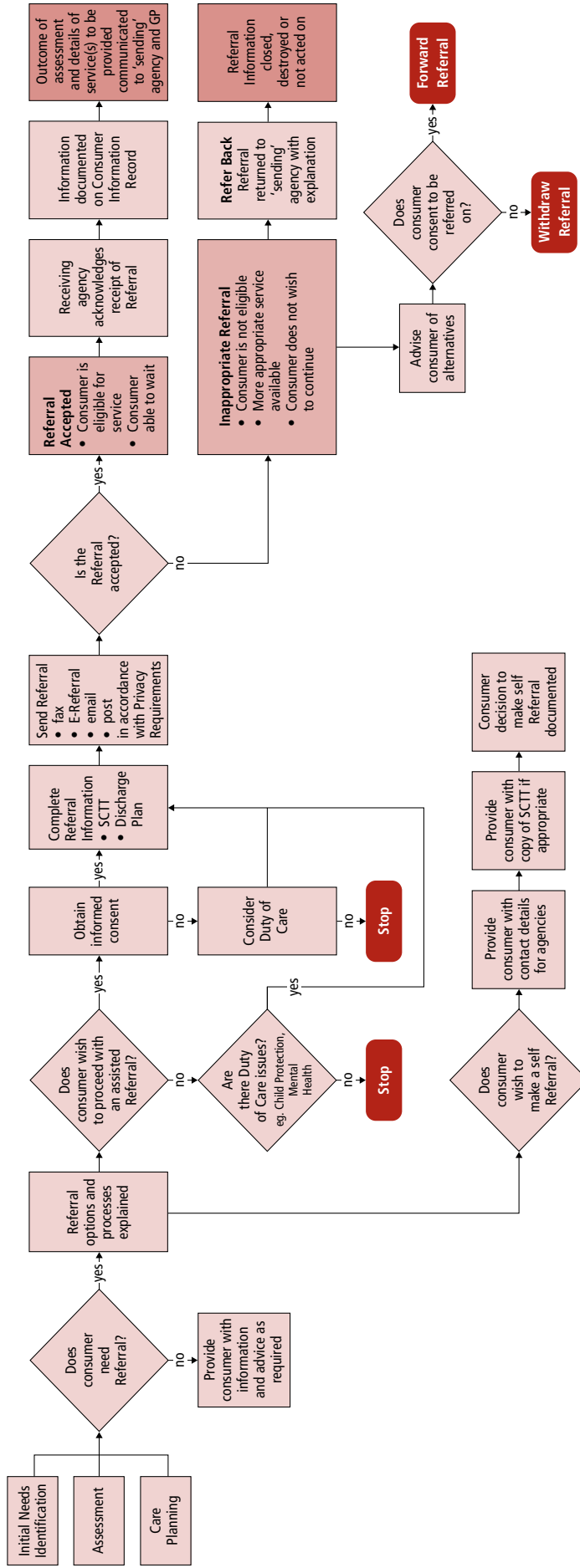
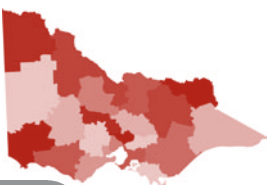


Diagram 12. Consumer Pathway through Referral

#### 4.6 System Tools

- The Service Coordination Tool Templates including The Confidential Referral Cover Sheet.
- The *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide*.
- The electronic referral systems.
- Patient/client management system software applications.
- Priority of Access Policy and Criteria.
- The Human Services Directory and/or other relevant service directories.



Part 5

Resources and Tools to Support  
Service Coordination



## Part 5. Resources and Tools to Support Service Coordination

### 5.1 What resources and tools are available to support Service Coordination?

A range of agency specific, regional and statewide resources and tools have been developed to support Service Coordination.

Service Coordination is supported at an agency level by:

- Agency specific policies, procedures and work instructions.
- Resources such as decision making tools, forms, resource folders and checklists.
- Information Technology and Telecommunications.
- Consumer management software applications.
- Information management processes and procedures related to service access, consumer registration and consumer records.
- Service directories such as the HSD.

Service Coordination is supported at a local and regional level by:

- Primary Care Partnerships.
- Locally agreed Service Coordination Protocols.
- Agreed referral pathways including the use of E-referral systems.
- Inter-agency networks and practitioner groups.

