



**INTERAGENCY CARE PLANNING PROTOCOL
PILOT PROJECT REPORT
November 2005**

**A NORTH AND WEST PRIMARY CARE
PARTNERSHIP ALLIANCE
SERVICE COORDINATION PROJECT**

**AUSPICED BY MOONEE VALLEY MELBOURNE
PRIMARY CARE PARTNERSHIP**



This Project was funded by the North West Department of Human Services Aged Care Program as a Regional Development Initiative. The Project was auspiced by the Moonee Valley Melbourne PCP and facilitated by Deb Warren (Community Services Consultant and Trainer)

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EXECUTIVE SUMMARY

This Project was the first step in ongoing development of the Care Planning component of Service Coordination in the North West Region.

The Project objectives included the development of practices and processes around multi-agency Care Planning including operationalising the Service Coordination Plan and determining the role and nomination of the key worker in this process. It involved the participation of a wide range of service providers in the development and trialing of an Interagency Care Planning Protocol across four PCPs in the North West Region (Moonee Valley Melbourne, Brimbank-Melton, Westbay and Banyule Nillumbik Primary Care Alliance).

The Protocol development involved determining the primary goals and objectives, the target client group, definitions, the roles and responsibilities of a key worker, practice standards and five process steps for developing a multi-agency Service Coordination Plan. This process took nearly six months and was extremely complex due to the wide range of participating agencies, their current practices and perceptions of their roles, different funding modes and levels, and a range of other issues.

It was determined through the process that the Protocol was to be developed to formalise existing practices and improve practices between agencies in working with HACC eligible consumers with both multi-agency involvement and complex needs.

The trial tested the practices and processes outlined in the Protocol, identifying the benefits, issues and challenges that agencies and sectors experienced. Following the trial, agencies provided data on the care planning process for each consumer/carer taking part in the trial. The outcomes were discussed at a post trial workshop at which future workforce, change management and information technology requirements for the future development of Interagency Care Planning were identified by participants. The outcomes of the trial were also discussed at a meeting with the General Practice Division Victoria to ensure future alignment of the Protocol with General Practice care planning activity.

At its final meeting on 16th November 2005, the Project Reference Group, in considering the outcomes of the Trial, developed a number of recommendations to progress work on the Care Planning component of Service Coordination. These recommendations include the establishment of an Interagency Care Planning Protocol Working Group to undertake the following:

- Promote the positive outcomes from the Care Planning Project both state-wide and within the North West
- Further explore, define and prioritise issues relating to additional resources

- Revisit and review the contents of the Protocol in light of the suggested changes identified by Service Coordination practitioners at the final project workshop, and at the meeting with General Practice Division Victoria
- Develop a staged whole of Region change management strategy for the effective implementation of the Protocol within agencies and between agencies (eg Aged Care, Chronic Disease initiatives etc)
- Develop a staged training/workforce development strategy for the Care Planning Protocol implementation (that is based on the training requirements identified by practitioners at the final project workshop)
- Keep abreast of relevant Commonwealth and State initiatives and relevant research.

It is hoped that the enormous commitment made by the Project Reference Group and participating agencies will be built upon both regionally and statewide, as the learnings from this Project are reflected upon and utilised in the future development of the Care Planning component of Service Coordination.

1. INTRODUCTION

CONTEXTUAL BACKGROUND

The North West Primary Care Partnerships (PCPs) have undertaken substantive work in the past three years on the Practices, Protocols, Processes and Systems components of Service Coordination including Initial Contact, Initial Needs Identification and Referral. As a first step in an ongoing process, this Pilot Project aimed to look at the Care Planning component of Service Coordination which encompasses the Service Coordination Plan.

The Project began in September 2004 initially with the three Western Metropolitan PCPs (Moonee Valley Melbourne, Brimbank-Melton and Westbay). In February 2005, additional funds were provided by the North West Department of Human Services, Aged Care Program to expand the scope of the Project and to brief the Northern Metropolitan PCPs (Banyule Nillumbik Primary Care Alliance, Hume Moreland PCP, North Central Metro PCP) about the Project.

PROJECT OBJECTIVES

The Project objectives were:

- To determine the role of the key worker
- To develop agreement about the nomination of a key worker between service providers
- To develop the Practices and Processes around how Interagency Care Planning is undertaken with consumer/carers and service providers, and how consumers/carers are to be involved in decision making around their Service Coordination Plan
- To ensure privacy requirements are met in regards to multidisciplinary care planning, and that agreement is provided around how collaboration with service providers will occur
- To develop Practices and Processes around review schedules for Service Coordination Plans, initiation of reassessments and providing feedback to referral agencies.

PROJECT DELIVERABLES

The expected outcomes from the Project were:

- A documented Protocol for Interagency Care Planning that addressed the Project Objectives (*refer to Attachment A for the Protocol that was developed and trialled*)
- The Piloting of the Protocol across a range of service providers (*refer to Attachment B for a Summary of Post Trial Data*)
- An evaluation of the Project to inform future development of the Care Planning component of Service Coordination.

PROJECT MANAGEMENT

The Project was managed by the Moonee Valley Melbourne PCP on behalf of the North West PCPs.

A Project Reference Group was established to oversee and guide the development of the Project. The Reference Group comprised:

Dianne Couch	Project Manager – Moonee Valley Melbourne PCP
Hazel Ingram	Reference Group Chairperson – Moonee Valley City Council
Bruce Watson	Brimbank-Melton PCP
Maureen Breen	Westbay Alliance (until August 05)
Lee Kennedy	Westbay Alliance (from August 05)
Melissa Rodgers	Banyule Nillumbik Primary Care Alliance (from June 05)
Una McGuckin	North West Department of Human Services
Judy Czerenkowski	North West Department of Human Services
Adele Hamlyn	Department of Human Services Central (from June 05)
Judith Perrin	Department of Human Services Central (from Sept. 05)
Jo McMillan	RDNS – Essendon
Jane Morehen	RDNS
Jim Karabinis	Moonee Valley City Council
Guy Walter	Moonee Valley City Council
Jeff Reid	Melbourne City Council
Leonie Kenny	Western Region Health Service
Ambi Kaur	Doutta Galla Community Health
Kevin Brimer	Doutta Galla Community Health – Macaulay Program
Mary Shaw	Djerriwarrh Community Health Service (from June 05)
Deb Leighton	PACFU
Anne Muldowney	Carers Victoria
Dimitra Xinarios	North West Migrant Resource Centre
Xam Chen	Melbourne Health - HARP
Jill Taylor	Melbourne Health – North West ACAS
Deb Warren	Project Consultant

Although attendance at the bi-monthly Reference Group meetings varied from meeting to meeting, all members were kept informed of Project developments via minutes of the meetings and bi-monthly Project Progress Reports.

2. PROJECT METHODOLOGY

TASKS AND TIMELINES

A range of participatory strategies were employed to achieve the objectives of the Project. A wide range of agencies were involved at various stages of the project to develop the Protocol and test the practical application of the Protocol in the field.

The Project involved a number of sequential and overlapping tasks as outlined below.

Task	Timeframe
1. A mapping of existing care planning work and scoping of care planning activities across the 3 PCPs in the Western Metropolitan area	October/November 2004
2. A Progress Report to the Reference Group on the findings of the scoping exercise to inform the direction of the Project	December 2004
3. Bi Monthly Project Reference Group Meetings to oversee and guide the development of the Project	October, December 2004 February, April, June, August, November 2005
4. The establishment of an Interagency Care Planning Protocol Development Working Group within the MVM PCP to identify and explore case studies that would benefit from an interagency approach to service coordination	January to April 2005
5. Protocol Development Workshops with the Western Metropolitan PCPs Service Coordination Working Groups (15 workshops were conducted – 5 in each PCP)	December 2004 to June 2005
6. Protocol Development Briefing Sessions with 2 of the Northern Metropolitan PCPs (Banyule Nillumbik Primary Care Alliance and Hume Moreland PCP)	April to June 2005
7. Documenting a Draft Protocol for Interagency Care Planning for testing in the field	January to July 2005
8. Training Sessions for Protocol Trial participants on the content of the Draft Protocol and Trial requirements	July/August 2005
9. Trialling the Protocol within 4 PCP catchments – Moonee Valley Melbourne PCP, Westbay Alliance, Brimbank-Melton PCP, Banyule Nillumbik Primary Care Alliance	August to October 2005 (10 week trial period)
10. Post Trial Regional Workshop with Trial participants to explore the findings/issues that emerged during the Trial	November 2005
11. Final Project Reference Group Meeting to review all Project findings and formulate recommendations for the future development of the Care Planning component of Service Coordination in the North West Region.	November 2005

3. PROJECT PROCESS

DEVELOPING THE PROTOCOL

The Protocol was developed between January and July 2005. It represents the culmination of Protocol Development Workshops conducted across the West Metro PCPs (Moonee Valley-Melbourne, Brimbank-Melton and Westbay). A total of 15 workshops were conducted (5 per PCP) and agencies attending included:

- Local Government (7 Councils)
- RDNS (3 Centres)
- Community Health (4 Centres)
- Melbourne Health
- Carers Victoria
- Carer Links West
- Western Health - Sunshine Hospital
- Australian Romanian Community Welfare
- Serbian Social Services & Support Inc
- Care Connect
- Norwood Association
- Migrant Resource Centre – North West

These agencies covered the following service types: Local Government HACC Assessment, District Nursing, Allied Health, Carer Support, PACFU, HARP, ACAS, Ethno-specific Social Support Services and Psychiatric Disability Support Services.

