Primary Health Branch
Towards a demand management framework for community health services
February 2008
Primary Health Branch

Towards a demand management framework for community health services
Foreword

Victoria’s health system continues to experience increased demand for services. This increase is in line with a number of key factors including the increased incidence of chronic and complex conditions, population growth and ageing.

Improving access to the existing network of Community Health Services throughout the State is an important aspect of providing the best possible care for Victorians within their community.

The Primary Health branch recognises the demand pressures that Community Health Services experience and appreciates the challenge in meeting these demands. The demand management framework articulates a consistent demand management model for Community Health Services. It addresses waiting list definition, prioritisation and management of allied health, counselling and nursing services funded through the Community Health Program.

The framework was developed for and with the Community Health sector. I would like to thank those clinicians, professional association representatives and members of the academic sector who contributed to the development of the priority tools. Attendance at the demand management forums and workshops, and willingness of agencies to participate in trialling and evaluating the priority tools has been greatly appreciated. The level of involvement by Community Health Services signifies the importance of, and commitment to this issue.

This document provides direction and decision making support to assist Community Health Services in prioritising their services to those that need them most, including population groups that are disadvantaged. The framework will assist in the alignment of practice to better reflect policy and strategic directions.

I encourage Community Health Services to use the strategies outlined in this document to help continue to meet the challenge of delivering the right care at the right time to those who most need it.

Janet Laverick
Director Primary Health
Acknowledgements

The development of this demand management framework is the result of input from many people. We would like to thank the Department of Human Services project team and program staff who contributed to the development of this document.

We would also like to acknowledge the input of the staff who participated in the working groups to develop the priority tools, and their agencies for allowing them the time to be involved. The members of the working groups are listed below.

Consumers and other CHS staff have also contributed via workshops and forums to the development of this framework. We thank them for their time and their feedback.

We acknowledge the previous work completed by Dental Health Services Victoria (DHSV) and TenSoft Consulting in developing the Dental Emergency Demand Management System (EDMS) triage tool.

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Glossary

BATS Better Access to Services: A policy and operational framework
C&WH Community and Women’s Health
CHN Community Health Nursing
CHS Community Health Service
CIYC Care in Your Community policy
DHS Department of Human Services
DHSV Dental Health Services Victoria
DVA Department of Veteran Affairs
ECIS Early Childhood Intervention Services
EDMS Emergency Demand Management System (Dental)
EPC Enhanced Primary Care
FTA Failed to Attend
GPV General Practice Victoria
HACC Home and Community Care
HARP CDM Hospital Admission Risk Programs Chronic Disease Management
IC Initial Contact
IHP Integrated Health Promotion
INI Initial Needs Identification
MBS Medicare Benefits Schedule
OT Occupational Therapy
PAC Post Acute Care
PASA Program and Service Advisor
PCP Primary Care Partnership
SCTT Service Coordination Tool Templates
SSW Single Session Work
TCA Team Care Arrangements
1. Introduction

1.1 Rationale
Community Health Services (CHSs) are part of a broader health system that faces major challenges. An ageing population and increasing burden of disease from chronic health conditions have increased demand on the health system, including CHSs. Current and future policy directions place the needs of consumers as central in developing an organised and integrated health care system that provides consumers access to services when and where they need them.

In preparing CHSs for their evolving role in delivering health care services, this document aims to improve and consolidate current practices in managing demand. The framework will:

• improve the consistency of practices in measuring and managing demand, providing improved data that can be used for benchmarking, service planning and funding allocation
• support fair and equitable access to services based on equal access across the state for equal needs, with disadvantaged people provided priority access to reduce the inequality in health status
• provide improved access to services for clients by assisting CHSs to provide high quality, efficient, effective, evidence-based services.

The framework has been developed in consultation with the sector and consumers.

1.2 Use of this document
This document:

• is referred to as ‘the framework’
• outlines the basic principles underpinning equitable and timely access to CHSs
• provides tools for prioritising clients requiring services
• identifies systems and strategies to manage clients from initial contact to exit from a service.

This framework provides direction and decision-making support to assist CHSs to prioritise their services to those who need them most, including population groups that are disadvantaged, thus ensuring practice reflects policy and strategic directions (Primary Health Branch Policy and Funding Guidelines 2006–07 to 2008–09).

While the framework aims to generate consistency in practice through application in all CHSs, it can be applied flexibly at a local level. CHSs can incorporate local priorities derived from area-based plans, participate in local/Primary Care Partnership (PCP)/regional initiatives and protocols, and continue to respond to local community needs. Implementation of the framework should occur in consultation with the regional Department of Human Services Program and Service Advisor (PASA).

1.3 What services does this framework apply to?
This framework applies to all services provided from CHSs, where practicable, in order to provide an integrated and consistent approach to managing demand for the CHS and clients. Some programs delivered through CHSs have overriding policies that may require CHSs to modify the application of this framework to those programs. For example, program areas with eligibility criteria, such as Dental, should apply the principles of this framework to those eligible for their service.

This framework also applies to community dental clinics in other health services that are funded by the Community Dental program.
2. Background

2.1 Role of Community Health Services
Promotion of health, wellbeing and independence within the social model of health are central to community health. This includes preventing illness, disease and injury; promoting equity, accessibility and participation in service delivery; and reducing health inequalities. CHSs target services to minority, high risk and difficult to manage client groups, including people with complex conditions, disabilities and chronic illnesses, such as diabetes, cardiovascular disease and depression. CHSs also respond to current and emerging local community needs.

CHSs play an important role in preventive, rehabilitative, maintenance and support programs. Many deliver services funded by the Community and Women’s Health program (C&WH) and the Community Dental program in conjunction with services funded from other program areas including Home and Community Care (HACC), drug and alcohol and others.

2.2 Policy context
The following State and Federal policies and initiatives impact on this framework and demand management in CHSs.

2.2.1 A Fairer Victoria
A Fairer Victoria is the State Government’s overarching social strategy for meeting Victoria’s future challenges and improving the lives of all Victorians. It emphasises the provision of accessible and affordable universal services and targeting support for those in greatest need, and tackles inequality and disadvantage by:
• emphasising early intervention and prevention
• matching local service delivery to individual needs
• assisting communities to support individuals to overcome problems
• making services easier to access, more responsive and more successful.

These principles have been considered in the development of this framework.


2.2.2 Metropolitan Health Strategy
The Metropolitan Health Strategy has a focus on provision of services at an optimal level to meet growing and changing demands on the health system. CHSs need to ensure services provided are safe, high quality, appropriate, sustainable and accessible.

This framework will complement other activities, such as the Hospital Demand Management Strategy, to provide a complete picture across the health care system.

This policy is located at: http://www.health.vic.gov.au/metrohealthstrategy/index.htm

2.2.3 Rural Directions for a Better State of Health
Rural Directions for a Better State of Health provides a framework for rural health services to continue to develop and enhance their role in the systems of care in rural Victoria. This includes safe, planned, high quality and coordinated services designed to meet community needs.

This policy is located at: http://www.health.vic.gov.au/ruralhealth/hservices/directions.htm

2.2.4 Care in Your Community
Care in Your Community (CiYC) sets out a ten-year vision for the delivery of integrated and coordinated health care around the needs of people, rather than service types, professional boundaries, organisational structure, program funding or reporting requirements. Health services will be increasingly delivered in community-based settings, reducing the need for inpatient care and improving the health outcomes of Victorians.

CiYC is particularly important to the community health sector because it articulates the rationale for a greater shift towards ambulatory-based care. Factors influencing the focus on providing health care in community-based settings include:
• recognition that care can be delivered safely and effectively without prolonged inpatient admissions
• development of new technology that enables out-of-hospital care
• pressure on expensive inpatient resources
• improved collaboration between Australian and state governments supporting increased community-based care
• recognition of the importance of health promotion and illness prevention.

As the redesign of the delivery of ambulatory services directed by the CiYC policy will impact upon CHS demand, clear access criteria and systems are required to enable appropriate service use by clients requiring community-based care.

This policy is located at: http://www.health.vic.gov.au/ambulatorycare/careinyourcommunity/index.htm

2.2.5 Primary Care Partnerships strategy

The Primary Care Partnerships (PCP) strategy aims to:
• improve the experience and outcomes for people who use primary care services via the service coordination initiative
• reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.

More than 800 services have come together in 31 PCPs across Victoria to progress the reforms. Further information is available at: http://www.health.vic.gov.au/pcps/index.htm

The PCP strategy includes the following:

Service Coordination

Service coordination aims to place consumers at the centre of service delivery to ensure they have access to the services they need, opportunities for early intervention and health promotion, and improved health and care outcomes. This framework articulates the relationships between the Initial Contact, Initial Needs Identification elements of Service Coordination and prioritisation of clients using the language and principles of Better Access to Services: A policy and operational framework (2001) (BATS).

This policy is located at: http://www.health.vic.gov.au/pcps/publications/access.htm

CHSs have developed service access models that reflect local consumer and community characteristics, local circumstances and service availability. This framework has considered the different practices and systems of the range of service access models in CHSs.

There are three main service access models, which are described in the document Service Access Models: A way forward. Resource guide for Community Health (2006). It provides information about how to review, select, implement and evaluate a service access model. This document is located at: http://www.health.vic.gov.au/communityhealth/publications

Integrated Health Promotion (IHP)

IHP refers to collaborative work across a catchment aimed at improving the health of local communities, especially those with the most disadvantaged and poorest health status, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues. Further information is available at: http://www.health.vic.gov.au/healthpromotion/what_is/index.htm

This framework applies primarily to direct service delivery to clients, therefore it is not directly applicable to activities delivered through health promotion funding from the C&WH program.