The Department of Human Services has developed a number of key resources to support the implementation of Service Coordination across Victoria. These include:

- The Human Services Directory.
- The Service Coordination Tool Templates, the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide*.
- Two Training packages:
  - *Service Coordination – What? Why? How?* – a self paced training module.
  - *Service Coordination Orientation Program*.
- The *Service Access Models: A Way Forward Resource Guide for Community Health Services*.
- Functional Specifications for the Service Coordination Tool Templates 2006.

### 5.2 How does the Human Services Directory support Service Coordination?

The statewide Human Services Directory comprises comprehensive and up-to-date service information to assist referral and access to services. Consumers, carers and practitioners may use the HSD to search for GPs, Dentists, and other health practitioners, and health/welfare services such as Community Health, Alcohol and Drug Services, Carer Services, and Psychiatric Disability Rehabilitation Support Services anywhere in the state of Victoria. Agencies are expected to maintain and update their service information on the HSD in accordance with the HSD Conditions of Use.

To view the Human Services Directory go to the following link and follow the prompts:  
[www.humanservicesdirectory.vic.gov.au](http://www.humanservicesdirectory.vic.gov.au).

### 5.3 How do the Service Coordination Tool Templates support Service Coordination?

The DHS Service Coordination Tool Templates have been designed to facilitate Service Coordination within and between agencies. They were developed for agencies to collect and share consumer information, undertake Initial Needs Identification, make referrals and document consumer consent to share information between agencies.

Importantly, the SCTT should support Service Coordination, not drive it. Use of the SCTT is determined by your agency's business processes and core responsibilities.

In most instances only some of the SCTT will be completed as part of a referral. Practitioners should not collect consumer information that isn't relevant for their agency's practice. For example a practitioner should not collect and document on the SCTT another agency's minimum data set requirements.

The Department of Human Services has produced the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide* to assist practitioners to complete the SCTT.

A copy of each of the SCTT, the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide* can be downloaded from [www.health.vic.gov.au/pcps/coordination](http://www.health.vic.gov.au/pcps/coordination).

General Practitioners (GPs) are encouraged to use the Victorian Statewide Referral Form embedded in most GP Clinical Software when making referrals to agencies. Further information about the Victorian Statewide Referral Form can be found at [www.health.vic.gov.au/pcps/publications/servcord](http://www.health.vic.gov.au/pcps/publications/servcord).

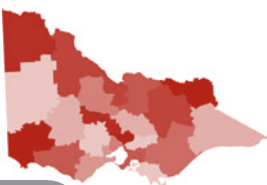
#### How does Initial Contact link with the Service Coordination Tool Templates?

The Consumer Information Template may be used at Initial Contact. In some agencies staff begin to collect and document Consumer Information at Initial Contact. In these agencies information such as 'Consumer Details' and 'Services Requested' is either hand written onto the Consumer Information Template or entered directly into the agency's consumer data base. The information required to complete the Consumer Information Template is usually collected during the INI phase, however in some agencies (such as Community Health), all the information may not be collected until a consumer presents for their first appointment. In hospitals Initial Contact information is likely to be collected by a Triage Nurse or on admission to hospital.

#### How does Initial Needs Identification link with the Service Coordination Tool Templates?

Initial Needs Identification is supported by the following Service Coordination Tool Templates:

- Consumer Information Template.
- Consumer Consent to Share Information Template. (A supporting privacy brochure is also available. The brochure and Consumer Consent Template are available in other languages.)
- Summary and Referral Information Template.
- Optional Profiles:
  - Living and Caring Arrangements Template.
  - Functional Profile Template.
  - Health Conditions Template.
  - Health Behaviours Template.
  - Psychosocial Template.



In some agencies information is collected and documented straight onto the SCTT by staff responsible for INI activities. In other agencies, information is collected and entered directly into the consumer data base, from which a SCTT can be produced and:

- printed and faxed or mailed,
- encrypted and emailed,
- sent via other secure electronic referral systems.

#### **How does Assessment link with the Service Coordination Tool Templates?**

Typically, each agency will have their own tools for assessment based on relevant program guidelines, requirements and templates.

Each service should be actively encouraged to consider how the SCTT fits with their assessment tools, to reduce any duplication.