In addition to these workshops, briefing sessions were held in the Northern Area with the Hume-Moreland PCP and the Banyule Nillumbik Primary Care Alliance (BNPCA). The North Central Metro PCP was kept informed about the progress of the Project via the North West PCP Chairs Group.

During the process of developing the Protocol, a range of issues were identified and debated within and between sectors. The development process was complex due to the wide range of different agencies participating and their various internal care planning practices; the degree to which multi agency care planning was already part of day to day core work practices or not; and the various modes and levels of funding agencies receive for assessment, care planning and care management. These issues made it difficult for agencies to uniformly determine their respective roles in interagency care coordination and the subsequent role and responsibilities of a key worker.

Throughout the Protocol development process and the debating of these issues, a number of resolutions were made by the Project Reference Group in order to progress the development of the Protocol. These resolutions included:

- i. Making explicit to all those involved that the Project was attempting to both formalise existing practices between agencies and also improve practices between agencies;

- ii. Making explicit to all those involved that the Project was not about creating a completely new role for a Key Worker, but rather incorporating this role into existing work practices; and that the Protocol is intended to be implemented within the context of an agency's resources and capacity;
- iii. As the Project was HACC funded the Target Client Group was to be HACC eligible people. However, those clients receiving a formally funded case management service would not be part of the Trial. (It was considered case managed clients would not require a Key Worker as this would be duplicating effort and resources.)
- iv. As the primary objective of the Protocol was to develop agreed processes and practices in the development of a multi agency Service Coordination Plan, the target group was also to be defined by the group of consumers this Tool was designed for:
"Consumers with both multi-agency involvement and complex needs"¹ and consumers who:
 - "are being seen by more than one agency and more than one discipline
 - have multiple issues/problems that need to be addressed concurrently, and
 - whose outcomes are likely to be better if the care and services they receive are coordinated across agencies and over time."²
- v. As the Project was HACC funded, the Victorian HACC Program Guidelines (2003) for Care Management would underpin the Protocol. Protocol participating agencies/services would therefore need to internally determine how the guidelines do and/or can relate to their agency, how they are implemented and by whom.

During the life of the Project the key issue that was debated was the resources required for undertaking the role of the Key Worker. Some agencies considered the Protocol was part of their existing requirements/expectations of their staff undertaking assessment and care planning activities and as such the Protocol would formalise and improve practices, whilst practitioners from some other agencies considered the Protocol when operationalised would mean an escalation in workloads for themselves and their colleagues and would not be sustainable in the longer term without additional resources to undertake the key worker role.

¹ SCTTs: Guideline 4: Completing the Service Coordination Plan, May 2002

² Ibid

Part of the problem in trying to resolve this issue was the difficulty the Project experienced in trying to define the Key Worker role as being substantially different from a Case Manager's role. Despite the efforts by Protocol development workshop participants to define the role, some agencies still consider the role boundaries between these are too blurred and that in essence the Key Worker is a pseudo case manager without the extra resources.

This issue remained unresolved with conflicting views about the level and nature of resources that may or may not be required. It was revisited post trial and the Reference Group resolved that further exploration, and prioritising of issues relating to additional resources was required.

Notwithstanding all these challenges and complexities the Project resulted in collective agreement between all participating agencies on the components of the Protocol including its

- Primary Goals and Objectives;
- Target Client Group;
- The Role of the Key Worker (including its limitations);
- Definitions;
- Practice Standards; and
- Five Process Steps for developing a multi-agency Service Coordination Plan.

By July 2005 the Protocol was documented and ready to trial.

TRIALING THE PROTOCOL

Four PCPs in the North West Region trialled the Protocol.

The aims of the Trial were to:

- i. To test the Practical Operation of the Protocol i.e. to pilot the practices and processes outlined in the Protocol for developing a multi-agency Service Coordination Plan and for determining a Key Worker to facilitate care coordination between agencies;
- ii. To identify and document the benefits, issues and challenges that each participating agency experiences during the trial period in operationalising the Protocol;
- iii. To identify future workforce development, change management and information technology requirements for the future development of Interagency Care Planning.

The trial began on Monday 15th August and concluded on Friday 21st October 2005 (a 10 week period).

Participating agencies agreed to undertake the following during the Trial period:

- (a) aim to trial the Protocol with at least 6 consumers during the trial period for large agencies/centres (e.g. LGA, RDNS, CHC) and 2 for smaller agencies (e.g. PDSS, Social Support);
- (b) nominate a Lead Contact person to coordinate the trial within the agency. The agency Lead Contact would:
 - periodically check with all participating staff in their agency how the trial was proceeding
 - be the central contact person for the Project Consultant during the trial
 - collect (via email) all completed trial data forms within their agency and provide to the Project Consultant by no later than Friday 28th October;
- (c) inform the consumer/carer from the outset that they are part of a trial that is testing the use of a multi-agency Service Coordination Plan in the field and the nomination of a Key Worker;
- (d) ensure that care coordination activities between agencies assisting consumers continue post trial, if required;
- (e) complete the Trial Data Form for each consumer from either a Key Worker perspective or 'Participating Agency' perspective as applicable;
- (f) attend a Workshop in early November facilitated by the Consultant after the Trial was completed to discuss the Trial outcomes and formulate solutions/ recommendations re any issues/challenges that had arisen during the trial for consideration by the Project Reference Group.

POST TRIAL DATA COLLECTION

A Trial Data Form was developed to collect data from service providers for each individual consumer/carer who took part in the Trial. An indication of the strong commitment by agencies to the trial process was the return of completed Trial Data Forms by all participating agencies. *(Refer to Attachment C for a copy of the Trial Data Form.)*

4. PROJECT OUTCOMES

INTERAGENCY CARE PLANNING PROTOCOL

The key outcome of this Project was the collective development by a wide range of agencies of the Final Draft Interagency Care Planning Protocol (*refer to Attachment A for Protocol*).

The Protocol represents a work in progress: the first step in ongoing development of the Care Planning component of Service Coordination in the North West Region. It provides a generic framework for interagency care planning and has been developed for the mutual benefit of consumers/carers and service providers. The Protocol is essentially about operationalising the Care Planning element of Service Coordination between agencies that are assisting the same consumer. Importantly,

- It builds on the consumer data collected (and shared via interagency referral processes) in the previous Service Coordination elements: Initial Contact (IC), Initial Needs Identification (INI) and Assessment; and
- It relies on the PCPs Protocols for IC, INI and Interagency Referral being embedded in participating agencies practices and processes. Effective Interagency Care Planning cannot therefore be achieved without these elements having become a part of the day to day/core work processes and practices of agencies.

The intent of the Protocol is to ensure a continuous improvement approach to Service Coordination and can be aligned with an agency's quality improvement processes for care planning.

- It is not the intent of the Protocol to replace the need for an agency/discipline specific care plan/service plan/treatment plan. These internal care plans will continue to be necessary.
- The Protocol aims to complement the range of care planning activities that are part of the usual practice of agencies and to build on existing cooperation and collaboration between agencies.
- It aims to clarify and formalise the nature of interagency care planning as an important part of the broad range of care planning activities that are undertaken on a day to day basis by agencies.