Integrated Chronic Disease Management (ICDM)

ICDM includes:
• planned and proactive care to keep people as well as possible
• empowering, systematic and coordinated care that includes regular screening, support for self-management, and assistance to make lifestyle and behaviour changes
• coordinated care by a range of health services and practitioners
• care over time through the stages of disease progression.

PCPs work with and support agencies to provide a coordinated approach to the planning and delivery of health services for clients. The Wagner Chronic Care Model (see 6.3.10) has been endorsed as the framework to support service system development to meet the needs of clients with chronic and complex care needs.

2.2.6 Community Health Policy: Community Health Services—creating a healthier Victoria

Community Health Services—creating a healthier Victoria identifies five strategic directions:

• community health services as a platform for delivery of primary health care
• coordinated community-based disease management and ambulatory care
• expanded primary medical care
• focus on child and family health
• leadership in health promotion.

Key enablers to achieve the strategic directions include a focus on ‘business systems and quality’. This includes the development and improvement of systems, including demand management, to enhance their quality and efficiency across CHSs.


2.2.7 Primary Health Branch Policy and Funding Guidelines 2006–07 to 2008–09

The Primary Health Branch Policy and Funding Guidelines provide advice and directions regarding the C&WH and new initiatives such as Aboriginal Health Promotion and Chronic Care Partnership (AHPACC), Child Health Teams, Early Intervention in Chronic Disease, and Refugee Health.


2.2.8 Improving Victoria’s oral health

The vision for Improving Victoria’s oral health is that all Victorians will enjoy good oral health and have access to high quality health care delivered in an affordable and timely fashion when they require it. Improving Victoria’s oral health is the government’s four-year strategic oral health plan.

The principles for Improving Victoria’s oral health are consistent with CiYC. Improving Victoria’s oral health outlines six strategic developments or major projects that reorganise the management and delivery of public oral health care:

• oral health service planning framework
• integrated service model for adults and children
• workforce strategy
• oral health promotion
• responding to high-needs groups
• oral health funding, accountability and evaluation.


2.2.9 Medicare Benefits Schedule and chronic disease management

The suite of new Medicare Benefits Schedule (MBS) items introduced as part of the Enhanced Primary Care (EPC) program is a Federal health initiative that provides additional options for preventive care for older Australians and coordinated, ongoing care for people with chronic conditions and complex care needs. Some clients who access services through CHSs may be eligible for additional services funded through the EPC program. Details of these MBS items can be found at the website: [http://www.health.gov.au/epc](http://www.health.gov.au/epc)

Each MBS item number requires certain services to be performed in order for a rebate to be claimed, so CHSs need to carefully consider the appropriateness of these services for their clients. Planning these service models may require new partnerships with private practitioners to help provide services or the development of new business models that allow CHSs to deliver services in a way that enables clients to access rebatable Medicare services.

2.2.10 General Practice Victoria

Divisions of General Practice are located across Victoria and aim to improve health outcomes of people in their local area by encouraging GPs to work together and with other health professionals to raise the quality of local health service delivery. General Practice Victoria (GPV) is the representative body that functions as a central contact point between GP divisions and other organisations for health system development in Victoria. Further details can be found at the website: http://www.gpv.org.au/

CHSs should contact their local GP division when looking to communicate, establish protocols or build relationships with local GPs. Contact information for GP divisions is on the GPV website.

Additionally, those CHSs with GP clinics need to be aware of the activities of their local GP division to support best practice for managing demand. For example:

- quality improvement initiatives such as accreditation support or the National Primary Care Collaborative (NPCC)—Access stream (see website: http://www.npcc.com.au)
- supporting access to external private providers, for example, private psychologists, through the Better Outcomes to Mental Health Care Program (see website: http://www.primarymentalhealth.com.au)

2.2.11 Victorian State Disability Plan 2002–2012

The Victorian State Disability Plan 2002–2012 outlines the government’s vision to enable people with a disability to engage more equally and fully in the life of the Victorian community, with the same rights, responsibilities and opportunities as all other citizens. The goals of the plan are:

- Strengthening the Victorian community so that it is more welcoming and accessible to people with a disability.
- Enabling people with a disability to pursue individual lifestyles.
- Developing more inclusive and accessible public services, and promoting non-discriminatory practices.

The Disability Act 2006 provides the legislative framework to support these goals. An important aspect of the Victorian State Disability Plan and the Disability Act is ensuring people with a disability have equitable access to the services and supports that are provided to other Victorians.

3. Demand Management Framework

3.1 What is demand and demand management?
In health, demand refers to the number of clients and consumers with health concerns who present for services and the amount of services they require. In recent years several factors have contributed to growing demand, including an ageing population, higher client expectations, and an increase in prevalence of chronic disease. As a result, clients often need to wait for the services they require.

Demand management is not easy. It requires CHSs to:
• continue to address the broader health needs of the community through health promotion and early intervention activities that take a preventative approach to health
• review their internal practices to ensure the services are efficient, of high quality and targeted to the needs of clients.

Demand management requires attention to the processes and practices that occur during each stage of the client pathway through the CHS. This framework identifies three stages: Inflow, Flow through and Outflow. These are described below in sections 3.4, 4, 5 and 6.

This framework identifies opportunities for improvement on current practice and provides tools to assist CHSs to provide timely access to services for those who need them. It aims to address the need for the CHSs to adopt a consistent approach to demand management for current services, while acknowledging that the sector will increasingly participate in the development of comprehensive demand management strategies within an integrated health service system.

3.2 Measuring demand
The use of a consistent process to measure demand can provide useful and powerful information. It requires a system that accurately records waiting times and client throughput.

Benchmarking within and across agencies can assist with service planning and local resource allocation decisions. Differences in ability to manage demand can be identified. Consistent statewide practice will facilitate equitable access to services, and strengthen the benchmarking process.

The demand measurement guidelines describe the new system for measuring and comparing demand in Community Health funded programs. This document is located at: http://www.health.vic.gov.au/communityhealth/downloads/dm_waitingtimes.pdf

To ensure C&WH funded services are comparing demand in the same way, it is important that the Primary Health Branch Policy and Funding Guidelines are implemented for these programs, including the points outlined below.

3.2.1 Maintaining an 'open' waiting list
Services funded through the C&WH and Dental programs must not close waiting lists to new referrals.

3.2.2 No geographical restrictions
Services funded through the C&WH and Dental programs must not restrict services on the basis of where people live. People are free to choose which CHS they will attend, and CHSs must not restrict access to people living or working in a specified catchment area. This includes people living across state borders but near service sites in Victoria.

The gazetted catchments of stand-alone CHSs relate to membership and governance, and while a CHS will primarily relate to, plan for and serve the community in its catchment, people outside the catchment may still access its services. This is relevant when a particular service is not provided at the local CHS, or a client finds a CHS outside their catchment more accessible. If any difficulties arise due to these circumstances, they should be addressed in partnership with neighbouring agencies and the department’s regional office.

Most clients prefer, and should be encouraged, to access their local CHS provider; however they retain the option of choosing to attend a CHS outside their local area. Decisions regarding priority for out of area clients should be based on their individual needs, not where they live.

3.2.3 Communicating about available services
CHSs should communicate any changes to their services to the local community and referring agencies. This includes changes due to new services, staffing loss, service plans or holiday closures.

The level and nature of the communication may be based on strategies to manage demand and to target priority client groups, as determined at the agency level.
3.3 Local area influences on demand

This framework is intended to guide consistent good practice across the state; however, CHSs need to maintain their ability to respond to local community needs. Agencies should consult with their regional Department of Human Services PASAs as well as neighbouring CHSs and PCP partner agencies regarding proposed additions to the priority areas recommended in the priority tools included in this document. However, the priority population groups included in the Generic Priority Tool should not be removed. CHSs should consider the following factors in the implementation of this framework.

3.3.1 Integrated area-based planning

The CiYCYC policy advocates an integrated area-based planning approach that includes the identification of catchment priorities for service and capital development. Some CHSs have already participated in integrated area-based CiYCYC planning and, over time, others can expect to be involved. As a result, CHSs should consider including both their local integrated area-based planning priorities and the broader CiYCYC target groups and programs as priorities.

3.3.2 Current demographic profiles

CHSs not currently involved in CiYCYC planning should still review the demographic profiles of their local area to assist with identifying local impacts on demand. This analysis can assist in identifying local community needs to ensure services are delivered to meet these needs. CHSs should utilise documents such as service plans and Integrated Health Promotion plans, to identify the needs of their community and gaps in the local service system. This analysis may lead to local modifications to implementation of the Generic Priority Tool. For example, CHSs with a high representation of clients identified as a priority population may need to modify the way they deliver services to these clients or a CHS may add additional client groups identified as a priority based on their unique population characteristics.

3.3.3 Emerging issues

Issues may emerge within a local community that are not anticipated. These include natural events such as drought or flood, which can have devastating effects on the local community, and may also include a significant change in demographics or community structure due to a changing economic and/or political climate. This framework provides the capacity to respond to these emerging issues through agency consultation with their regional PASA.

3.3.4 Staffing and service provision

Not all CHSs provide the same services. Certain services may be unavailable at some CHSs or there may difficulty filling some positions. Services unavailable due to temporary staff vacancies should maintain a waiting list. An active waiting list management system (see section 5.1 below) should be in place to monitor clients as time extends. CHSs should communicate with the local community and referring bodies to inform them about this process. Alternate models of care and service delivery should be explored to be able to address these clients’ needs, in consultation with like organisations and the regional PASA.

