

Good Practice Guide for Practitioners

A resource of the Victorian Service Coordination Practice Manual



A STATEWIDE PRIMARY CARE PARTNERSHIPS INITIATIVE

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What's in the Practitioner's Guide?

The Practitioner's Guide sets out the agreed good practice for the implementation of Service Coordination across Victoria.

Who is the Practitioner's Guide for?

This document *Good Practice Guide for Practitioners* has been designed for practitioners involved in the implementation of Service Coordination. It is based on the *Victorian Service Coordination Practice Manual* and complements the *Continuous Improvement Framework*. Copies of these documents can be downloaded from www.health.vic.gov.au/pcps/publications.

How was the Practitioner's Guide developed?

This Guide was developed as part of the Statewide Service Coordination Practice Manual Project undertaken in 2006. The project was initiated by the Statewide Primary Care Partnership Chairs' Working Group with funding from the Department of Human Services Primary Health Branch.

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 within PCPs.

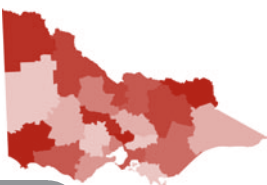
The terminology used by the various program areas and practitioners differs significantly, for example the terms consumer, client and patient can be used to describe an individual receiving care concurrently from a General Practitioner, Alcohol and Drug Counsellor, Social Worker, Podiatrist and Community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

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

Acronyms

The following acronyms are used in this Guide

DHS	Department of Human Services
GP	General Practitioner
INI	Initial Needs Identification
MBS	Medicare Benefits Schedule
PCP	Primary Care Partnership
SCTT	Service Coordination Tool Templates



1. Introduction

1.1 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.¹

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

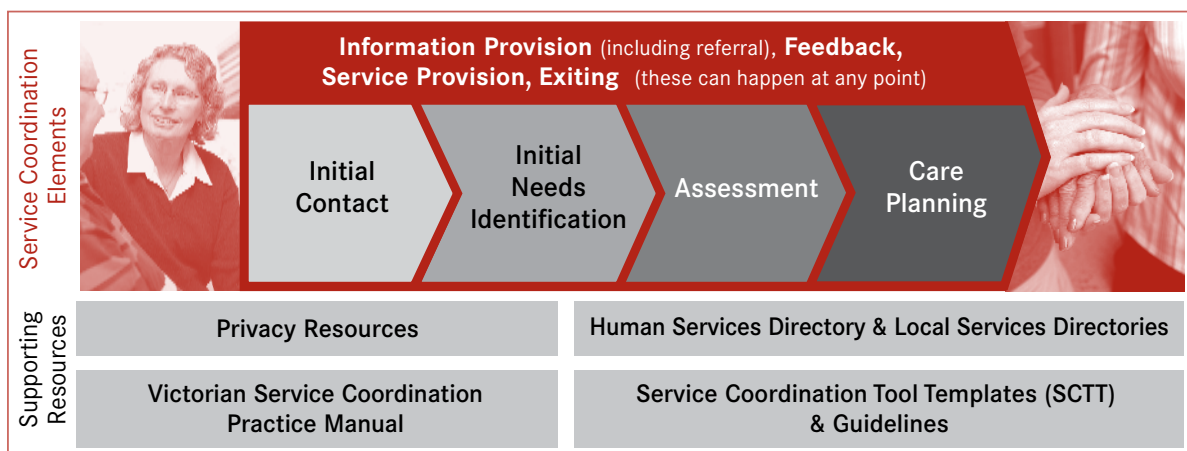


Diagram 1. Service Coordination Elements and Supporting Resources

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 living in 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 Initial Needs Identification), it is important that as a practitioner you know where consumers can be referred to for these services.

General Practitioners (GPs), 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”.²

A summary of the Victorian Service Coordination Practice Standards is set out in this Guide. Further information can be found in the **Victorian Service Coordination Practice Manual**. A copy can be obtained from www.health.vic.gov.au/pcps/publications.

¹ *Better Access to Services: A Policy and Operational Framework, p.1, DHS, June 2001.*

² Royal Australian College of General Practitioners (RACGP) Council 2001.

1.2 What tools and resources 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:

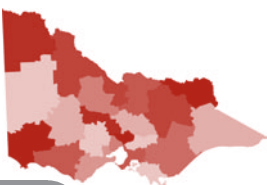
- Agency specific policies, procedures and work instructions.
- Information Technology and Telecommunications.
- Consumer management software applications.
- Information management processes and procedures related to service access, consumer registration and consumer records.
- Service directories such as the Human Services Directory.