The Protocol is a Final Draft in recognition of the need to further refine and adapt its scope, definitions and practical operation elements as future work on the care planning component of Service Coordination unfolds at the Regional and State levels and within and between sectors.

TRIAL OUTCOMES

A summary of the results of the Protocol Trial are provided in Attachment B. Overall the Trial revealed that the Protocol was relatively successful in terms of its practical operation. There was high commitment to its implementation from agencies involved, and the benefits for both consumers/carers and service providers were generally reported as being positive.

A brief overview of the salient outcomes of the Trial is provided in this section.

- 47 clients participated in the Protocol Trial. Of these 37 (79%) were existing clients and 10 (21%) were new clients (*refer to Table 1 in Attachment B*)
- A wide range of service providers participated in the Trial including GPs (*refer to Table 2 in Attachment B*)
- During the Trial, 25 case conferences meetings were conducted. Clients were in attendance at 21 of these.
- The key outcomes for the client/carer were reported as including:
 - enhanced client/carer involvement in the planning of their care arrangements
 - more coordinated and effective provision of services
 - having a designated person (key worker) to whom the client/carer could refer ensuring some degree of accountability in day to day support
 - improved communication and feedback from service providers.

(*Refer to Post Trial responses to Question 7 in Attachment B for more details.*)
- The key benefits from service provider perspectives were reported as:
 - time saving
 - peer support for each service provider
 - increased clarity for agencies around roles and responsibilities
 - better communication between agencies
 - working in a collaborative and coordinated way
 - providing consistency and accountability in service implementation and delivery
 - having GPs involved with other service providers
 - maximising the utilisation of resources across involved service providers.

(*Refer to Post Trial responses to Question 8 in Attachment B for more details.*)

- The issues/challenges experienced during the trial by participating service providers were reported as including:
 - Time and resources
 - time required to organise case conference meetings
 - the requirements of the key worker
 - time consuming for follow up
 - Difficult to pull back from taking on a case management role
 - Changes are needed to Information Technology to accommodate the documentation
 - Reluctance of some agencies to take on formal key worker role
 - General lack of appropriate resources for people with a psychiatric disability
(Refer to Post Trial responses to Question 8 in Attachment B for more details.)

- The Service Coordination Plan was reported as being a very useful Tool for setting goals and a review time for actions between agencies. The Tool provided a structure for the Case Conference meetings and was reported as being relatively simple to use. Suggested improvements to the form included a section to describe in more detail the background to the presenting issue.
(Refer to Post Trial responses to Question 9 in Attachment B for more details.)

- The key issue raised about the Trial itself was the timeline for the Trial. A number of service providers considered the planning and preparing of staff within their agencies was difficult due to the short trial period (10 weeks). It was considered that a longer trial would have allowed more time to operationalise the Protocol and allow for a change management approach within agencies.

5. MOVING FORWARD

Following the Trial of the Protocol, three meetings were held to review the project findings and to consider the question: Where to from here?

- i. A Post Trial Regional Workshop with agencies that participated in the Trial
- ii. A meeting with the General Practice Division Victoria to explore and discuss a number of issues relating to the interface between Community/Primary Care Care Planning and General Practice Care Planning
- iii. A Final Project Reference Group meeting to review *all* Project outcomes and formulate recommendations for moving forward.

This section provides the resolutions from these three meetings. These collective outcomes will be utilised to inform the future development of the Care Planning component of Service Coordination in the North West Region.

POST TRIAL REGIONAL WORKSHOP

The following is a summary of the responses to a range of questions discussed at the Regional Post Trial Workshop held on 10th November 2005.

1. Suggested Changes Required to Content of the Draft Protocol

- Broaden the care planning methodology to include telephone contact as well as teleconferencing (*comment made by RDNS*)
- Link worker role needs to be further clarified (*comment made by RDNS & Community Health*)
- Need for further clarification of how to select a key worker at the case conference (*comments made by Local Government & Community Health*)
- Need for additional guidelines for key worker (*comments made by Local Government & Community Health*)
- No changes required – issues are around practice (*comments made by smaller agencies – CarerLinks, MRC, Wesley Do Care*)
- Service Coordination Plan needs more space for further information (*comment made by Community Health*)

2. Key issues that need to be addressed to effectively implement interagency care planning into the future

Resources

Resources were reported as the number one issue. There still remains a range of views in the field (that need to be further explored) around what the additional resources should comprise. The range of views encompassed the following:

- resources dedicated to create a new role (i.e. key worker)
- resources to supplement existing roles
- resources for short term case managers
- resources for enhanced service provision and for more packages
- resources for selected agencies funded to take on 'lead agency role' - these agencies to be specifically funded to be the key workers to facilitate the care planning process
- resources for change management and workforce development.

Workforce Development

- i. Training in case conferencing (how to conduct a case conference effectively to obtain the best outcomes for clients)
- ii. Training on the Protocol content and implementation
- iii. Training on further defining the key worker role and how/who selects
- iv. Training on care planning, monitoring/review, client centred practice.

Change Management

- i. Organisations with support from the PCPs now need to drive the change.
- ii. There is a need for an attitudinal change within agencies to effectively implement multi agency care planning
- iii. Management commitment and support is required to effectively implement the Protocol
- iv. Agencies to review worker Position Descriptions and decide if the key worker role is a core activity
- v. Agencies need to review case loads to accommodate the key worker role
- vi. Education of clients on the purpose of interagency care planning and why a key worker is needed
- vii. Education of other service providers/sectors about the Protocol.

Information Technology requirements

- i. Agencies to work with IT providers to ensure the requirements of the Service Coordination Plan are met
- ii. Uniform software across all agencies
- iii. ConnectingCare to refer to the Protocol to ensure any relevant changes are made to ConnectingCare to accommodate the Protocol
- iv. MDS and SCOTT interface.

3. The role the PCPs now needs to take to progress this work

- Advocate/lobby for an increase in resources for key worker function in agencies
- Training/encouragement to agencies to focus on the Protocol's benefits
- Establish an Interagency Care Planning Protocol Working Group
- Further develop the key worker role by providing training/workshops
- Undertake further work on the interface between the Protocol and formally funded Case Management services
- Promote the positive outcomes of the Trial including the involvement of GPs

With support from DHS;

- Conduct whole of region workshops to develop more guidelines for identifying a key worker at a case conference meeting
- Provide/disseminate information about the Protocol – promote the work
- Encourage the genuine sharing of secure client information to facilitate effective interagency care planning
- Continue to support projects that seek to provide needed services to maintain complex care clients in the community
- Develop a change management strategy with all agencies that includes education and training to drive the project.

POST TRIAL MEETING WITH GENERAL PRACTICE DIVISION VICTORIA (GPDV)

A Post Trial meeting with GPDV, DHS Central Office Primary Care Branch and the MVM PCP was held on 14th November 2005 to ensure future alignment of the Protocol with General Practice care planning activity.

The issues discussed included:

- i. The existence of two care planning systems which do not interface may lead to duplication of input from agencies and service providers and confusion for the client group.
- ii. The draft protocol (ie. GP contribution to a care plan) may preclude access for this client group to Medicare rebateable private allied health and dental care services.
- iii. Whilst there was high GP participation in the Protocol pilot, evidence from other projects indicates systematic involvement is challenging for General Practice.
- iv. GPs are not mandated to use the Service Coordination Plan (SCP) and at a national level electronic templates within medical software have been developed. It is not feasible to expect GPs to use the SCP in preference to recommended formats promoted through Divisions.

The meeting resolved the following:

- i. That the protocol strongly recommends GP inclusion in the team from the outset.
- ii. Key workers need to be aware of possible existence of GP initiated Care Planning activity.
- iii. Training for GPs and Key workers around the dual care planning process with practical examples of how that interface can occur or even value add.
- iv. Close analysis shows there are a lot of commonalities across both the SCP and GP care planning templates. The GPDV recommends that the DHS funded sector accept the use of different formats by general practice as we head toward paperless transfer of patient information with agreed minimum data sets.
- v. There needs to be further exploration of the opportunities for interfacing the two care planning systems to maximise best care for the client group.

These resolutions were endorsed by the Project Reference Group at its meeting on 16th November 2005.