3.4 Elements of managing demand

The following diagram represents the key elements in managing demand. This includes health promotion activities (see section 4) and the client pathway through CHSs. This pathway identifies three discrete stages:

• Inflow (see Section 5)
• Flow through (see Section 6)
• Outflow (see Section 7).

Client management at each stage of this pathway has an impact on the demand within a service. Strategies and systems to support efficient and best practice are required along this continuum. This framework addresses each of the stages of this pathway, and assumes that a client enters and subsequently exits the service system.
Elements of managing demand

A comprehensive demand management model needs to address these elements

Health promotion
Prevention and population-based approaches

Inflow
- Initial client contact
- (I)NI
- Service access models and issues
- Prioritisation (generic and clinical)

Flow through
- Assessment
- Care planning
- Service provision
- Client pathways
- Waiting list management and appointment processes including review and recall systems
- Cancellations and Failed To Attends
- Service models (e.g. SSW)
- Use of group sessions
- ‘Roadblocks’ or unnecessary or duplicated steps

Outflow
- Exit
- Referral
- Exit preparation
- Exit criteria
- Exit policies, processes and information
- Review and recall systems

Referral out
4. Health promotion

The Ottawa Charter (1986) defines health promotion as:

the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

There is growing evidence that an integrated approach to health promotion delivers benefits for the community through promoting positive wellbeing, strengthening community capacity and minimising the burden of serious diseases.

CHSs have an important role in health promotion, in conjunction with their PCPs and other member agencies. The health gains and outcomes achieved through health promotion activities can reduce the need for health services, or reduce the intensity/frequency of the need for health services.

CHSs should continue their collaborative work to improve the health of local communities, especially those with the most disadvantaged and poorest health status, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.

Further information is available at:
5. Inflow

Inflow refers to the point of entry to the CHS, where the key tasks are to establish the most appropriate service/s for the client, and to determine their level of priority for the services they need.

5.1 Service Access Models

While CHSs vary in size, business practices and service access models, all conduct the service coordination elements of initial contact and initial needs identification (INI). These activities may be conducted and staffed differently depending on the service access model in place.

There are a number of resources to assist with implementation of service coordination within an organisation and to establish processes between referring partners. These include:

- Service access models: a way forward. Resource guide for community health
- Victorian Service Coordination Practice Manual
- Service Coordination Tool Templates (SCTT) 2006 User Guide
- Service Coordination Tool Templates (SCTT) 2006 Reference Guide


The case studies included in Appendix 10 demonstrate the process of service coordination and use of the priority tools with different service access models in place.

5.2 Initial needs identification (INI) and priority of access

INI is the initial screening process that explores the presenting and underlying issues of a client and assists with determining the need for referral to other services.

The INI is not a diagnostic process or detailed assessment. It aims to identify the client’s needs, and determine their level of risk and priority for service. A number of resources assist with the INI process:

- Victorian Service Coordination Practice Manual
- SCTT, in particular the profiles that assist with broad investigation of a client’s needs
- priority tools that assist in determining a client’s priority for service within the CHS (see sections 4.3 and 4.4 below).

Prioritisation ensures that clients with high clinical needs and/or disadvantage are provided a timely assessment and access to services. Doing this effectively, appropriately and in an evidence-based fashion is a critical part of meeting duty of care obligations and addressing client and community needs. Chronological waitlists that do not consider client need and urgency for services should not be used.

The priority tools included in this document are:

- a Generic Priority Tool applicable to all clients
- clinical priority tools for the following disciplines:
  - Counselling
  - Dietetics
  - Occupational Therapy (Adult and Paediatric)
  - Physiotherapy (Adult)
  - Podiatry
  - Speech Pathology (Paediatric)
  - Dental Emergency Demand Management Strategy triage tool.

These clinical priority tools should be used once the need for a particular service has been identified. Where clients require more than one of these services, all applicable clinical priority tools should be used.

Use of the priority tools will establish the client’s priority level (priority 1, 2 or 3). Priority 1 clients are the highest priority and should be seen as quickly as possible. Priority 3 clients have the lowest priority and will wait the longest. All people placed on a waiting list should receive a service.

Once a client receives an assessment, the service should tailor their intervention to the client’s needs, regardless of their level of priority when they entered the service.

The diagram Community Health Service Priority Tools and the Consumer Pathway through Service Coordination (see below) provides a visual representation of the relationship of INI and the priority tools.

Information provided by clients and/or referral sources during INI, including the priority level, should always be documented, using the SCTT. This provides clinical staff with baseline client information to inform their specialist assessment and intervention.
Initial Needs Identification (INI)
INI is an initial assessment process where the underlying issues as well as presenting issues are uncovered to the extent possible. It is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service and a balancing of the service capacity and the consumers need.¹

Service Coordination Tool Templates (SCTT)²

Service Coordination Tool Templates (SCTT)²

Consumer Information
Summary and Referral
Profiles
Consent to Share Information

Information and Documentation Interact

CHS Priority Tools ³

Generic Priority Tool

People that do not meet population group priority criteria (see box to right)

Priority population groups:
Indigenous people
Refugees
Homeless (at risk of homelessness)
People with complex/multiple needs

Clinical Priority Tool/s:
- Counselling
- Occupational Therapy - Adult
- Occupational Therapy - Psychiatric
- Physiotherapy - Adult
- Podiatry
- Speech Pathology - Paediatric

Determine Priority Level for Relevant Discipline/s

Priority 1
Priority 2
Priority 3

Assessment
A decision-making methodology that collects, weighs and integrates relevant information about the client. Assessment is not an end in itself but part of a process of delivering care and treatment. It is an investigative process using professional and interpersonal skills to uncover relevant issues to develop a care plan.⁴

Assessment processes depend on agency structure

Comprehensive Assessment
A face-to-face interaction with a consumer, involving an intense level of inquiry, and an advanced dimension of history taking, examination, observation and measurement/testing. It facilitates a more extensive process of inquiry that requires analysis and interpretation of the assessment information and a clinical judgement, diagnosis and differential diagnosis.¹

This may be conducted by a key worker or a multidisciplinary team.

Service Specific (Individual Discipline) Assessments may also be required.

Care Planning
A process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, reviews, reassessment and monitoring. Care planning involves the identification of needs as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.⁴

Service Delivery
The structure, frequency and delivery of services should be tailored to suit the client.

Service delivery should:
- Be evidence based
- Be goal focussed (client-centred)
- Encourage and support self management and client empowerment.

It may include:
- Individual intervention
- Group sessions
- Information/education sessions
- Home programs
- Recall appointments

Information provision (including referral), Feedback, Service Provision, Exiting (these can happen at any point) ¹

References:
2. Department of Human Services (2001). Service Coordination Tool Templates

Victoria
The Place to Be
5.3 Generic Priority Tool

A Generic Priority Tool applicable to all clients presenting to CHSs has been developed in consultation with the sector (see Appendix 1). It reflects the philosophy and policy directions outlined in section 2.2, especially the Community Health Policy which prioritises service delivery for people with the poorest health status and the greatest economic and social need for service. It values the multiple determinants that influence the health of individuals and communities (social model of health).

The Generic Priority Tool should be used as a first step in determining the priority of access for clients. It identifies the appropriateness of CHSs to address clients’ needs, responds to clients with an immediate need, and establishes priority based on population characteristics rather than clinical risk or presentation.

The Generic Priority Tool addresses population groups that require a consistent approach from all services in terms of prioritising. Population groups requiring different approaches to prioritisation from individual discipline perspectives have been considered in the clinical priority tools.

As outlined above (section 3.3), agencies may add priority groups in response to local community needs.

5.3.1 Establishing the most appropriate service

The health care system is complex and often confusing for consumers. It is important that clients are assisted to access the most appropriate service to meet their needs.

As the scope of services provided through CHSs varies across the state, individual services need to identify the client groups most appropriate for their service. This allows services to identify clients that may be better serviced through another part of the service sector. Identifying such clients may occur during any stage of the Initial Contact (IC), INI and throughout assessment and intervention. With their consent, these clients should be referred on to the most appropriate service to meet their needs.

Clients who require services within the CHS should be prioritised based on the following considerations.

5.3.2 Prioritisation based on immediate risk/need

People with an immediate risk to their safety or the safety of others

Priority should be given to clients who present with an immediate risk to their safety or pose a risk to the safety of others, for example, those at risk of harm to self or others. An initial response is required by the CHS, as there is a duty of care to provide support and ensure the safety of clients while awaiting appropriate services. Staff with appropriate skills and qualifications should manage the situation until appropriate care is in place. Some CHSs may have staff who are appropriate to manage these clients and others are likely to require input from specialist services such as a Crisis Assessment Team (CAT).

5.3.3 Prioritisation based on population health

Indigenous people (see Appendix 1 for definition)

There are significant inequalities in the health status of Indigenous Australians compared to non-Indigenous people. Therefore they should be considered a priority group for access to services.

Service provision for Indigenous people needs to be culturally respectful, be underpinned by principles of self-determination and collaboration, and address all aspects of health, including prevention, health promotion and treatment.

All CHSs should identify this population group and provide a culturally appropriate service.

Refugees (see Appendix 1 for definition)

Refugees have been identified as having unique and greater health needs than the general population. As a result this client group should be prioritised.