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 electronic 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 the state. These include:

- The Human Services Directory (HSD).
- The Service Coordination Tool Templates, the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide* which can be viewed or downloaded from www.health.vic.gov.au/pcps/coordination.
- The self paced training module, *Service Coordination: What? Why? How?* which can be viewed at www.health.vic.gov.au/pcps/coordination/module/module.
- *Service Access Models: A Way Forward Resource Guide for Community Health Services* which can be downloaded from www.health.vic.gov.au/pcps/publications.



2. Practice Standards: Initial Contact

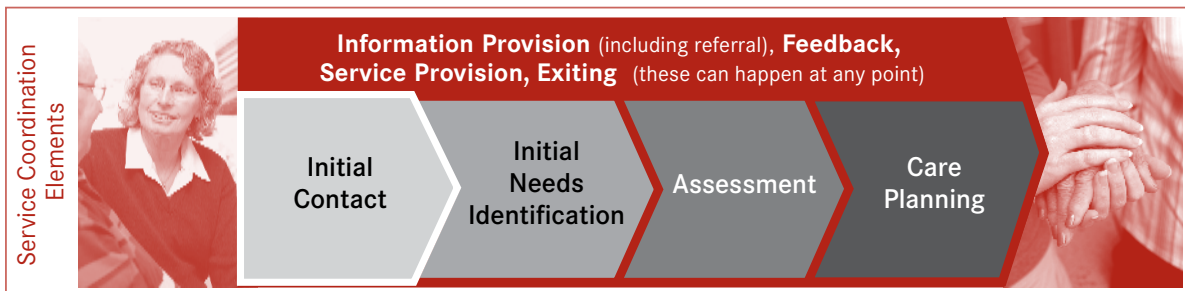


Diagram 2. Initial Contact

All agencies provide some Initial Contact. **Initial Contact** is the point at which a consumer makes his or her first contact with the service system and will most commonly include:

- the provision of agency and/or service information eg. available services, eligibility criteria and service access/intake processes,
- the provision of other information such as health promotion literature from the agency or via websites such as the Better Health Channel, and
- direct access to services via an Initial Needs Identification (INI) either at your agency or another agency/ service.

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 Initial Needs Identification process has commenced.

This Service Coordination element (**Initial Contact**) supports service access ie. it provides information that helps direct consumers into the service system in an efficient, timely and sensitive manner.

2.1 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.

2.2 What can consumers expect from agencies providing Initial Contact?

Agencies are expected to provide access to Initial Contact within 1 working day of a consumer contacting the agency. In addition consumers can expect to:

- Receive a timely response and appropriate information at Initial Contact.
- Be informed about:
 - the services available and eligibility criteria,
 - entry and Initial Needs Identification processes,
 - their rights and responsibilities in relation to accessing services.

- Be empowered to make informed choices about the service system and referrals, through the provision of accurate and appropriate information.
- Have access to INI, assessment and referrals.
- Experience a coordinated, planned, culturally sensitive and reliable service at Initial Contact.

2.3 Good Practice Guidelines for Workers



- Greet/welcome consumer and ask what they require help with.
- Provide information about the services in your agency and the services available at other agencies, using the Human Services directory and/or other relevant service directories.
- Listen to the consumer in a sensitive and non intrusive manner.
- Source an interpreter or advocate if required.
- Direct or assist consumer to proceed to Initial Needs Identification, Assessment or Referral as appropriate.
- Provide consumer with information in a manner which enables the consumer to make informed choices and decisions about accessing INI or further referral/s.
- Provide consumer with copies of relevant information.
- Assist the consumer by making the referral on their behalf (an assisted referral), if they find their options confusing, distressing or frustrating.
- Assist a consumer to make a self referral by providing agency contact details etc.