RECOMMENDATIONS FORMULATED BY THE PROJECT REFERENCE GROUP

At its final meeting on 16th November the Project Reference Group, in considering the outcomes from the Post Trial Regional Workshop and the meeting with the General Practice Division Victoria, developed the following set of recommendations to progress the Care Planning component of Service Coordination:

1. That the North West PCPs collaboratively establish an Interagency Care Planning Protocol Working Group with representation from all relevant sectors to progress inter-agency care planning work.
2. That the North West PCPs Care Planning Working Group undertake the following:
 - Promote the positive outcomes from the Care Planning Project both state-wide and within the North West
 - Further explore, define and prioritise issues relating to additional resources.
 - Revisit and review the contents of the Protocol in light of the suggested changes identified by Service Coordination practitioners at the final project workshop; and at the meeting with General Practice Division Victoria (GPDV)
 - Develop a staged whole of Region change management strategy for the effective implementation of the Protocol within agencies and between agencies (eg Aged Care, Chronic Disease initiatives etc)
 - Develop a staged training/workforce development strategy for the Care Planning Protocol implementation (that is based on the training requirements identified by practitioners at the final project workshop)
 - Keep abreast of relevant Commonwealth and State initiatives and relevant research.
3. That the North West PCPs Care Planning Working Group seek project funds from DHS to progress further work on care planning including support for the change management processes and workforce development program that is required.
4. That the PCPs gain endorsement from their Steering Committees to work with the Managers of agencies to increase their understanding of and support for the implementation of Interagency Care Planning.

5. That GPs are included in any ongoing Care Planning development work to ensure issues of inclusion and coordination are addressed.
6. That any future work on Interagency Care Planning Protocols both state-wide and regional be based on the learnings from this Project.
7. That the electronic referral processes in the North West are updated to reflect the Interagency Care Planning Protocol.
8. That outcomes of the project are provided to the state-wide Chairs Working Group for consideration in the context of the state-wide PCP review and integration of all Protocols, Processes and Practices for Services Coordination.

FINAL DRAFT

INTERAGENCY CARE PLANNING PROTOCOL

This Protocol was developed between January and July 2005 and trialled during the period 15th August to 21st October 2005.

1. INTRODUCTION & RATIONALE

This Protocol is based on the trust, professionalism and good will of the participating agencies.

It provides a generic framework for interagency care planning and has been developed for the mutual benefit of consumers/carers and agencies. The Protocol is intended to be implemented within the context of an agency's resources and capacity. This Protocol is not a Service Agreement or Contract.

Care planning is one of the six elements of the Statewide PCP Service Coordination Framework.

Interagency Care Planning is a multi-agency process and includes:

- with consumer/carer consent, the synthesis of data from IC, INI, assessment and agency specific care plans/treatment plans from the range of services involved in the consumer's care
- collaborative development of a service coordination plan
- collaborative monitoring and review of the plan
- nominating a Key Worker to facilitate all of the above.

This Protocol is about operationalising the Care Planning element of Service Coordination between agencies that are assisting the same consumer. Importantly,

- It builds on the consumer data collected (and shared via interagency referral processes) in the previous elements: Initial Contact (IC), Initial Needs Identification (INI) and Assessment; and
- It relies on the PCPs Protocols for IC, INI and Interagency Referral being embedded in participating agencies practices and processes. Effective Interagency Care Planning cannot therefore be achieved without these elements having become a part of the day to day/core work processes and practices of agencies.

The intent of the Protocol is to ensure a continuous improvement approach to Service Coordination and can be aligned with an agency's quality improvement processes for care planning.

- It is not the intent of this Protocol to replace the need for an agency/discipline specific care plan/service plan/treatment plan. These internal care plans will continue to be necessary.
- The Protocol aims to complement the range of care planning activities that are part of the usual practice of agencies and to build on existing cooperation and collaboration between agencies.
- It aims to clarify and formalise the nature of interagency care planning as an important part of the broad range of care planning activities that are undertaken on a day to day basis by agencies.

The Protocol is underpinned by the principle of Duty of Care. Duty of Care is an issue for each individual worker and service provider and the Service Coordination environment does not necessarily affect duty of care considerations.³ All participating agencies should have their own specific Duty of Care Policies and Guidelines in place for their workers. In the context of Interagency Care Planning, Duty of Care extends to all service providers and not solely to workers in a particular professional group or one sector; that is, Duty of Care is a shared obligation between agencies/professions.

The Protocol is also underpinned by the requirements of the Victorian Health Records Act 2001. The Act includes a number of Health Privacy Principles which cover the life cycle of information and is designed to provide privacy protection, promote consumer independence, ensure effective service delivery and continued improvement of health services.

This Protocol represents the culmination of Protocol Development Workshops conducted across the West Metro PCPs (Moonee Valley-Melbourne, Brimbank-Melton and Westbay) between January and July 2005. A total of 15 workshops were conducted (5 per PCP) and agencies attending included:

- Local Government (7 Councils)
- RDNS (3 Centres)
- Community Health (4 Centres)
- Melbourne Health
- Carers Victoria
- Carer Links West
- Sunshine Hospital
- Australian Romanian Community Welfare
- Serbian Social Services & Support Inc
- Care Connect
- Norwood Association
- Migrant Resource Centre – North West

These agencies covered the following service types: Local Government HACC Assessment, District Nursing, Allied Health, Carer Support, PACFU, HARP, ACAS, Ethno Specific Social Support Services and Psychiatric Disability Support Services.

In addition to these workshops, briefing sessions were held in the Northern Area with the Hume-Moreland PCP and the Banyule Nillumbik Primary Care Alliance (BNPCA).

2. GOALS

The two primary goals of this Protocol are:

- i) To formalise and improve existing care planning practices and processes between agencies
- ii) To improve the experience and outcomes for consumers and carers who require interagency care planning.

3. OBJECTIVES

The objectives of this Protocol are:

- i) To strengthen partnerships and enhance the clarity of roles and communication pathways between service providers
- ii) To facilitate a central point of contact for the consumer and carer
- iii) To maximise consumer and carer involvement in care planning processes and decisions
- iv) To enhance the sharing and updating of relevant information between agencies

³ Department of Human Services, Victoria: Better Access to Services – A Policy and Operational Framework, Primary Care Partnerships, June 2001, p.11

4. SCOPE

This section describes both the breadth and the limitations of the Protocol arrangements.

Target Client Group

The Target Client Group for this Protocol is HACC eligible consumers with both multi agency involvement and complex needs who are not receiving a formally funded case management service (e.g. CACPs, Linkages, EACH, HARP etc).

HACC Guidelines

At the time of developing this Protocol it was decided by the agencies involved in the workshops and the Project Reference Group that the Victorian HACC Program Guidelines (2003) for Care Management would underpin the Protocol. Protocol participating agencies/services will therefore need to internally determine how these guidelines do and/or can relate to their agency, how they are implemented and by whom.

The Victorian HACC Program Manual (2003) describes the roles and responsibilities that *all* HACC agencies are expected to undertake for clients.

To ensure smooth pathways between services, *all* funded agencies, regardless of whether or not they are funded for Assessment and Care Management, are expected to:

- *receive from, or make timely referrals to, other services on an approved information record. This will be on the SCOTTs;*
- *develop policies, practices and protocols with other agencies regarding service coordination and care management practices and inform consumers and other services in the system of these;*
- *clearly explain their agency's role to consumers and how information gathered during the service coordination process will be used*
- *regularly monitor and review consumer's conditions and circumstances*

Agencies funded for Assessment and Care Management are also to ensure that:

- *individuals receive support to remain in the community and maximize their levels of functioning and independence*
- *a coordinated and integrated service response is organised.*

Agencies funded for the Assessment and Care Management activity are further expected to undertake care planning and care management activities:

Care Planning includes:

- *contacting service providers and arranging services to be provided*
- *negotiating roles and responsibilities of service provider(s), the consumer, their carer and/or advocate and the care manager*
- *setting appropriate dates for review and reassessment of the care plan and the consumers needs.*

A Care Manager is usually nominated during the care planning process. This is not necessarily the same worker who did the assessment or developed the plan, but can be the most appropriate provider or worker involved with the consumer. Care Managers usually have responsibility for coordinating and monitoring services being delivered and ensuring the implementation of the care plan.⁴

⁴ Victorian HACC Program Manual (2003) pps 11,12,72,73,79,80,83

The Service Coordination Plan and Key Worker

The Protocol is primarily concerned with agreed processes and practices in the development of a multi-agency Service Coordination Plan and the nomination of Key Workers for the Target Client Group.