Service provision for refugees needs to be culturally appropriate, and provided through interpreters as required.

All CHSs should identify this population group and provide a culturally appropriate service.
Clients who are homeless or at risk of homelessness (see Appendix 1 for definition)

This client group needs to be prioritised to maximise the opportunity to provide services to this disadvantaged client group. Service delivery needs to be flexible; an outreach model of care may be more appropriate than a centre-based service.

5.3.4 Prioritisation of clients with complex care needs to ensure a coordinated team approach

This client group is prioritised to ensure the best outcomes are achieved and to prevent inefficiencies that occur when services within the CHS and partner agencies are not coordinated. These clients should be identified on the basis of the complexity of their need for services rather than the complexity of their health condition.

This includes people with existing Inter- or Intra-agency care plans, for example, Team Care Arrangements (MBS# 723 or #727) and GP Mental Health Care Plans (MBS #2710 or #2712) from GPs, Disability Support Plans, Child and Family Action Plans and Care and Placement Plans (for Child Protection and Family Services clients).

It also includes people who are identified through the INI process as requiring a care plan, such as people with multiple services currently in place who would benefit from a care plan, and those presenting for the first time who require multiple services. CHSs should offer to facilitate the care planning process for these people. This includes providing information about care planning, obtaining consent, selecting an appropriate key worker or care plan coordinator, and liaising with all service providers and carers where appropriate (within the CHS and partner agencies) involved in the client’s care. For further information about care planning see: http://www.health.vic.gov.au/pcps/cooordination/care_planning.htm

This approach is evidence-based and is reflected in current policy and strategic directions, such as the Early Intervention for Chronic Disease initiative and Child Health Teams, and should be expanded to include core services in CHSs.

5.4 Clinical priority tools

The clinical priority tools (previously called the discipline specific priority tools) prioritise clients on the basis of their clinical presentation. They should be used once the need for a particular discipline has been determined.

Clinical priority tools have been developed through seven working groups representing each discipline. These groups include representatives from the community health sector (program managers and clinicians), academic institutions and peak bodies.

The groups have reviewed available literature and examined examples of priority tools currently used by CHSs to form an evidence base for the development of each priority tool. They have consulted with peers and colleagues through existing networks during this process.

The Clinical Priority Tools developed are:

- Counselling (see Appendix 2)
- Dietetics (see Appendix 3)
- Occupational Therapy—Adult (see Appendix 4)
- Occupational Therapy—Paediatric (see Appendix 5)
- Physiotherapy—Adult (see Appendix 6)
- Podiatry (see Appendix 7)
- Speech Pathology—Paediatric (see Appendix 8).

A Community Health Nursing (CHN) working group was also formed. This group identified a large disparity in practice, and minimal or no waiting times for accessing their services. The group decided it was not appropriate to develop a clinical priority tool.
The Emergency Demand Management System (EDMS) triage tool for dental services (see Appendix 9) should be used for screening clients requiring dental services to identify those who need emergency treatment. The Dental program has also established priority groups, in addition to those identified in the Generic Priority Tool, which should be offered the next available appointment for routine care. The groups are:

- children up to 12 years of age, and 13–17 year olds who are dependents of health care or pensioner concession card holders
- children and young people in residential care provided by the Office of Children up to 18 years of age
- eligible pregnant women.

The Department of Human Services encourages the use of the clinical priority tools.

The introduction of clear and consistent prioritisation of clients can assist services that make referrals to more than one CHS and referring agencies can ensure that referrals include all relevant information for the CHS to determine the client’s priority level. This improved communication strengthens collaboration and assists clients to receive the services they require.

### 5.5 Case studies

Appendix 10 contains a number of case studies around the practical application of the priority tools and how they should be applied with different service access models.
6. Flow through

Flow through refers to the activities that occur once a client has entered the CHS for a service or services until the time they leave the CHS. This typically includes a service-specific or comprehensive assessment, followed by a planned period of intervention.

A number of policies and procedures are needed to effectively manage and coordinate the client’s pathway from intake to service delivery. These are identified below. They are included to assist agencies in developing and documenting their own policies and procedures to guide practice.

6.1 Waiting list management

Clients should be given an appointment during the time of initial contact, where possible. Services that can respond to clients quickly will not require a waiting list. However, those unable to offer an appointment should form a waiting list. It is recommended that an active waiting list management system is used to ensure that the waiting list reflects current demand. This should include the elements outlined below.

6.1.1 Providing information to the client

Clients should be provided written information at the time they are placed on a waiting list. This should include:

- the anticipated waiting time
- advice that the client can initiate a review of their level of urgency if their condition changes (either improvement or decline)
- who to contact, and how to contact the service, if required
- advice to update the agency if their contact details change
- options available for interim management while awaiting individual care.

6.1.2 Maintaining current client information

Any client contact should be used to confirm that the client’s information remains current. This will help ensure clients are contactable when an appointment is available.

6.1.3 Reviewing the client’s level of urgency

Clients should be encouraged to contact the CHS regarding changes in their condition as this allows for reassessment/reprioritisation. In addition, services with long waiting lists should consider contacting clients to review their needs and priority at pre-determined time intervals. This time period will depend on the length of the waiting list and the characteristics of the clients on the waiting list.

6.1.4 Removing the client from the waiting list

Clients should be removed from the waiting list when appointments are made, or when it is identified that they no longer require an appointment.

6.1.5 Communicating with referral source

CHSs should provide feedback to the referral source regarding receipt of the referral and the anticipated waiting time. This communication provides the ability to monitor, track and coordinate client care, and can facilitate stronger relationships with referring agencies. The Victorian Service Coordination Practice Manual includes tools that can assist with this process. These are located at: http://www.health.vic.gov.au/pcps/coordination/index.htm.

6.2 Appointment processes

Processes for making appointments vary across CHSs, and may depend on the service access model in place and the resources available (human resources and information technology). The client’s level of priority should be considered when booking appointments. Policies and procedures should cover the following areas.

6.2.1 Appointment diary

To allocate appointments in a way that reflects the level of services available, and the demand for services, CHSs require information about the number and type of referrals they receive. This can be obtained through an audit of current practices which includes:

- number of new referrals for each discipline
- number of appointment times available in each discipline
- length of time required for each appointment
- number and/or percentage of priority 1, priority 2 and priority 3 clients
• number and/or percentage of clients who require an ongoing course of care
• number and/or percentage of clients who have complex needs and require intervention by more than one discipline.

This information can be used to determine how to allocate appointments. Timely access for high priority clients (priority 1) should be a primary objective for allocation of appointments; however provision of service to ongoing and other clients needs to be considered. Agencies may need to allocate a proportion of appointments for lower priority clients to ensure they receive a service, as it is expected that all clients placed on a waiting list will receive a service. This can assist staff to maintain a balanced caseload, with a mix of clients.

Agencies may decide to set internal performance targets reflecting a timeframe for clients to be seen, for example, all priority 1 Podiatry clients to be seen within a specified number of days. This should be determined for each discipline, as it may vary depending on the type of clients, the nature of the intervention required and the resources available.

Performance targets for dental services have been set by Dental Health Services Victoria (DHSV) and are included in Appendix 9. CHSs should configure their dental service to meet these standards.

### 6.2.3 Recall and review

Recall and review systems are an effective way of managing clients who have long-term needs and/or chronic disease. They support planned, managed care and aim to reduce exacerbations in symptoms that may result in crisis interventions.

Systems to identify clients who would benefit from ongoing review or recall appointments should be developed. The process of making these review appointments needs to be incorporated within the appointment and waiting list management process.

### 6.2.4 Cancellation and Failure To Attend policies

Service delivery is disrupted when clients fail to attend or cancel appointments at the last minute. It is often difficult to identify clients likely to cancel or not to attend appointments. Failures to attend (FTAs) create problems in planning for service delivery as time is often wasted. Strategies to minimise the number of FTAs and their impact are required. This may include:

• discharging clients who miss three appointments and returning them to the end of the waiting list
• scheduling new client appointments for the beginning or the end of the day (agencies using this system have identified that new clients tend to be most likely to miss appointments)
• charging clients for missed appointments (clients would need to be informed about this policy at the time the appointment was made)
• contacting the client via email, SMS or phone call the day before the scheduled appointment (this is resource intensive and has potential privacy issues if unable to directly contact the client)
• identifying clients from the waiting list who can attend at very short notice when a vacancy presents as a result of a sudden cancellation
• considering the location of the service delivery and the need for outreach or school-based services to meet client needs.

There is limited research to support these strategies, and further exploration is required about their benefits and application to CHSs. Agencies should consider these strategies and incorporate those appropriate.

It is important that clients are informed of any policies relating to FTAs early in their contact with the CHS. Policies should be supported by signage within the CHS waiting area and written or verbal information provided at the time of referral. This will assist with informing client expectations and assisting them to participate in managing their own health.

While there is consensus from the sector and consumers that clients repeatedly missing appointments should not have ongoing access to the service and should be discharged, individual consideration of need should inform this practice, particularly for clients at greatest social or clinical risk.
6.3 Models of service delivery

Different models of service delivery have developed in response to improving client assessment and management, and the demand placed upon services. Alternative and emerging models of service delivery should be based on the best available evidence. This includes published and documented research and, in the absence of such information, expert opinion. A quality improvement process that regularly reviews and evaluates the development of new models should be in place.

As populations, demographics, models of service delivery and the need for services change over time, it is important that agencies review the design of their services periodically. This may result in a need to reconfigure services, reallocate resources, use additional or different types of staff, and establish or strengthen partnerships to best meet the needs of the community.