3. Practice Standards: Initial Needs Identification

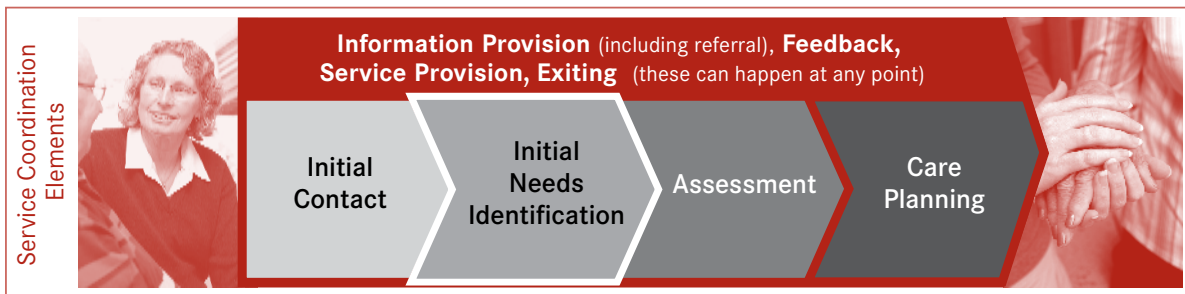


Diagram 3. Initial Needs Identification

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 **Initial Needs Identification** 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.

This Service Coordination element supports referrals by offering screening that helps identify consumer needs in an efficient, timely and sensitive manner.

3.1 Which staff are involved in Initial Needs Identification?

Initial Needs Identification is usually carried out by a trained practitioner, with a high level of interpersonal skills, and the skills to identify, respond to, and prioritise a broad range of service needs.

Initial Needs Identification happens differently in every agency and across funding 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 **Initial Needs Identification** 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.

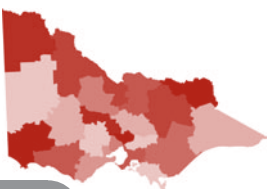
It is essential that all consumers living in Victoria can easily access the **Initial Needs Identification** process when required. If your agency does not provide this service, it is important that as a practitioner you know where consumers can be referred to for an **Initial Needs Identification**. The types of agencies which provide INI include Community Health and Aged Care Assessment Services.

3.2 What can consumers expect from agencies providing Initial Needs Identification?

Agencies are expected to commence an **Initial Needs Identification** within no more than 7 days of Initial Contact by a consumer. Where an agency does not provide **Initial Needs Identification**, if a consumer needs this service, practitioners should refer them to an agency which conducts **Initial Needs Identification** within 7 working days of Initial Contact.

Consumers can expect to:

- Be informed about:
 - the **Initial Needs Identification** process,
 - why information is being collected and how that information will be used,
 - their rights and responsibilities including access to their health records,
 - the implications of providing and not providing information, and
 - consent requirements.
- Receive support and assistance to determine their issues, identify their needs and options available.
- Have their needs identified in a timely manner, for the purpose of screening for service needs.
- Have access to appropriate assessments and referrals, including assisted referrals.
- Experience coordinated, planned, culturally appropriate and reliable service at **Initial Needs Identification**.



3.3 Good Practice Guidelines for Workers



- Undertake a skilled process of inquiry with the consumer about their health and wellbeing needs including the consumer's social, psychological, medical and physical aspects as appropriate. This may require you to explore issues other than the presenting issues.
- Collect information in a sensitive manner, with particular regard to cultural requirements, language issues, special communication needs, privacy, confidentiality and anonymity. Source an interpreter or advocate if required.
- Assist consumers to determine their issues, identify their needs and refer on if required.
- Screen for service requirements, risk, priority of access and opportunities for health promotion.
- Provide information about services and discuss potential service options.
- Recommend an appropriate course of referral action ie. for a service/s or recommend health promotion literature or strategies.
- Be cognisant of the consumer's right to refuse recommended referrals and services, and discuss other options.
- Consider Duty of Care and Mandatory Reporting requirements.
- Ensure consumers who only require an appointment or access to a specific assessment are able to access the assessment or service without intrusive questioning.
- Use the Human Services Directory and/or other relevant service directories to access current information on services available, eligibility criteria and waiting times.
- Complete relevant sections of the Service Coordination Tool Template (SCTT) if you need to make a referral.
- Complete the Service Coordination Tool Templates in accordance with the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide*.
- Explain the consumer's privacy rights.
- Obtain and document the consumer's consent to sharing of information with other agencies for referral.
- Make referrals using the electronic referral system or via fax using the Confidential Referral Cover Sheet.