#### **How does Care Planning link with the Service Coordination Tool Templates?**

The Service Coordination Plan Template is part of the suite of tools making up the SCTT. The Service Coordination Plan has been designed to support inter-agency care planning for consumers with complex or multiple needs.

The *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide* provide practitioners with a comprehensive guide to completing the Service Coordination Plan.

#### **How does Referral and Referral Feedback link with the Service Coordination Tool Templates?**

Referral is supported by all the SCTT. In addition to the templates listed above, the Functional Assessment Summary Template can be used to transfer assessment level information after a face-to-face assessment of the consumer's functional status. If this template is used for referral, there is no need to also send the Functional Profile.

Further information about how to use the SCTT can be found in the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide* at [www.health.vic.gov.au/pcps/coordination](http://www.health.vic.gov.au/pcps/coordination).

### **5.4 How does electronic referral support Service Coordination?**

The electronic referral systems support Service Coordination by:

- encouraging good communication between agencies by providing an opportunity to easily send a referral, acknowledge the referral and inform on referral outcomes,
- reducing duplication of information and improving the quality and consistency of information exchanged, and
- enhancing and improving the security of consumer information, privacy and confidentiality.

### **5.5 How does the Confidential Referral Cover Sheet support Service Coordination?**

The Confidential Referral Cover Sheet can be used as:

- A cover sheet to accompany the SCTT when making a faxed referral.
- A tool for acknowledging receipt of a referral.
- A communication tool for informing referring agencies or GPs about the outcome/s of a referral.

It is expected that practitioners:

- Faxing referrals will complete the relevant sections of the Confidential Referral Cover Sheet.
- Receiving a faxed referral will complete the Referral Acknowledgement section of the Confidential Referral Cover Sheet and return to referrer.

Practitioners using electronic referral systems will not need to use the Confidential Referral Cover Sheet, as the data requirements are built into electronic referral systems. Copies of the Confidential Referral Cover Sheet can be found at [www.health.vic.gov.au/pcps/coordination](http://www.health.vic.gov.au/pcps/coordination).

## 5.6 How do the DHS Training Packages support Service Coordination?

The Department of Human Services has developed two training packages to support the implementation of Service Coordination across Victoria. They are the:

- Self paced training module, *Service Coordination – What? Why? How?*
- *Service Coordination Orientation Program*.

### Service Coordination – What? Why? How?

*Service Coordination – What? Why? How?* is a self paced interactive training package for practitioners involved in Service Coordination activities. The package comprises five interactive learning modules which can be tailored to the roles and responsibilities of staff involved in Service Coordination. The package has been designed to be incorporated in an agency's induction program and provides learners with:

- An understanding of the policy context, objectives, principles and practical approaches of Service Coordination in Victoria.
- An awareness of how Service Coordination enhances services' capacity to respond to consumers' and carers' needs.
- An understanding of the benefits of Service Coordination.
- An overview of the elements of Service Coordination including Initial Contact, INI, Assessment, and Care Planning.
- An overview of how Referral fits within Service Coordination.
- An understanding of the resources available to support Service Coordination including the SCTT.
- A general understanding of Practices, Processes, Protocols and Systems (PPPS) and their role in guiding agency practice.

The *Service Coordination – What? Why? How?* training resource can be accessed at [www.health.vic.gov.au/pcps/coordination/module/module](http://www.health.vic.gov.au/pcps/coordination/module/module).

### Service Coordination Orientation Program

The Service Coordination Orientation Program was developed to be used in regional 'Train the Trainer' sessions for PCP member agency staff. The kit was then provided to these staff members to enable them to run training sessions and/or use the resources in their own agencies.

The key objectives of the program are for participants to:

- Develop an understanding of the policy context, principles and practical approaches of a Service Coordination system.
- Develop an understanding of how Service Coordination enhances services' capacity to respond to consumers' and carers' needs.
- Understand the elements of Service Coordination and the SCTT and Guidelines that support these.
- Promote the capacity of reflective practitioners who may apply their knowledge within any community, organisational or cultural context.
- Maximise learning opportunities, particularly through experiential learning.
- Build a sustainable skill base and increase local capacity for local PCP agencies to deliver courses that ensure relevance for participants.