6.3.1 Goal-focused intervention

Goal-focused interventions provide a service based on client’s goals, formed in collaboration with the clinician or key worker during the assessment process. Identifying clear, concise and measurable goals provides direction and opportunity to reflect on achievement of goals. This can assist in assessing the effectiveness of interventions and inform future care plans. Appropriate and planned exit from the service can be facilitated when clients achieve goals, or when it is agreed that the goals are unable to be achieved.

6.3.2 Evidence-based practice

All clinical intervention should be based on up-to-date evidence. Boards, CEOs and program managers can use clinical governance structures to ensure that the CHS infrastructure supports this. The Victorian Healthcare Association, on behalf of the Department of Human Services, is conducting a project on clinical governance. Information is available at: http://www.vha.org.au/?c_id=1012

It is important that clinicians keep informed of new developments and research that identifies best practice. Professional development and networks, journals, books and the Internet should be used to access this information.

Best practice should be considered across the components of service delivery, including appropriate assessment, informed consent, appropriate diagnosis and treatment, regular monitoring of management to determine efficacy, and exit.

6.3.3 Information sessions

Providing group information sessions for clients before their individual assessments can provide an opportunity to identify the organisational expectations of clients, and can maximise the use of time by providing health information for a number of clients at the same time. This can minimise duplication during appointment times.

6.3.4 Individual intervention

Many client conditions require individual intervention with a clinician. Clinicians should work with clients during their clinical assessment to identify goals, a timeframe to review progress and a plan for exit.

The need for ongoing individual intervention should be reviewed regularly to ensure it remains appropriate and effective. An alternative management plan may be required if a client’s progress or condition no longer responds to current intervention or if the therapeutic relationship reinforces a level of dependency.

6.3.5 Single session work

Single session work (SSW) is a service delivery framework that recognises that many clients attend only once or twice. It is an approach that optimises the possibilities inherent in a single session, but still accommodates clients who require more sessions. The SSW model was developed for counselling and has been implemented across many CHSs. It provides benefits to CHSs in managing demand and to clients in accessing a service in a timely manner. Application of this model to counselling and other services should be considered. Further details are available from The Bouverie Centre website: http://www.latrobe.edu.au/bouverie/sst/whats_new.html
6.3.6 Group work
Group work can be an effective approach for the management of some clients. It can facilitate good client outcomes and also be an effective strategy to manage demand. Client safety and outcomes are central to the decision to implement a group program. The appropriate use of group interventions can allow staff to maximise their time and reach.

6.3.7 Self-management principles and programs
Self-management principles place the client at the centre of their own health care, and include building the capacity, skills and resources that a person needs to negotiate the health system and maximise their quality of life across the continuum of prevention and care. These principles should be integrated into assessment and intervention with all clients.

Specific self-management programs, such as the Stanford Chronic Disease Self Management Program, have been identified as a positive way to maximise the management of chronic disease. These programs can be used following, or in combination with, a period of one-to-one intervention.

6.3.8 Comprehensive assessment
A comprehensive assessment is a face-to-face interaction with a consumer, involving an intense level of inquiry and an advanced dimension of history taking, examination, observation and measurement/testing. It facilitates a more extensive process of inquiry that requires analysis and interpretation of the assessment information and clinical judgment, diagnosis and differential diagnosis.

Clients with complex conditions and/or complex care needs may benefit from a comprehensive assessment. Agencies can use a range of staff and structures to provide comprehensive assessments, such as:
- a key worker or care plan coordinator with this designated role
- a multidisciplinary team
- individual clinicians who incorporate the additional elements involved in a comprehensive assessment to their service specific assessments.

A comprehensive assessment provides an opportunity to plan and coordinate services to achieve good client outcomes. Ideally, it would be conducted soon after referral and provide clients with interim care plans if there is a wait for ongoing services.

6.3.9 Multi- or inter-disciplinary collaboration
Multi- or inter-disciplinary collaboration with clients can lead to improved client outcomes. The communication between professionals and clients allows them to bring different perspectives and skills to identifying needs and working together to achieve goals. Communication is required to ensure clarity of roles, responsibilities and client goals.

Providing structures and processes that facilitate multi- or inter-disciplinary management will enable staff to use this best practice approach.

Teams may be located within the CHS or may exist across a number of agencies. Clients GPs should be involved as appropriate.

Development of an intra- or inter-agency care plan can provide a basis for the ongoing multi- or inter-disciplinary work. Further information about care planning is available at:

6.3.10 Wagner Chronic Care Model
The Wagner Chronic Care Model has been endorsed as the framework to support service system development to meet the needs of clients with chronic and complex care needs. It is applicable to all health care providers embarking on change management processes to effect high quality chronic disease management.

The components of the Wagner Chronic Care Model are:
- self-management
- decision support
- delivery system design
- clinical information system
- organisation of healthcare
- community.

Further information is available at:
http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/
6.3.11 The Expanded Chronic Care Model

The Expanded Chronic Care Model builds on the Wagner Chronic Care Model through a stronger focus on prevention and health promotion. This allows agencies to broaden the application of this model to a wide range of services for all of the target population.

The components of the Expanded Chronic Care Model are:
- self-management/develop personal skills
- decision support
- delivery system design/re-orient health services
- information systems
- build healthy public policy
- create supportive environments
- strengthen community action.

Reference:

6.3.12 Workforce

Staffing configurations and resource allocations should be reviewed periodically to use resources in the best possible way. For example, the use of administrative staff and allied health assistants to support clinicians can allow them to focus their time on areas that require their professional expertise. This can lead to improved efficiency as staff focus on the tasks they are most skilled to perform. Services with changing demographics, such as a growth in children and families, may need to reconfigure services to dedicate additional staff to meet the needs of their changing population.

6.4 Roadblocks

It is important to continually reflect upon systems and processes to identify roadblocks and inefficiencies in service delivery. These should be included in continuous quality improvement plans as areas for development.

Some examples identified during consultation as potential threats to client throughput and managing demand, and possible management strategies, are provided in the table below. CHSs should consider the impact of these roadblocks and others they identify in their organisation.

<table>
<thead>
<tr>
<th>Roadblock</th>
<th>Management strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited information about the number and type of clients on the waiting list</td>
<td>Active waiting list strategy</td>
</tr>
<tr>
<td>Inconsistent processes across disciplines with intake processes</td>
<td>Review and evaluate the effectiveness and efficiency of the service access model</td>
</tr>
<tr>
<td>Limited information about service capacity</td>
<td>Regular audits of staffing levels and appointment templates</td>
</tr>
<tr>
<td>Service types and staffing levels</td>
<td>Use service plans to review the mix of services provided</td>
</tr>
<tr>
<td>Public private relationships</td>
<td>Review models of service delivery to maximise client access to MBS items Develop relationships with local private providers through PCPs and local Divisions of General Practice</td>
</tr>
</tbody>
</table>
7. Outflow

Developing an exit or discharge policy can assist clients to achieve an appropriate exit from services. An exit policy may be appropriate for your agency as a whole or individual programs may need to develop their own policies. Safe and appropriate exit from services will ensure appropriate use of resources and allow CHSs opportunities to see new clients. Most clients can exit a service upon resolution of their presenting need, or after an appropriate management period; others may require ongoing monitoring and reassessment. The conclusion of service needs to be planned and tailored to suit each client’s needs. Strategies that may assist with maintaining throughput include:

- referral to other services more appropriate to address a client’s needs
- service delivery that promotes, supports and encourages self-management which empowers clients and allows them to better manage their own health needs, and may include referral to structured self-management programs
- goal-focused intervention—where clients and workers develop goals based on the client’s needs identified during assessment, and review the need for ongoing intervention based on achievement of these goals, which can help facilitate exit from a service
- concluding intervention for clients who are no longer able to benefit from further intervention.

7.2 Exit processes

Readiness for exit should be determined by the client and clinician in collaboration. Clinicians are encouraged to use achievement of goals and potential to achieve outstanding goals as a point of reference for instigating discussions about exit. Referral to other programs to support clients to maintain health outcomes is encouraged, for example, self-management programs and self support groups. During the course of intervention it may become evident that the client’s needs may be addressed more appropriately through another part of the service system, for example, Hospital Admission Risk Programs Chronic Disease Management (HARP CDM), or Early Childhood Intervention Services (ECIS). These clients should be provided with information about the alternative service and with support and encouragement to accept referral and transition to the other service.

Referral sources should be informed about client exit from services. This is considered best practice in terms of ensuring any ongoing client needs are met and other providers are informed about changes in the client’s condition. Clients who exit a service may access services again if their needs change. If this change is the result of a new issue or a change in circumstances the client should be considered as a new referral to the service and the client’s level of priority should be determined on the basis of this new presentation. If issues arise as a result of poor management of the exit process the client’s needs should be addressed immediately.

7.1 Exit preparation

To ensure good client outcomes, service providers should discuss with clients the expected course of management during the early stages of contact. This is likely to occur during the service specific assessment. Exit from services should be linked to client needs, goals and progress. Clients’ expectations regarding the length and type of services they receive should be discussed when they first access the service. Clients should be involved in the process of planning for exit from the service. This may include referral to other services, programs or self-support groups. This ensures clients are informed and involved in the management of their needs.
8. Next steps

CHSs need to consolidate the processes and practices for service provision to best manage their services for those who require them. Processes and practices need to be reviewed and updated as the nature of the demand on CHSs evolves with broad health systems reforms. Increasing integration of the health system will bring changes to the roles and capacity of CHSs. CHSs need to ensure that they function as an integrated component of a modern health system that provides continuity of care across different health settings. This framework is a step towards a future community health sector that is able to provide high quality evidenced-based care that ensures clients’ needs are met in a timely manner.