The Service Coordination Plan (SCP) forms an essential part of the Service Coordination Tool Templates (SCOTTs) for enhancing care coordination between agencies assisting the same person.

The SCP is designed for consumers who:

- are being seen by more than one agency and more than one discipline
- have multiple issues/problems that need to be addressed concurrently, and
- whose outcomes are likely to be better if the care and services they receive are coordinated across agencies and over time.⁵

The SCP is a way of linking the information contained during IC, INI and Assessment with a more detailed interagency care planning process. The SCP is not an assessment tool but assumes that assessment tools have been used to inform care planning. An important aspect of documenting a multi-agency Service Coordination Plan is the assigning of a Key Worker.

In the context of this Protocol the Key Worker role will encompass:

- facilitating communication (as appropriate and agreed) between partner agencies and the consumer/carer
- providing a central point for the consumer/carer for care coordination activities
- explaining the Key Worker role and its limitations to client/carer
- documenting the SCP and providing a copy to all team members
- notifying changes in the SCP to agencies involved (as relevant)
- prompting and/or facilitating the review of the SCP.

In the context of this Protocol the Key Worker is not:

- responsible for ensuring that all service provision is meeting the client's needs
- the case manager or providing a case management service
- responsible for service specific issues/complaints
- responsible for the consumer's/carer's decisions and actions
- responsible for day to day service changes for all services involved
- the point of contact for the consumer/carer for day to day service delivery

A Key Worker is considered important for people who are in the service network and use multiple services and there is a need to ensure that one person in the service network is identified as having responsibility to facilitate interagency care coordination. Formally funded case management services address the needs of the most vulnerable clients in the service system, but there are still others who do not need the intensity of support provided through case management but for whom coordinated care is still vitally important.

⁵ SCTTs: Guideline 4: Completing the Service Coordination Plan, May 2002

5. DEFINITIONS

For the purposes of this Protocol the following definitions as discussed and agreed to in the Protocol Development workshops are used.

Link Worker is the practitioner who initially identifies the need for and initiates the process of interagency care planning.

Key Worker is the nominated person who works with the consumer/carer and other agencies to facilitate interagency care coordination (*Refer to Scope Section for more details*)

Care Coordination is a multi-agency and multi-disciplinary process that aims to avoid unnecessary duplication of services and facilitate navigation of the service system. Care Coordination involves the collaborative development, monitoring and review of a Service Coordination Plan between agencies to ensure common achievable goals and actions. Care Coordination is facilitated by a nominated Key Worker.

Service Coordination Plan (SCP) is intended to be used only for consumers with both multi-agency involvement and complex needs. It provides a framework for an ordered, consistent and coordinated approach to planning and delivery of care and support across different agencies and sectors. The SCP is intended to build on, not replace, individual agency/service care plans/treatment plans.

Multi-agency refers to 3 or more agencies (for this Protocol GPs will be defined as an agency).

Complex needs: There is no one definition of 'complex' that is appropriate to all age groups and service types. When defining people with complex needs living at home the term covers a wide range of circumstances and types and levels of need for assistance. For the purposes of this Protocol (with its focus on HACC eligible clients) characteristics of people with complex care needs can include one or more of the following:

- *People with multiple disabilities (health, social, cognitive) needing assistance in a number of areas of their life*
- *People who are vulnerable and live alone and have no effective or immediate support from family or friends, particularly those with confusion and memory loss*
- *People with behaviours that others find difficult and don't want assistance from services or don't perceive the need for assistance when there is objectively a clear need for it*
- *People with frequently changing and fluctuating needs*
- *People who have a multiplicity of disabilities combined with communication and relationship difficulties or social isolation*
- *Situations where there are two 'clients' – the person with the disability and the carer, both of whom have significant needs*
- *People who have considerable disabilities and lose their carer*
- *People from non-English speaking backgrounds, where language or culture or family expectations mean that traditional service responses are not appropriate, or at least need modification or, where they cannot identify services as they have no understanding of the role of these services*
- *People who have an acute decline in ability to self manage⁶*

Case Conferencing is the bringing together in one place and at one time, workers and the consumer and carer/s who, in an ordered way, exchange information, explore problems, discuss methods for addressing needs, decide on goals and actions and allocate tasks.

⁶ Aged and Community Care Division: Department of Human Services and Health, People with Complex Needs: Effective Support at Home, A Discussion & Resource Document for HACC Service Providers, 1993, pps 9 & 10

6. CONSUMER FOCUSED PRACTICE STANDARDS

These Standards aim to provide agencies with:

- a shared vision for the delivery of consumer focused care planning practices across agencies
- a checklist for agencies to collaboratively ensure best practice during the processes of interagency care planning

Access and Equity

- 1) Each consumer/carer has their need for a multi-agency Service Coordination Plan identified in a timely manner

Empowerment

- 2) Each consumer/carer is well informed about the interagency care planning process
- 3) Each consumer/carer is empowered to make informed choices and decisions during the processes of interagency care planning
- 4) Each consumer/carer is provided with appropriate opportunities to be an active partner in the processes of interagency care planning

Access to Information

- 5) Each consumer/carer is provided with accurate, appropriate and reliable information

Privacy and Confidentiality

- 6) Each consumer/carer's rights to privacy and confidentiality are upheld in accordance with relevant legislation

Coordination and Integration

- 7) Each consumer/carer experiences an integrated, cooperative and coordinated service provider response to interagency care planning

Flexibility and Responsiveness

- 8) Each consumer/carer is provided with a flexible and responsive multi-agency Service Coordination Plan that is tailored to individual needs and requirements

7. PRACTICAL OPERATION

General Principles

The practical operation of this Protocol is based on:

- a shared commitment to collaborative and active cooperation between agencies assisting the same person, to support optimal consumer outcomes
- maximizing consumer/carer participation
- ensuring consumer privacy and confidentiality
- encouraging and facilitating the contribution of self management to effective care
- preventing duplication and confusion between multiple service providers by ensuring all team members in each care planning process have a clear understanding of their roles and responsibilities
- ensuring all team members receive relevant information in a timely and coordinated manner
- a shared responsibility for duty of care to the consumer

Interagency Care Planning: Practices and Processes

There are 5 main process steps involved in interagency care planning and the subsequent development of a multi-agency Service Coordination Plan:

1. Determining the need for this level of planning
2. Obtaining consumer agreement and consent and identifying participants
3. Developing the Plan and determining who will facilitate care coordination (i.e. nominating a Key Worker)
4. Documenting and distributing the Plan
5. Monitoring/updating and formally reviewing the Plan

Step 1: Determine the Need
<p>By whom, when, how</p> <p>The need for interagency care planning occurs when a practitioner identifies during IC, INI and/or assessment/reassessment that a consumer with complex care needs (<i>refer to definition</i>) is needing or receiving multiple forms of assistance (3 or more agencies) and would benefit from a coordinated approach to care arrangements. This can occur particularly at the time of referrals, especially when there are referrals to multiple services.</p> <p>The need for interagency care planning and the subsequent development of a Service Coordination Plan may also be identified during existing interagency case conference arrangements (e.g. North West ACAS meetings, Melton Care Coordination Meetings, Werribee Aged Services Meetings).</p>

Step 2: Obtain Consumer Agreement/Consent and Identify Participants**By whom, when, how**

Whom: The practitioner who identifies the need (Link Worker) in collaboration with the consumer/carer (Note: the initiator of the process is not automatically the Key Worker for the consumer. The Key Worker is determined in Step 3)

When: During the IC, INI, Assessment or Reassessment process; or at an existing Interagency Case Conference meeting.

How:

- Discuss the purpose of interagency care planning process with the consumer and obtain agreement to proceed. Potential benefits for the consumer include:
 - common goals for all service providers
 - reduction in any duplication in service delivery
 - improved communication between service providers
 - a central contact person for care coordination activities
- With consumer/carer, identify services (current and/or anticipated) and determine who needs to participate in developing the multi-agency SCP
- Ask consumer/carer to complete the standard SCOTTs Consent Form (if not previously completed) to enable the appropriate sharing of information⁷
- Document consumer's agreement to interagency care planning and identified participants in the relevant agency specific assessment record/case file or database, together with copy of the consent form.