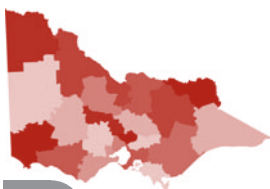
A copy of the Service Coordination Orientation Training Package can be downloaded from [www.health.vic.gov.au/pcps/coordination/orientation.htm](http://www.health.vic.gov.au/pcps/coordination/orientation.htm).

### 5.7 Where to learn about Service Coordination

In addition to this resource, there are a number of other resources that can assist you to learn about Service Coordination (see chart below). Copies of these resources can be found at [www.health.vic.gov.au/pcps/coordination](http://www.health.vic.gov.au/pcps/coordination).



Diagram Source: Department of Human Services



# Project Participants

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## Project Participants

### Introduction

This section provides details of those individuals who, and program areas which, contributed to the development of the Manual. In addition, representatives from over 250 agencies participated in the project consultations (June/July 2006) and/or provided feedback on the draft documents circulated in August, September and November 2006.

### Project Management Group

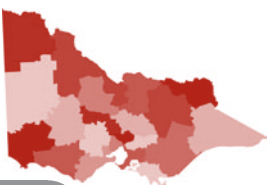
	Name:	Organisation:
Chairperson	Clare Amies	Statewide PCP Chairs Working Group
Project Manager	Jonathan Pietsch	Statewide PCP Chairs Working Group
Department of Human Services	Jenk Akyalcin	Department of Human Services
	Kim Marr	Department of Human Services

### Project Consultants

Juliet Frizzell, Effective Change Pty Ltd and Dr Ro Saxon, HDG Consulting Pty Ltd.

## Steering Committee Members

Region:	Name:	Organisation:
Gippsland Region	Pat Lovelock	Gippsland Latrobe Community Health Service
	Kirk Warren	South Coast Health Services Consortium
Loddon Mallee Region	Catherine Fuller	Central Victorian Health Alliance
	Lisa Delaney	Central Victorian Health Alliance
	Monique Baxter	Bendigo Health
North and West Metro Region	Judy Gregurke	Brimbank Melton PCP
	Jim Karabinis	Moonee Valley Council
	Vicky Mason	Darebin Community Health Service
	Danielle Clayman	North Central Metropolitan PCP
Southern Metro Region	Sarah Brown	Greater Dandenong Community Health Service
	Barry Hahn	Inner South East Partnership in Community and Health
Eastern Metro Region	Sabine Hauesler	Villa Maria
	Jonathan Pietsch	Inner East PCP and Executive Officer of the Statewide PCP Chairs Working Group
	Christopher Foley-Jones	Inner East PCP
Barwon South West	Margaret Sinnott	South West Alliance of Rural Health
	Fiona Torpy	South West Healthcare
Grampians Region	Kate Serrurier	Grampians Pyrenees PCP
	Kate Astbury	Grampians Pyrenees PCP
Hume Region	Neil Stott	Goulburn Valley PCP
	Daniel Whiting	Upper Hume/Central Hume PCP
Statewide	Sonya Tremellen	GPDV
	Jane Morehen	RDNS
DHS	Lesley Hubble	Department of Human Services
	Michelle Kotis	Department of Human Services
	Dean Williams	Department of Human Services
	Carol Pyke	Department of Human Services
	Kim Marr	Department of Human Services
	Jane Canaway	Department of Human Services
	Jenk Akyalcin (from August 2006)	Department of Human Services
	Judith Perrin (until August 2006)	Department of Human Services
Chairperson	Clare Amies	Statewide PCP Chairs Working Group



### DHS Internal Reference Group

- Office for Health Information Systems.
- Mental Health.
- Office for Children.
- Chronic Disease Management, Primary Health.
- Drugs Policy and Services.
- Cancer and Palliative Care, Programs Branch.
- Partnerships, Primary Health.
- Community and Women's Health.
- State-wide Emergency Program, Access and Metropolitan Performance.
- Child Protection, Loddon Mallee Region
- Dental Health.
- Public Housing and Community Building.
- Outpatients Framework, Quality and Safety.
- Post-acute care, Sub-acute care, HARP-CDM, Programs Branch.
- Grampians Region
- HACC, ACAS and Assessment Unit, Aged Care.
- Service Development, Aged Care
- Homelessness Services.
- Disability Services.