4. Practice Standards: Assessment

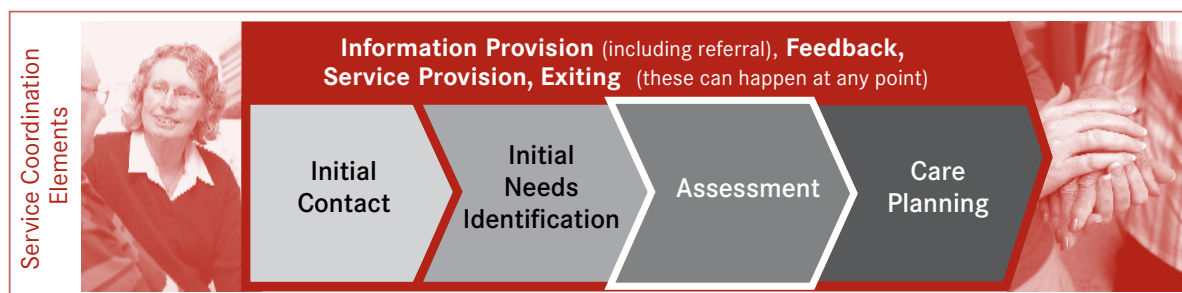


Diagram 4. Assessment

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.

4.1 Which staff are involved in Assessment?

Assessments are always undertaken by a trained practitioner, whose role and expertise is dedicated to that particular area of service delivery. All agencies are funded and structured differently:

- In some agencies, the **Assessment** element is separate to that of the preceding Service Coordination element of INI.
- In other agencies, an individual practitioner may undertake an INI before proceeding to an **Assessment**.
- The elements may be completed on the same day, or on different days over time, depending on the capacity of the practitioner and the complexity of the issues.

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

4.2 What can consumers expect from agencies providing Assessment?

Consumers can expect to:

- Be informed about:
 - the **Assessment** process,
 - why information is being collected and how that information will be used,
 - their rights and responsibilities including access to their health records,
 - the implications of providing and not providing information, and
 - consent requirements.
- Actively participate in determining their issues and assessing their needs.
- Actively participate in the planning of interventions that are solution focused.
- Have direct access to further **Assessments**, Care Planning and Referrals.
- Experience coordinated, planned, culturally appropriate, timely and reliable **Assessment**.

4.3 Good Practice Guidelines for Workers

✓	<ul style="list-style-type: none"> ■ Undertake a skilled process of Assessment based on program, agency and professional guidelines. ■ Collect information in a sensitive manner, with particular regard to cultural requirements, language issues, special communication needs, privacy and confidentiality and anonymity. ■ Assist the consumer to actively participate in determining their issues, identifying their needs and planning solution focused interventions. ■ Provide information about the interventions, treatments or therapies available through your service or other agencies. ■ Utilise the Human Services Directory and/or other relevant service directories to access current information about services available, eligibility criteria and waiting times. ■ With the consumer's consent consult and share information with other practitioners as necessary. ■ Consider Duty of Care and Mandatory Reporting requirements. ■ If further referral is required, complete relevant sections of the Service Coordination Tool Templates (SCTT). ■ Feedback referral outcomes such as assessment findings, treatment goals and agreed interventions to the agency which initiated the referral, the consumer's GP and other stakeholders, using the electronic referral system, Confidential Referral Cover Sheet or other agreed process.
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5. Practice Standards: Care Planning

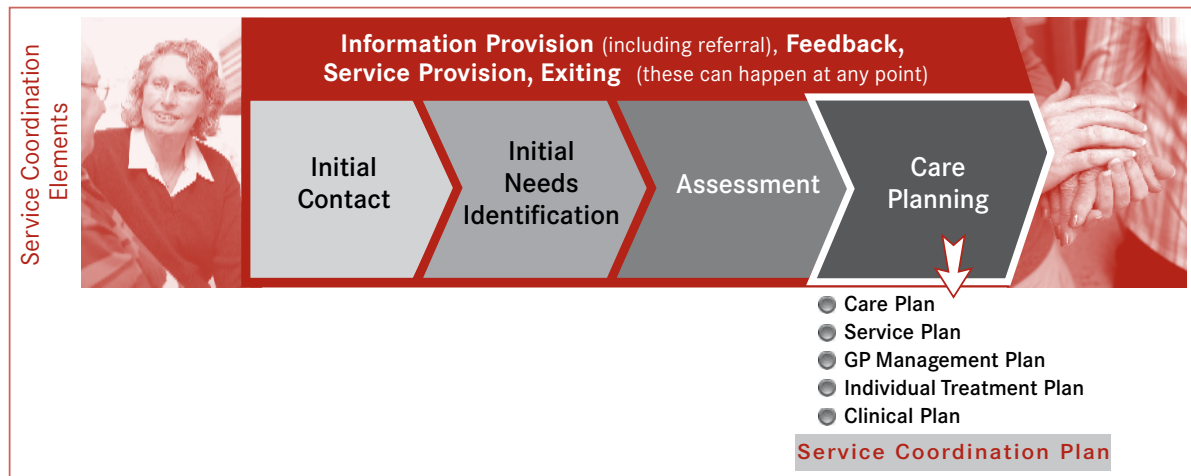


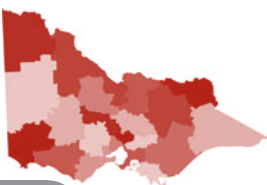
Diagram 5. Care Planning

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. **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.