If the consumer/carer does not agree/consent do not proceed with an interagency care planning approach to care arrangements at this time. Document the reasons for refusal on internal agency recording system and review circumstances within 3 months if still considered required.

Step 3: Developing the Plan and determining who will facilitate care coordination**By whom, when, how**

Whom: Initially the link worker (i.e. practitioner who initiated the need for an interagency care planning process) communicates the identified need for a multi-agency SCP with all the relevant service providers via phone or secure fax/e-referral.

When & How: At this time the services who are/or will be involved with the consumers care arrangements decide on the method(s) for developing the SCP:

- face to face case conference
- telephone conference
- written exchange of information
- combinations of the above to cater for all partners/team members in the care planning process, including the consumer/carer

Note: The most appropriate and comprehensive method for developing the Plan is considered to be face to face case conferences and as such every effort should be made to accommodate this best practice option.

⁷ "Consent is required for the sharing of health information with another provider(s). Once consent is given, health information can generally be shared with the identified provider(s) for the primary or directly related secondary purposes without need for further consenting *if this is within the reasonable expectation of the consumer.*" (Source: WMA Service Coordination Best Practice & Continuous Improvement Manual, First Edition Dec. 2002, Interagency Multidisciplinary Care Coordination Meeting Protocol, p.8)

- Convening a Case Conference to develop the SCP
 - Convened by the link worker at a time and place that reasonably suits all participants, including the consumer and carer if wishing to attend
 - Within 2 to 4 weeks of identifying the need for a case conference
 - All participants to bring appropriate information and be able to make relevant decisions
 - Meeting to:
 - appoint Key Worker to lead the SCP⁸
 - clarify roles, responsibilities, key contacts of all key services involved
 - identify priority goals and actions to be included in the Plan (these will be based on but less detailed than those in individual service provider care plan/treatment plans)
 - deciding processes for monitoring and review
 - may also identify and document services gaps and strategies to address these
- Convening a Telephone Conference to develop the SCP
 - organised by the link worker
 - telephone conference process as for the face to face case conference meetings above
- Written exchanges of information to develop the SCP by secure fax/e-referral ensuring privacy requirements are met at all times. This method on its own assumes that via phone discussions a Key Worker has been appointed, all relevant agency specific assessment/care plan information is provided to the Key Worker who synthesizes all information, develops the SCP on behalf of all providers with the consumer/carer and provides the SCP to all interagency care planning team members

Step 4: Document and Distribute the Service Coordination Plan

By whom, when, how

SCP to be documented and distributed by the Key Worker within 5 working days of the Case Conference, Telephone Conference and/or receipt of written information.

- Document on the Service Coordination Plan (*refer to Attachment for Summary Guidelines for completing the SCP*)
- To include the Consent Form and a plan for updating and review
- Distribute to all participants (via secure fax/e-referral, post, home visit to consumer/carer)
- All Care Planning Team members to ensure that the SCP is placed prominently on the relevant client record/case file or database within 2 working days of receipt.

⁸ The nomination of the Key Worker is based on agreement between service providers and consumer/primary carer and may include consideration of:

- the consumer/primary carer's preferred choice of Key Worker
- the nature of the consumer's primary need/issue/problem and the most appropriate service provider to address such
- capacity of the agency to undertake this role (i.e. existing interagency care planning case loads of staff)
- the agency with most frequent involvement
- the expertise relating to client's primary care needs.

Note: A consumer/carer may also be the nominated Key Worker. Sometimes, a primary carer or consumer does some or all of the care coordination functions. Service providers should offer support, advice and information to carers and consumers to assist them to manage their own care entirely, or in part. If joint Key Workers have been arranged (i.e. between consumer/carer and service provider) this should be clearly identified on the plan and documented, along with the roles, responsibilities and expectations.

Step 5: Monitoring and Review**By whom, when, how**

If the multi-agency SCP is to be useful it is crucial that the goals and actions are monitored and the Plan overall has a scheduled formal review date. Effective feedback informs the ongoing relevance and appropriateness of interagency care planning.

- All participants to notify the Key Worker (via phone, secure fax/e-referral) if they become aware of any relevant changes in the consumer's situation, or changes in their own contact details. The Key Worker to notify all other parties (via phone, secure fax, e-referral). All participants to update their copy, including the date of change.
- All participants to monitor their particular agreed goals/actions as specified in the Plan.
- The Key Worker to convene a review as documented in the SCP, or for an earlier review within 2 to 4 weeks of a request by any of the participants including the consumer/carer. The review will usually occur via a case conference but other methods could be used. Reviews to take place at no less than 6 month intervals.
- During the formal review process a new Key Worker may need to be nominated and a new SCP developed.
- All participants to ensure the new SCP is placed on the relevant client record/case file or database within 2 working days of receipt.

A Summary Flowchart of the process steps 1 to 5 is provided overleaf. This Flowchart is not intended as a stand alone diagram and needs to be read in conjunction with the goals, objectives, definitions, standards and more detailed process steps provided in this Protocol.

Summary Flowchart of Interagency Care Planning Process

Step 1: Determine the Need

Practitioner (Link Worker) identifies need for interagency care planning

Step 2: Obtain Consumer Agreement/Consent & Identify Participants

Link Worker discusses with consumer & asks consumer for consent to proceed

Consent not

Consent given

Link Worker:

- documents the reasons for refusal
- offers again within 3 months

Link Worker with consumer

- identifies services to participate in developing the multi-agency SCP
- completes SCOTTs Consent Form

Link Worker

- documents consumer agreement and identified participants
- files copy of Consent Form

Step 3: Developing the Plan and determining Key Worker

Link Worker:

- communicates the identified need for a multi-agency SCP with all the relevant service providers via phone or secure fax/e-referral
- with relevant service providers and consumer/carer (team members) decides on the method(s) for developing the SCP
- within 2 to 4 weeks organises face to face case conference, telephone conference or written exchange of information (or combination of methods)

If case conference or telephone conference

If written exchange of information

Case conference meeting or telephone conference

- appoints Key Worker to lead the SCP
- clarifies roles, responsibilities, key contacts
- identifies goals and actions for Plan

Written exchange of information following phone discussions to appoint key worker

- Key Worker develops SCP with the consumer/carer on behalf of team members
- Key Worker provides SCP to all team members

Step 4: Documenting and distributing the Plan

Within 5 days Key Worker

- documents the Service Coordination Plan
- includes the Consent Form and a plan for updating and review
- distributes to all participants

All Care Planning Team members place SCP on client record within 2 working days of receipt.

Step 5: Monitoring/updating and formally reviewing the Plan

Key Worker to:

- convene Review as documented in Care Plan or within 2 to 4 weeks of request by other participants (including consumer/carer)
- document and distribute new Care Plan

All Care Planning Team members to

- notify the Key Worker of any changes in consumer circumstances
- update changes notified by Key Worker
- monitor their particular agreed goals/actions as specified in the Plan
- ensure new Plans placed on file within 2 days of receipt

Summary Guidelines for Completing a Multi-Agency Service Coordination Plan

1. **Identify all issues/problems** based on the documents indicated in the Evidence of Assessment Need check box.
2. **Identify the primary problem or issue** to be addressed in this current SCP and list it first. The primary problem or issue is the one that is expected to require the most interagency planning and coordination.
3. **Identify all other problems and issues** to be addressed in this current SCP. If possible, list them in priority order. Attach additional sheets of page 2 of this form if necessary.
4. **Identify one or more goals** for each problem or issue. The goal is the best outcome that can realistically be achieved during the period covered by the current SCP. The goal can be recorded in text.
5. As an additional aid to making sense of the goal of the consumer and provider's plan by using one of the following five codes, more generic and mutually exclusive goals can be coded and described:
 - Safety and protection (physical, psychological, emotional, social, environmental)
 - Acute/post acute – the goal is restoration of the person's pre-acute level of health and function within a short time frame (weeks to months)
 - Functional gain – the goal is to improve (not maintain) current levels of independence and/or optimise (not maintain) current living arrangements (weeks to months)
 - Maintenance and support – the goal is to maintain function, quality of life or current health status (required action may be indefinite in some cases)
 - Prevention and early intervention – the goal is early identification and intervention to promote health and prevent problems developing.
6. **Identify a realistic target date** for achieving each goal
7. **Identify action to be taken** (this may include self-help as well as the services required) to achieve each goal within the period covered by the service coordination plan.
8. **Identify the individual or service** that will be responsible for implementing or managing the required action and enter the date that the responsible person/agency accepted this responsibility.
9. **Once the SCP is developed**, provide a copy to the consumer and to all team members.
10. **As consumer issues are resolved**, record the date under the 'Issue Resolved Date'. The date of consumer discharge from a particular service can also be subsequently recorded under 'Issue Resolved Date'.⁹