The implementation of the new demand management data collection system described in the document *Waiting Time measurement within Community Heath Services* (DHS, 2006) has been delayed. It will be implemented in the near future to ensure the accurate collection of information about the waiting times for services. This will provide CHSs a strong base on which to build as they continue to work to meet the growing demands of clients and the health care system.

Further work to improve consistency of practice during the flow through and outflow stages of a client journey will be incorporated into the next stage of the demand management project. This could include the identification of models of best practice of service delivery, a focus on client outcomes, benchmarking, and the evaluation of the priority tools included in this document.

Working to improve demand management is an ongoing process requiring regular monitoring and evaluation to ensure it is adapting to the future needs of both the community and individual users of CHSs.
Appendix 1—Generic Priority Tool

Towards a demand management framework in CHSs provides the context to this priority tool. Together with the clinical priority tools it forms a suite of priority tools applicable to all CHS clients.

Introduction

The Generic Priority Tool is designed to identify people who require a priority for service due to their population characteristics. This includes groups that are known to have poor health status, disadvantaged groups and those at risk.

The Generic Priority Tool can be applied to all clients accessing the CHS. For those programs/services delivered through CHSs that have specified eligibility criteria, those criteria should be applied first and this Generic Priority Tool can then be used to assist in prioritising all eligible clients.

Following use of the Generic Priority Tool, one or more of the clinical priority tools may be used.

Instructions for use

Staff should screen clients during the INI to identify people who belong to the groups identified as a priority in this tool. The information required to complete the Consumer Information page of the SCTT will assist staff to do this. Staff should remain alert to any signs of risk to the client or others that may require immediate intervention and support. CHSs should have a clearly documented and understood policy and approach to managing these clients.

People who are not considered a priority through the use of the Generic Priority Tool will have their level of priority determined through use of the relevant clinical priority tools or through a comprehensive assessment where required.

Information collected during the INI should be recorded on the SCTT, using either the Summary and Referral Information and/or Profiles templates.

The priority level should also be recorded on the Summary and Referral Information template of the SCTT.

High priority clients include:

- **People at risk to their own safety or the safety of others**
- **Homeless people and people at risk of homelessness**

   Definition: Homelessness includes any person who is left without a conventional home and who lacks the economic and social supports that a home normally affords. This includes people living in insecure, unsafe or unaffordable housing, who are at risk of homelessness, and people who are in a state of outright homelessness, living in the street, in parks or squats.

- **Refugees**

   Definition: A refugee is any person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it (Protecting Refugees, UNHCR, 2003, p. 5).

- **Indigenous people**

   Definition: An Aboriginal or Torres Strait Islander person is defined as a person of Aboriginal or Torres Strait Islander descent, who identifies as being Aboriginal or Torres Strait Islander.

- **People with complex care needs who require a priority service to ensure a coordinated team approach**

   These people are prioritised to ensure the best client outcomes are achieved, and to prevent inefficiencies that occur when services within the CHS and partner agencies are not coordinated. They should be identified on the basis of the complexity of their need for services, rather than the complexity of their health condition.

This includes people with existing Inter- or Intra-agency care plans, for example, Team Care Arrangements (MBS# 723 or #727) and GP Mental Health Care Plans (MBS #2710 or #2712) from GPs, Disability Support Plans, Child and Family Action Plans and Care and Placement Plans (for Child Protection and Family Services clients).

It also includes people who are identified through the INI process as requiring a care plan, such as people with multiple services currently in place who would benefit from a care plan, and those presenting for the first time who require multiple services.
Generic Priority Tool

Initial contact (client presents to service)

Initial Needs Identification required

Does the person have an immediate risk to their safety or pose a risk to the safety of others?

- Yes
- No

Is the person:
- homeless or at risk of homelessness
- a refugee
- an Indigenous person

- Yes
- No

Does the person have complex care needs that require a priority service to ensure a coordinated team approach?

- Yes
- No

An immediate response, within the scope of expertise of the CHS, is required to meet duty of care to ensure safety of client and others. Referral to specialist provider for crisis response service where appropriate

Is this Community Health Service the most appropriate service to meet the person's needs?

Staff should consider which services are most appropriate to meet the person's needs throughout the journey through Community Health. This should commence during Initial Contact and Initial Needs Identification, and continue throughout service delivery.

Referrals to other more appropriate services can occur at any stage, with the client's consent (except in some emergency or high risk situations).

Other service options include:
- Crisis/emergency services:
  - hospital emergency department, ambulance service, Crisis Assessment Team, Police
- Other community-based services:
  - locally-based agencies such as welfare and housing services, local council, ethnic specific, specialist services etc.
- People eligible and suitable for alternative services:
  - MBS services (provided within the Community Health Centre or externally)
  - DVA
  - PAC
  - Private practitioners
  - HARP CDM programs
  - Rehabilitation services
  - Early Childhood Intervention Services
  - Community Mental Health services
Appendix 2—Counselling Priority Tool

Towards a demand management framework in CHSs provides the context to this priority tool. It is part of a suite of clinical priority tools and a Generic Priority Tool applicable to all CHS clients.

Introduction

Counselling services in CHSs aim to improve wellbeing in the community by offering supportive counselling, therapy, practical support, advocacy and referral and links to other services as needed. Services can be provided on a one-to-one basis and in groups to adults, adolescents, children and families. The aim is to ensure that all Victorians have access to affordable, effective counselling that is physically accessible and culturally appropriate.

CHS counselling services can assist with a wide range of issues, such as family and relationship issues, coping with chronic illness, depression, anxiety and related conditions.

Instructions for use

This tool should be used where appropriate following use of the Generic Priority Tool. It may be used in conjunction with other clinical priority tools.

This priority tool is designed to determine the need for counselling and the client’s level of priority for service. A series of questions guides the collection of an appropriate level of information required for an intake worker to determine the client’s level of priority. Intake workers without qualifications that enable them to practise in a counselling role should clearly advise clients that they are not the counsellor, and should not initiate in depth discussion regarding the client’s problems. It is important that clients with a risk of harm to self or others are identified, and those who require immediate assistance and support receive this from an appropriately skilled and qualified worker.

The information collected during the INI, and the priority level, should be recorded on the SCTT, using the Summary and Referral Information and/or Profiles templates.

The Counselling Priority Tool guides the decisions that are required to determine the priority level of a new client. The tool identifies three groups:

- Priority 1 clients—their safety or wellbeing is at risk and an immediate response is required.
- Priority 2 clients—a significant delay in providing a service will exacerbate the situation.
- Priority 3 clients—interim supports are available and the situation is stable.

High priority clients include those:

- who are at risk of harm to themselves or others
- who have a high level of carer/family stress jeopardising their care/safety at home
- who feel unsafe or vulnerable for any reason, for example, elder abuse or domestic violence (physical/financial/psycho-emotional).

References

Department of Human Services (2005), Counselling in Community Health Services: future directions and guidelines for quality counselling, DHS, Melbourne.
Counselling Priority Tool

Generic Priority Tool—
does client meet priority criteria?

Yes → Priority 1

No → Can you tell me briefly what the main issue is that you would like to address in counselling and how it is affecting your life?

Issue identified

Yes → Priority 1

No → Does your current situation impact on your safety or wellbeing or that of anyone you care for or live with? (this is asking about risk and safety)

Yes → Priority 1

No → • How long has this been an issue?
• Has anything changed recently to make it harder for you to manage?
• Was there anything specific that led you to call us now?

Yes → Priority 3

No → • New event, or
• New or recent problem, or
• A specific reason that reflects that receiving counselling at this time is important

Yes → Priority 3

No → What current supports do you have? Are these adequate?

Yes → Priority 3

No → Priority 2
Appendix 3—Dietetics Priority Tool

Towards a demand management framework in CHSs provides the context to this priority tool. It is part of a suite of clinical priority tools and a Generic Priority Tool applicable to all CHS clients.

Introduction

This priority tool is designed for use with both adults and children requiring dietetic services.

Dietitians provide nutritional support for individuals and groups in health and illness, incorporating a population/public health nutrition approach to targeted population groups. They provide assistance to clients for conditions including (but not limited to) diabetes, heart disease, hypertension (high blood pressure), arthritis, weight loss, involuntary weight loss, gastrointestinal disorders (such as irritable bowel syndrome, diverticular disease, coeliac disease), as well as general dietary advice to people without any recognisable condition, and to people who need to change their dietary habits.

Instructions for use

This tool should be used where appropriate following use of the Generic Priority Tool. It may be used in conjunction with other clinical priority tools.

The Dietetics Priority Tool is designed to determine the need for dietetic service and the level of priority for service. The tool lists a range of conditions and reasons people have for wanting to see a dietitian. The conditions and reasons are grouped and assigned a priority level. It should not be necessary for the intake worker to read through all the conditions in the priority tool. When the client identifies a particular condition, the intake worker can allocate the relevant priority level, unless they are unsure, in which case they should ask the dietitian. The information collected during the INI should be recorded on the SCTT, using either the Summary and Referral Information form and/or Profiles templates.

The priority tool guides the decisions that are required to determine the priority level of a new client. The tool identifies three groups:

- Priority 1 clients—those with a more urgent need for service
- Priority 2 clients
- Priority 3 clients.