Where a consumer has complex and 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.

5.1 Which staff are involved in Care Planning?

Care Planning should be carried out 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,
- undertaken 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.

How are GPs involved in care planning?

The involvement of General Practitioners (GPs) 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 is 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.

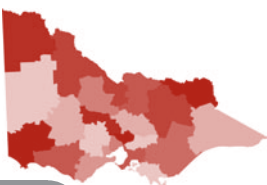
If a consumer has a chronic disease, and/or complex or multiple needs, practitioners should consider checking (with consent) if a consumer's GP has completed a GP Management Plan and/or Team Care Arrangements (TCA). If not, it might be appropriate to check if the GP is interested in initiating a TCA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

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

5.2 What can consumers expect from agencies providing Care Planning?

Consumers can expect to:

- Be informed about:
 - care planning options and processes,
 - the value of a Service Coordination Plan and care coordination,
 - the roles and responsibilities of the various practitioners, in particular the key worker role,
 - privacy, confidentiality and consent procedures and his/her rights in relation to these procedures.
- Be empowered to participate in the development, implementation, monitoring and review of their service specific plan, intra-agency care plan or inter-agency care plan eg. Service Coordination Plan.
- Be certain that information is collected, stored, shared and updated in accordance with the Health Records Act and other privacy requirements.
- Experience coordinated, planned, culturally appropriate and reliable care planning and care coordination.



5.3 Good Practice Guidelines for Workers

- Refer to documentation generated through the Initial Contact, INI and assessment processes.
- Complete a service specific care plan for each consumer.
- Discuss care planning options (including intra-agency care plans and/or inter-agency care plans) with the consumer.
- Where a consumer has a chronic disease and/or complex or multiple needs, check (with consent) if a consumer’s GP has completed a GP Management Plan and/or Team Care Arrangements.
- Coordinate the development of a Service Coordination Plan for consumers with complex or multiple needs and multiple agency involvement.
- Empower the consumer to participate in the development, implementation, monitoring and review of their Service Coordination Plan.
- Ensure a key worker is identified for consumers with an inter-agency care plan eg. Service Coordination Plan.
- Obtain consent to share the Service Coordination Plan and other consumer information with other agencies if required.
- Provide a copy of the Service Coordination Plan to other agencies, the consumer’s GP and the consumer.
- If you are the key worker, coordinate:
 - the implementation of the Service Coordination Plan including reviews and re-assessments,
 - any monitoring activities,
 - care,
 - the liaison and communication with key stakeholders such as the GP and organise Case Conferences etc if required,
 - the development of exit options and procedures, and
 - information management processes to meet the requirements of the Health Records Act and other privacy legislation.
- Participate in Care Planning initiated by other practitioners or the consumer’s GP.

6. Practice Standards: Referral

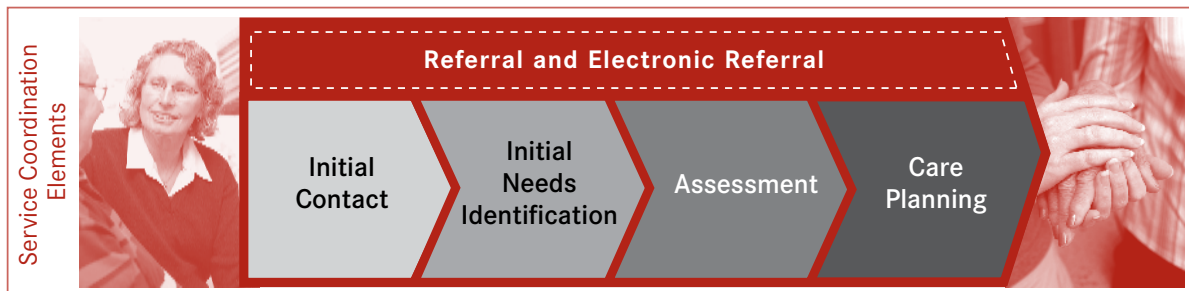


Diagram 6. Referral

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

Referrals can be 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.
- At INI, the practitioner may identify additional 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.