(For further explanation of the items in the Service Coordination Plan Template, refer to Primary Care Partnerships, Service Coordination Tool Templates, Guideline 4: Developing a Service Coordination Plan, May 2002, pps. 9 – 13)

⁹ Primary Care Partnerships, Service Coordination Tool Templates, Guideline 4: Developing a Service Coordination Plan, May 2002, pps. 8& 9

ATTACHMENT B

Interagency Care Planning Protocol Pilot Project
SUMMARY OF POST TRIAL DATA PROVIDED BY AGENCIES THAT
PARTICIPATED IN PILOTING THE PROTOCOL

Table 1: Number of Clients per PCP

PCP	Number of Clients
Moonee Valley Melbourne	14
Westbay	14
Brimbank - Melton	11
BNPCA	8
Total Clients	47

Characteristics of clients in Trial

- 37 (79%) of clients were existing clients. 10 (21%) were new clients.
- Approximately one third of clients fitted into the category “where there are two ‘clients’ – the person with the disability and the carer, both of whom have significant needs”
- Approximately half fitted into the category “with multiple disabilities (health, social, cognitive) needing assistance in a number of areas of their life”
- Clients also included people from non-English speaking backgrounds “where language or culture or family expectations mean that traditional service responses are not appropriate” and younger people with disabilities e.g. ABI, psychiatric, stroke
- Clients ranged from those with low complexity of needs to very high complexity. The level of complexity was reflected in the range of agencies involved – ranging from 3 to 7 agencies per client.

Table 2: Agency Involvement and Interagency Care Planning Method of Participation

Participants	Key Worker	Participating Agency Member	No. of Case Conference Meeting participated in (25)	Written Exchange/ Telephone (22)	Total Clients (47)
Local Government	13	24	19	18	37
RDNS	15	10	15	10	25
Community Health	9	8	5	12	17
Carer Links West	4	5	6	3	9
ACAS	-	9	3	6	9
Norwood	2	-	-	2	2
Wesley Do Care	1	1	1	1	2
MRC	2	-	-	2	2
GPs	-	29	15	14	29
Client(s)	1	-	21		
Other participants*	-	41	10	31	41
Total	47				

***Other Participants**Participated in Case Conferences

- Alzheimers Association x 3
- Ambulance Service
- APATT
- Benetas
- Care with Quality
- Carers Victoria x 2
- CMV
- DHS Disability Services x 2
- Gateway Social Support Options Program
- HARP
- MECWA
- Parkville Day Centre
- Psychiatrist
- Sunshine Office of Housing
- Sunshine Hospital Community Rehab

Participated by phone/written exchange

- COASIT
- Essendon Day Centre

- Hospital in the Home
- Hospitals – Peter MacCallum, Werrribee,
- HPP
- Mercy West Palliative Care
- PACFU
- PAG
- Pharmacists x 3
- Royal Park Campus
- Safety Link
- Salvation Army Supported Housing Service

Community Health Key Worker according to worker position

- Physiotherapist (1)
- Podiatrist (3)
- Social Worker (1)
- Community Health Nurse (1)
- Aged Worker (1)
- Community Support Worker (1)
- Carer Support Worker (1)

Table 3: Agency Involvement and Role of Agency by PCP

Moonee Valley Melbourne PCP			
Agency	Key Worker	Participating Agency	Clients
Moonee Valley City Council	4	7	11
RDNS – Essendon Centre	4	5	9
Doutta Galla Health Service	4	2	6
North West ACAS	-	5	5
Carer Links West	1	2	3
Melbourne City Council	1	1	2
GPs	-	8	8
Total Clients MVM PCP	14 clients		
Brimbank – Melton PCP			
Agency	Key Worker	Participating Agency	Clients
Brimbank City Council	-	4	4
ISIS Primary Care	3	1	4
Norwood Association	2	-	2
RDNS - Sunshine Centre	2	2	4
North West MRC	2	-	2
Shire of Melton	-	1	1
Carer Links West	1	1	2
Djerriwarrh Health Service	-	1	1
GPs	-	7	7
Total Clients B–M PCP	11 clients (1 client was a Key Worker)		

Westbay			
Agency	Key Worker	Participating Agency	Clients
Hobsons Bay City Council	4	3	7
RDNS – Altona Centre	4	1	5
Wyndham City Council	3	-	3
ISIS Primary Care	-	2	2
Western Region Health Centre	-	-	-
ACAS	-	4	4
Maribyrnong City Council	-	2	2
Carer Links West	2	2	4
Wesley Do Care	1	-	1
GPs	-	9	9
Total Clients Westbay	14 clients		
BNPCA			
Agency	Key Worker	Participating Agency	Clients
RDNS – Diamond Valley	4	2	6
RDNS – Heidelberg	1	-	1
Banyule City Council	-	5	5
Banyule Community Health Service	2	1	3
Nillumbik Community Health Centre		1	1
Nillumbik Shire	1	1	2
Wesley Do Care	-	1	1
GPs	-	5	5
Total Clients BNPCA	8 clients		

Table 4: Agency Involvement by PCP and Interagency Care Planning Method of Participation

Moonee Valley Melbourne PCP			
Agency	Case Conference Meeting	Telephone/Written Exchange	Clients
Total	7	7	14
Moonee Valley City Council	4	7	11
Melbourne City Council	1	1	2
RDNS – Essendon Centre	4	5	9
Doutta Galla Health Service	2	4	6
North West ACAS	2	3	5
Carer Links West	3	-	3
GPs	3	5	8
Brimbank – Melton PCP			
Agency	Case Conference Meeting	Telephone/Written Exchange	Clients
Total	3	8	11
Brimbank City Council	1	3	4
Shire of Melton	1	-	1
ISIS Primary Care	-	4	4
Djerriwarrh Health Service	1	-	1
Norwood Association	-	2	2
RDNS - Sunshine Centre	1	3	4
North West MRC	-	2	2
Carer Links West	1	1	2
GPs	1	6	7

Westbay			
Agency	Case Conference Meeting	Telephone/Written Exchange	Clients
Total	8	6	14
Hobsons Bay City Council	3	4	7
Wyndham City Council	-	3	3
Maribyrnong City Council	2	-	2
RDNS – Altona Centre	4	1	5
ISIS Primary Care	-	2	2
Western Region Health Centre	-	-	-
ACAS	1	3	4
Carer Links West	2	2	4
Wesley Do Care	1	-	1
GPs	6	3	9
BNPCA			
Agency	Case Conference Meeting	Telephone/Written Exchange	Clients
Total	7	1	8
Banyule City Council	4	1	5
Nillumbik Shire	2	-	2
RDNS – Diamond Valley	5	1	6
RDNS – Heidelberg	1	-	1
Banyule Community Health Service	2	1	3
Nillumbik Community Health Centre	1	-	1
Wesley Do Care	1	-	1
GPs	5	-	5

Post Trial Questions

The following is a sample of individual responses from key workers and participating agencies to the post trial questions 7 to 9 (see Attachment C).

Q. 7: From your perspective what have been the key outcomes for the client/carer?

Value of having a Key Worker

- Having a key worker to deal with when issues are raised. Family are feeling more secure knowing there is a key worker taking a special interest in the client.
- The care for the client is integrated for him and his wife as there is one person coordinating.
- The carer now has in place a designated person that they can refer to. Both the carer and the client now say that they feel that they have some degree of accountability again in their day to day support.

Value of multi-agency care planning

- The Case Conference Meeting allowed the client to relate to all the agencies involved in her care at the same time.
- Opportunity for carer to express concerns particularly around the need for improved communication/feedback from service-providers.
- Client and carers needs were clearly identified and then met through coordinated referrals to appropriate service providers
- Access to multiple service providers ie: Physios, OT, Podiatrist, Dietitian, Social Worker, etc.
- Provided forum for carer to share information with multiple service providers

Enhanced client/carer involvement

- Client has opportunity for more input into short term and long term planning.
- Greater involvement in the planning for the client's care. Ability to discuss problems in an open forum, with most relevant services present.
- Ability to be part of decision making and delivery of services.