Priority 1 clients are the highest priority and should be seen as quickly as possible.

The priority level should also be recorded on the Summary and Referral Information template of the SCTT.

High priority clients include people with:

- diabetes that is newly diagnosed (including gestational diabetes), poorly controlled or commencing insulin or medication
- difficulties swallowing and/or chewing
- diagnosed eating disorder
- significant unintended weight loss
- diagnosed medical conditions such as:
  - coeliac disease, Crohn’s disease, inflammatory bowel disease, ulcerative colitis
  - liver problems
  - food allergies or multiple food intolerance.

And:

- children 0–12 years
- adults over 65, frail, disabled or diagnosed with more than two chronic health conditions.

References

Dietetics Priority Tool

**Generic Priority Tool**—does the client meet priority criteria?

- **Yes** → Priority 1
- **No** → What is the main reason you want to see a dietitian?

**Issue identified**

- **Diabetes related**
  - Is the person:
    - Newly diagnosed (less than 12 months)—including pregnant women with gestational diabetes?
    - Commencing use of insulin or medication?
    - Unable to control their diabetes at the recommended level (high blood glucose levels or frequent hypoglycemia)?

- **Other issue**
  - Is the person:
    - Over 65 and frail or disabled?
    - Diagnosed with more than two chronic health conditions, such as high blood pressure, arthritis, emphysema, heart disease, mental health?
    - Having difficulties swallowing/chewing?
    - A child aged 0–12
    - Experiencing significant unintended weight loss (e.g. lost 5 kg in 1 month)?

**Is the person:**
- Pre-diabetic or impaired glucose tolerant?
- Requesting to see a dietitian for the first time?

**Is the person:**
- Requiring a general diabetes review by a dietitian?

**Do they have one of the following diagnoses:**
- Celiac disease; inflammatory bowel disease, (e.g. Crohn’s disease; ulcerative colitis)?
- Liver or renal problems?
- Food allergy or multiple food intolerances?
- Eating disorder (e.g. anorexia, bulimia)?

**Is the person:**
- Pregnant or breast feeding?
- Youth aged 13–18 years?

**Do they have one of the following diagnoses:**
- Polycystic Ovarian Syndrome (PCOS)?
- Cancer?
- Osteoporosis?
- Constipation, diverticulitis or irritable bowel syndrome?
- High blood fats (cholesterol or triglycerides)?
- High blood pressure?
- Anaemia/iron deficiency?

**Is the person requesting assistance for any other dietary advice:**
- Healthy eating or general nutrition?
- Overweight/obesity?
- Nutrition for sport?
- Vegetarian or vegan diets?
- Dental problems?
- Other?

Consider referral to other services, as appropriate. Consult with Dietitian if unsure of appropriate service to meet client needs, or priority level.
Appendix 4—Occupational Therapy Priority Tool—Adult

Towards a demand management framework in CHSs provides the context to this priority tool. It is part of a suite of clinical priority tools and a Generic Priority Tool applicable to all CHS clients.

Introduction

This priority tool is designed for use with adults requiring Occupational Therapy services. A separate priority tool has been developed for paediatric Occupational Therapy (see Appendix 5).

Adult occupational therapy services provide assistance to clients in coping, adapting and overcoming the demands and tasks of their everyday life. This is done by using normal daily activities and tasks or occupations in a therapeutic way to promote health and maintain a person’s wellbeing, which may be affected by disease, disability or injury.

Instructions for use

This tool should be used where appropriate following use of the Generic Priority Tool. It may be used in conjunction with other clinical priority tools.

The Occupational Therapy Priority Tool is designed to determine the need for Occupational Therapy and the client’s level of priority for service. A series of questions guides the collection of an appropriate level of information required to determine the level of priority. Intake workers without a background in Occupational Therapy should consult with an Occupational Therapist if unable to determine the level of priority for service.

The information collected during the INI, and the priority level, should be recorded on the SCTT, using the Summary and Referral Information and/or Profiles templates.

This Priority Tool guides the decisions that are required to determine the priority level of a new client. The tool identifies three groups:

- Priority 1 clients—those with a more urgent need for service
- Priority 2 clients
- Priority 3 clients.

Priority 1 clients are the highest priority and should be seen as quickly as possible.

High priority clients include people:

- with a palliative care diagnosis
- with or at risk of developing pressure ulcers
- who have recently experienced a fall that has led to an injury or had an impact on their ability to complete their usual activities
- with changes to their health that result in decreased independence in usual activities
- who are unable to perform most activities independently and require maximum assistance
- who require essential equipment for daily use, where they are at risk without it
- at risk of admission to residential care or hospital due to inadequate supports or support networks at risk of breaking down.

References


Occupational Therapy Priority Tool—Adult

**Generic Priority Tool**—does the client meet priority criteria?

**No**

- What is the problem you would like to see an occupational therapist for?

- What is your medical condition that impacts on your ability to manage your usual activities?

- Have you had one or more falls during the last 4 weeks that has led to an injury or had an impact on your ability to complete your usual activities?

- Are you at risk of falling or have you restricted your activities because you are worried about falling over or are dizzy?

**Yes**

- Consult with occupational therapist if unsure of appropriate service to meet client needs or priority level.

**Priority 1**

- Palliative care diagnosis

- Pressure ulcer diagnosis or risk

- Minor impact on independence in usual activities

- Able to do most activities but with modification or assistance

- Inadequate supports in place or support networks at risk of breaking down—client at risk of admission to residential care or hospital

**Priority 2**

- No recent change in independence in usual activities

- Unable to perform most activities independently and requires maximum assistance

**Priority 3**

- Inadequate supports in place or support networks at risk of breaking down—client at risk of admission to residential care or hospital

Consult referral to other services, as appropriate, if unsure of appropriate service to meet client needs or priority level.
Appendix 5—Occupational Therapy Priority Tool—Paediatric

Towards a demand management framework in CHSs provides the context to this priority tool. It is part of a suite of clinical priority tools and a Generic Priority Tool applicable to all CHS clients.

Introduction

This priority tool is designed for use with children requiring Occupational Therapy services. A separate priority tool has been developed for adults requiring Occupational Therapy (see Appendix 4).

Occupational Therapy services provide assistance to clients in coping, adapting and overcoming the demands and tasks of their everyday life. This is done by using normal daily activities and tasks in a therapeutic way to promote health and maintain a person’s wellbeing, which may be affected by disease, developmental delay or injuries.

Community Health paediatric occupational therapy services target children with mild-moderate delays. Children with diagnosed developmental delays, such as autism, cerebral palsy and multiple disabilities, are eligible for services through Early Childhood Intervention Services and Department of Education and Early Childhood Development. These services are best placed to meet the needs of these children and their families, and eligible children should be encouraged to access them.

Instructions for use

This tool should be used where appropriate following use of the Generic Priority Tool. It may be used in conjunction with other clinical priority tools.

This priority tool is designed to determine the need for Occupational Therapy and the client’s level of priority for service. A series of questions guides the collection of an appropriate level of information required to determine the level of priority. Intake workers without a background in Occupational Therapy should consult with an Occupational Therapist if unable to determine the level of priority for service.

The information collected during the INI and the priority level should be recorded on the SCCT, using the Summary and Referral Information and/or Profiles templates.

The priority tool guides the decisions that are required to determine the priority level of a new client. The tool identifies three groups:

- Priority 1 clients—those with a more urgent need for service
- Priority 2 clients
- Priority 3 clients.

Priority 1 clients are the highest priority and should be seen as quickly as possible.

High priority clients include:

- children with mild-moderate delays, with difficulties participating in usual activities and:
  - starting primary school in the next year
  - not attending any school or kindergarten services
  - some primary school aged children where the parent reports a high level of concern, and a high need for additional support.

References


Occupational Therapy Priority Tool—Paediatric

Why does the child require occupational therapy?
Are you concerned about how your child participates in their usual activities?
What are your concerns?
• Self-care
  Tying shoelaces, doing up buttons, using cutlery, taking care of belongings
  Other:
• Physical activities
  Balance, clumsy, riding bike, playground, sport, level of activity, behind in developmental milestones
  Other:
• Play/learning
  Drawing, cutting, preferred hand, messy play, puzzles, attention, concentration, infant play
  Other:
• Education (school aged children)
  Reading, spelling, writing, attention, concentration, memory, organisation
  Other:
• Socialising
  Playing with peers, turn taking, co-operation, bullying
  Other:
• Coping with their emotions
  Frustration, confidence, irritable, self-control, withdrawn
  Other:

Is your child under 4?

Does your child attend school?

Is your child going to school next year?

On a scale of 1–10:
• How concerned are you about your child?
  (1 = not concerned, 10 = extremely concerned)
• How much support do you need?
  (1= none, 10 = significant support)
(Add scores for a total)

Consult with Occupational Therapist if unsure of appropriate service to meet client needs or priority level.

Consider referral to other services, as appropriate, if unsure of appropriate service to meet client needs or priority level.
Appendix 6—Physiotherapy Priority Tool—Adult

Towards a demand management framework in CHSs provides the context to this priority tool. It is part of a suite of clinical priority tools and a Generic Priority Tool applicable to all CHS clients.

Introduction
Physiotherapy services in CHSs are provided to people experiencing disorders of human movement.

This priority tool is designed for use in prioritising adults who require physiotherapy. It is not applicable to paediatric physiotherapy services. CHSs that have paediatric physiotherapy services should develop their own systems to manage children who present for service.