Referrals can also occur at any time during an episode of care, particularly in response to changing consumer needs.

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

There are two main types of referral.

A **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 Service Coordination Tool Templates (if appropriate).

An **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.

The *Service Coordination Tool Templates 2006 user guide* specifies 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.

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.

Copies of the SCTT, the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide* can be found at 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 or via your local Division of General Practice.

6.1 Which staff are involved in Referral?

All staff involved in Service Coordination and/or service delivery may make or receive a **Referral** at some time. Therefore it is important that all staff are familiar with Victorian Referral Practice Standards and agency requirements which govern how **Referrals** between agencies will occur.

There are four key requirements for all staff making inter-agency **Referrals**. Staff must:

- Make **Referrals** in accordance with agency guidelines, policies, procedures and work instructions.
- Use the SCTT to share consumer information when making **Referrals** and prioritise referrals as low, routine or urgent. The SCTT should be completed in accordance with the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide*.
- Meet the privacy and consent requirements.
- Utilise local or regional systems such as using the E-referral system.

6.2 What can consumers expect from agencies making and receiving Referrals?

The agency sending a referral is expected to:

- Send 'urgent' referrals within no more than 1 working day of obtaining consumer consent.
- Send 'low' or 'routine' referrals within no more than 7 working days of obtaining consumer consent.
- Send referral information using the SCTT.
- Make immediate referrals (for example over the telephone) when a consumer is in crisis, and follow this up with a more detailed referral using the SCTT.

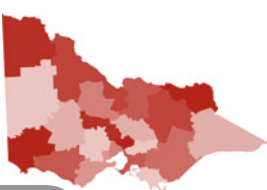
The agency receiving a referral is expected to:

- Respond to 'urgent' referrals within no more than 2 working days of receipt.
- Respond to 'low' or 'routine' referrals within no more than 7 working days of receipt.
- 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.
- Transmit information about the Referral Outcome (to agency which initiated the referral) within no more than 14 working days of the consumer being assessed. Referral outcome information may include relevant assessment findings, services or interventions which will be provided, care planning goals etc.

All agencies are expected to:

- Ensure consumers are referred at the right time, to the right service to maximise health and wellbeing outcomes and quality of life.
- Assist consumers with navigating and negotiating the service system, in particular when a consumer elects to make a self referral.
- Liaise and communicate with other agencies and GPs as required.
- Assist consumers in a seamless and timely manner by streamlining access to appropriate services through self referral or assisted referral.

Local Protocols may include specific referral requirements such as how to use the E-referral systems and required turn-around-times for specific program areas. Check with your local PCP.



6.3 Good Practice Guidelines for Workers



- When making a referral:
 - Organise an interpreter or advocate if necessary.
 - Explain referral options to the consumer.
 - Consult the Human Services Directory and/or other relevant service directories if required.
 - Obtain informed consent before making a referral.
 - Consider Duty of Care and Mandatory Reporting requirements.
 - Complete the relevant sections of the SCTT in accordance with the *Service Coordination Tool Templates 2006 user guide* and the *Service Coordination Tool Templates 2006 reference guide*.
 - Identify the level of priority for each referral using the SCTT priority definitions ie. low, routine, urgent.
 - Send referral in accordance with privacy requirements.
 - Inform consumer of expected waiting time and provide information on alternative options.
- When you have an ‘urgent’ referral, it is good practice to make contact with the agency which will be the recipient of that referral to ensure it has the capacity to respond. If you are unable to make contact with the agency or the agency does not have the capacity to respond to the referral, then alternative arrangements should be sought.
- When receiving a referral:
 - Acknowledge receipt of referral using your electronic referral system or the Confidential Referral Cover Sheet.
 - Return inappropriate Referrals to the ‘sending’ agency with an explanation.
 - Communicate information about referral outcomes to the ‘sending’ agency and GP.
- Encourage GPs to use the Victorian Statewide Referral Form.
- When a consumer chooses to make a self referral:
 - Provide consumer with contact details for agencies.
 - Provide consumer with a copy of the completed SCTT if requested.
 - Document the consumer’s decision to make self-referral.

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.



Diagram Source: Department of Human Services