Service outcomes

- Significant improvement in consumer's domestic situation
- Client will receive increased monitoring and review
- Joint planning between Agencies benefited client by generating new ideas and different ways of approaching issues/problems
- A more coordinated and effective provision of services
- We found service gaps that we filled

Q 8: As a service provider participating in this trial what have been the benefits?**Benefits for client**

- Client/Carer provided with single point of contact.
- Client able to witness services working together for their good
- Identifying an issue or problem for client and getting a satisfactory outcome is a positive for all involved
- It seems to be an empowering process for the client
- Fairly quick response to referral processes and services were able to engage and plan out a process of intervention
- Better understanding of client's condition/wellbeing
- Consistency of management leading to a faster and efficient recovery

Benefits for workers

- Saving time by meeting with carer and workers from other services so that information was exchanged and decisions made sooner
- Time saving – service providers and client meet together at one time
- More job satisfaction!
- Peer support for each service provider

Increased clarity for client/agencies

- Identification/clarification of roles & responsibilities of the individual service providers and/or agencies
- Enabled us to become more aware of the issues the client had and discuss problems with the other service providers as a group rather than individually
- Having a clear and defined pathway for interagency planning
- Clear review dates
- The recording of outcomes on Service Coordination Plan
- Timeframe for actions are clearly set
- The key worker is now a recognised / identified role, as opposed to the current informal support
- It formalised the process

Better communication between agencies

- Feeling of a unified, holistic approach where all parties have the same goal in mind. Able to contact and have contact information for other service providers involved with the client
- Clear action plan to support client/carers
- Saving time by meeting with carer and workers from other services so that information was exchanged and decisions made sooner
- Increased communication and information dissemination between agencies
- Consistent communication with family/agencies.
- Setting up networks for future referrals

Accountability

- Involved service providers working better in a collaborative and co-ordinated approach.
- Perhaps this more "formalised" process made people a little more accountable
- It provides consistency and accountability in service implementation and delivery.

Other Benefits

- Having GP involved with other service providers
- It maximises the utilisation of resources across involved service providers
- Consistency of care planning
- Expands our case involvement

Q8: As a service provider what have been the issues/challenges?**Key Issue raised by all sectors**

- Time and resources
 - time required to organise case conference meeting time
 - requirements of key worker
 - time consuming for follow up

Issues/Challenges raised by Local Government

- Where client requires case management it is difficult to pull back from a case management role
- Not all agencies would be interested in having time to participate in face to face case conference with a client where input is for a limited time only
- Hard to know if this Protocol is necessary when a comprehensive hospital discharge plan has occurred
- Choice of key worker difficult
- Identifying who would benefit from case conferencing type planning
- Changes needed to IT to accommodate documentation
- Engaging client's GP

Issues/Challenges raised by RDNS

- Change of key worker one week after the case conference
- Unavailability of OT(CHC) has delayed progress with organizing ongoing pressure relief which has resulted in prolonged episode with RDNS
- A lot of the services not aware of the trial and this made it more difficult to coordinate
- Time consuming paperwork
- Challenge to contact all agencies and await return calls
- Lack of resources (e.g. carer had to pay for a taxi to get to case conference)

Issues/Challenges raised by Community Health

- Reluctance of an agency to take formal key worker role
- Longer case discussion time preferable – limited by GP availability
- Communicating with so many services (7) – some part of PCP and others not
- Not all agencies may agree to participate
- A more specific definition of case conferencing may be of benefit
- Specialised services such as dietetics, physiotherapy and podiatry are often considered 'end of line' interventions with most referrals. The benefits from the SCP may be enhanced if conducted by 'generalist' case coordinators and care management personnel
- Paperwork
- The community health program has received extensive training on the use of a 'Flinders' model of complex conditions management. There appears to be significant duplication of interagency communication information with both models.

Issues/Challenges raised by PDSS

- General lack of appropriate resources for people with a psychiatric disability - any one who ends up with this diagnosis would need a Case Manager particularly for post - discharge diagnosis with follow up and monitoring
- Negotiating an appropriate plan for intervention often requires flexibility from service providers

Issues/Challenges raised by others

- Clients/carers need to be educated about the PCP interagency care planning (Carer Links West)

Q. 9: Please describe how useful or otherwise the PCP Service Coordination Plan was for this consumer and the services involved

Service Coordination Plan

Positives:

- The Service coordination Plan was useful as a documentation form, as it allowed us to set a goal / review time for actions taken.
- The form was relatively simple to use and enabled everyone involved to understand the eventual outcome.
- The Plan was very useful, it provided structure for the meeting. The process allows for lateral thinking. I think the Plan also provides a record for each service involved to refer back to.
- The PCP Service Co-ordination plan was useful as it provided a procedure for action.
- The identified problems and goals in the SCP would be extremely beneficial to new or changes in staff.
- We were able to plan appropriate care needs for client with communication of all agencies. This is a useful tool to use with high needs complex care clients.
- Useful for service-providers (and perhaps carer), re opportunity to outline concerns and gain realistic assessment data to guide joint action plan.
- Although the PCP Service Coordination Plan was not directly used to establish a service provision for this consumer, the Plan remains a sound format for addressing the needs of the consumer and how to go about structuring service delivery for a consumer.

Suggested improvements to form:

- The layout of the document needs improvement and it is not user friendly as not all issues can fit neatly in a Box with a target date, goal & action
- Useful in that goals and actions are briefly defined for all parties. However, would benefit from additional sections describing in detail the background to the issue, interventions trialled and requests of the other services to aid in health provision for the client
- Forms overlapping all documented care services which are evident on RDNS admission and general assessment forms and in notes as required

Issues raised about the Trial itself

- The biggest challenge was the limited time we had to actually put the trial in place
- The timeline for the pilot was very tight and probably led to us making some client choices that were not well thought out. The one client we did end up becoming involved with highlighted the deficiency we had in terms of staff skills, specialist resources to support the staff and the resources limitation for the unit
- More training on the protocol itself was required
- Difficult to identify clients – most who met criteria are receiving packages
- Outcomes for the clients were hard to assess in the short time frame
- Planning and preparing staff for the trial was difficult due to short trial period – hence inability to manage change associated with project
- The benefits of a longer trial would have allowed time for process from a broader operational point of view and from the perspective of practitioners integrating the concept into their practice i.e. more time for a change management approach

ATTACHMENT C

PCP INTERAGENCY CARE PLANNING TRIAL DATA FORM

Client Identifier (Initials)	"[Click here and type]"
PCP Catchment	"[Click here and type]"
Agency	"[Click here and type]"
Position Title	"[Click here and type]"
Role: <i>(Cross appropriate box)</i>	Key Worker <input type="checkbox"/> Participating Team Member <input type="checkbox"/> <i>If Key Worker, complete all questions. If Team Member only, complete Questions 7 to 9</i>
1. Which 3 or more agencies are involved in this care planning process? "[Click here and type]"	
2. Describe briefly the client/carer circumstances (i.e. the reasons for an interagency care planning approach) – include where appropriate, reference to 'complex needs' definition in the Protocol "[Click here and type]"	
3. When was the interagency care planning process initiated: <i>(Please x appropriate box)</i> <input type="checkbox"/> during INI <input type="checkbox"/> following assessment <input type="checkbox"/> following a review <input type="checkbox"/> during an existing case conference meeting <input type="checkbox"/> other (specify)	
4. Was the client: <i>(Please x appropriate box)</i> <input type="checkbox"/> a new client <input type="checkbox"/> an existing client	
5. What was the method of interagency care planning? <i>(Please x one or more boxes)</i> <input type="checkbox"/> Case Conference Meeting <input type="checkbox"/> Telephone Conference <input type="checkbox"/> Written exchange of information	
6. Was the client and/or carer present at Case Conference Meeting/Telephone Conference? <i>(Please x appropriate box)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. From your perspective what have been the key outcomes for the client/carer? "[Click here and type]"	
8. As a service provider participating in this trial what have been the benefits and issues/challenges? <u>Benefits</u> "[Click here and type]" <u>Issues/Challenges</u> "[Click here and type]"	
9. Please describe how useful or otherwise the PCP Service Coordination Plan was for this consumer and the services involved? "[Click here and type]"	