Instructions for use
This tool should be used where appropriate following use of the Generic Priority Tool. It may be used in conjunction with other clinical priority tools.

This priority tool is designed to determine the need for physiotherapy and the client’s level of priority for service. A series of questions guides the collection of an appropriate level of information required to determine the level of priority. Intake workers without a background in physiotherapy should consult with a physiotherapist if unable to determine the level of priority for service.

The information collected during the INI and the priority level should be recorded on the SCTT, using the Summary and Referral Information and/or Profiles templates.

This priority tool guides the decisions that are required to determine the priority level of a new client. The tool identifies two groups:

- Priority 1 clients—those with a more urgent need for service
- Priority 2 clients.

Priority 1 clients are the highest priority and should be seen as quickly as possible.

High priority clients include people:

- who have had broken bones or surgery related to muscle or joint problems in the last three months
- with chest infections requiring physiotherapy
- who have experienced a fall in the last six months, and those at risk of falling
- with a physical problem that impacts on their ability to care for dependents
- experiencing difficulty performing daily activities independently:
  - where this difficulty is significant and they require maximum assistance
  - or with moderate difficulty and experiencing severe pain.

References
**Physiotherapy Priority Tool—Adult**

**Generic Priority Tool**—does the client meet priority criteria?

1. Have you had a broken bone or surgery for a problem related to your muscles or joints within the last 3 months?
2. Have you been referred by your GP/Hospital for physiotherapy for a chest infection?
3. Have you had a fall in the last 6 months?
4. Are you at risk of falling or have you restricted your activities because you are worried about falling over or are dizzy?
5. Does your condition impact on the safety of anyone you care for or live with?

- **No**

What is the problem that you would like to see a physiotherapist for?

- **Yes**

**Priority 1**

Consult with Physiotherapist if unsure of appropriate service to meet client needs, or priority level.

Consider referral to other services, as appropriate.

- **No**

How long have you had the problem **this time**?

- **Less than 3 months**

  1. How does your current problem interfere with your normal activities around the house currently (getting up from bed/chair, walking, washing yourself, toileting, cooking)?
  2. How does your current problem interfere with your ability to work, give care to dependants or live independently?

- **Able to do most activities but with assistance and/or moderate modification**

  How much body pain have you had due to your current problem during the last 4 weeks (or if less than 4 weeks—since the problem began)?

  How would you rate your pain (none, mild, moderate, severe)?

- **Priority 2**

  Greater than 3 months
Appendix 7—Podiatry Priority Tool

Towards a demand management framework in CHSs provides the context to this priority tool. It is part of a suite of clinical priority tools and a Generic Priority Tool applicable to all CHS clients.

Introduction

This priority tool is designed for use with both adults and children requiring podiatry services.

Podiatry services involve the diagnosis and treatment of ailments of abnormal conditions of the human foot, including population/public approaches to targeted population groups. Podiatrists play an important role in the maintenance of individual mobility and independence, and consequently the general health of individuals, by alleviating foot conditions, particularly for those aged over 65, for whom an estimated 85 per cent require a range of podiatric services. Podiatrists do this through comprehensive assessment of lower leg and foot health issues and providing an appropriate care plan to meet the identified health outcomes.

Instructions for use

This tool should be used where appropriate following use of the Generic Priority Tool. It may be used in conjunction with other clinical priority tools.

This priority tool is designed to determine the need for podiatry service and the level of priority for service. A series of questions guides the collection of an appropriate level of information required to determine the level of priority. Intake workers without a background in podiatry should consult with a podiatrist if unable to determine the level of priority for service.

This priority tool guides the decisions that are required to determine the priority level of a new client. The tool identifies three priority groups:

- Priority 1 clients—those with a more urgent need for service
- Priority 2 clients
- Priority 3 clients

Some CHSs might choose to include people with uncomplicated medical histories and no identified associated foot pathology as Priority 3 clients.

Priority 1 clients are the highest priority and should be seen as quickly as possible.

The information collected during the INI and the priority level should be recorded on the SCTT, using the Summary and Referral Information and/or Profiles templates.

High priority clients include people with:

- an area on their foot that is swollen, discoloured or discharging
- a wound that is not healing
- a foot problem such as an ulcer or an infection that has required hospital admission within the last three months
- a history of foot ulcers or lower limb amputation
- a chronic and complex medical condition.

References


Robinson J. (1989), The Aldersgate study. Flinders Medical Centre, South Australia
Podiatry Priority Tool

**Generic Priority Tool**—does the client meet priority criteria?

- Yes → Priority 1
- No → What is the problem that you would like to see a podiatrist for?

  - Do you have an area on your foot that is swollen, discoloured or discharging? Yes → Referral to GP and/or Priority 1
  - Do you have a wound that is not healing? No → Priority 1

- Have you been admitted to hospital within the last 3 months with a foot problem such as an ulcer or an infection? Yes → Priority 1
- Do you have a history of foot ulcers and/or lower limb amputation? No → Priority 2
- Do you have a chronic and complex medical condition, e.g. unstable diabetes, an immunosuppressive condition or Peripheral Vascular Disease (PVD)?

**Diabetes related**

- Have you ever had a diabetes foot health assessment? Yes → Priority 2
- No → Does your foot/leg problem interfere with your ability to work, give care to dependants, or normal daily activities (e.g. showering, toileting, preparing meals, accessing medical appointments, shopping)?

**Other issue**

- Are you attending a vascular clinic or vascular specialist? Yes → Priority 2
- No → Does your child 0–12 have any foot or walking problems and/or are they in leg pain (please specify)? Yes → Priority 2
- No → Does your foot/leg problem interfere with your ability to work, give care to dependants, or normal daily activities? (e.g. showering, toileting, preparing meals, accessing medical appointments, shopping)?

- Uncomplicated medical history with identified foot problem Yes → Priority 3
- No → Recommend referral to:
  - foot health group for self-management
  - MBS (Enhanced Primary Care)
  - private podiatrist
  - GP
Appendix 8—Speech Pathology Priority Tool—Paediatric

Towards a demand management framework in CHSs provides the context to this priority tool. It is part of a suite of clinical priority tools and a Generic Priority Tool applicable to all CHS clients.

Introduction

As speech pathology services in CHSs primarily work with children, this priority tool only relates to children. CHSs that have adult speech pathology services should develop their own systems to manage the adults who present for service.

Speech pathology services in CHSs are provided for children aged 0–6 with communication and language delays. Children with diagnosed or suspected developmental delays, such as autism, cerebral palsy and multiple disabilities, are eligible for services through Early Childhood Intervention Services. These services are best placed to meet the needs of these children and their families, and eligible children should be encouraged to access them.

Services for school aged children are available through the Department of Education and Early Childhood Development.

Instructions for use

This tool should be used where appropriate following use of the Generic Priority Tool. It may be used in conjunction with other clinical priority tools.

The priority tool is designed to determine the need for speech pathology and the client’s level of priority for service. A series of questions guides the collection of information required to determine the level of priority. Intake workers without a background in Speech Pathology should consult with a Speech Pathologist if unable to determine the level of priority for service.

The information collected during the INI, and the priority level, should be recorded on the SCTT, using the Summary and Referral Information and/or Profiles templates.

This priority tool guides the decisions that are required to determine the priority level of a new client. The tool identifies two groups:

1. **Priority 1 clients**—those with a more urgent need for service
2. **Priority 2 clients**

Priority 1 clients are the highest priority and should be seen as quickly as possible.

**High priority clients include:**

- children experiencing swallowing difficulties and/or problems feeding. Please note, this is a specialised area of practice. CHSs may elect to refer these children to specialist providers or clinics.
- children considered ‘late talkers’ (by the definition provided)
- children who stutter, where at least one of the following applies:
  - they have been stuttering for more than 12 months (or will have been by the time an appointment is available)
  - they are going to school the following year
  - there is a high level of concern from the parent and child about the stuttering (by the definition provided).

References

Hanen Early Language Program (2004). *Making Hanen Happen for Target Word®—The Hanen Program for Parents of Children who are Late Talkers ©.*
Speech Pathology Priority Tool—Paediatric

Generic Priority Tool—does the client meet priority criteria?

Yes

Priority 1

No

What are your concerns with your child's communication?

No

Yes

Is the child experiencing swallowing difficulties and/or problems feeding?

No

Yes

Urgent service required, refer to specialist service provider for local area

Is the child experiencing problems with:
- talking (language)

No

Yes

How old is your child?

How many words do they use?

Are they a late talker as per definition below:
- 18–20 months, less than 10 words
- 21–24 months, less than 25 words
- 24–30 month, less than 50 words and/or no 2 word combinations

Priority 2

Priority 1

No

Yes

When did you first notice your child stuttering? (month/year)

Based on the date of onset:
- Has the child been stuttering for greater than 12 months?
- Will 12 months have elapsed by the time the child receives an appointment?

Priority 2

Priority 1

No

Yes

Is your child going to school next year?

On a scale of 1-10:
- How concerned are you about your child's stuttering? (1 = not concerned, 10 = extremely concerned)
- How concerned is your child about their stuttering? (1 = not concerned, 10 = extremely concerned)

(Add scores for a total)

Score greater or equal to 14

Priority 1

Priority 2

Score less than 14

Is the child experiencing problems with:
- unclear speech
- understanding (following instructions)
- voice
- drooling/dribbling
- other (play/social skills)

Yes

Priority 2

No

Consider referral to other services, as appropriate.

Consult with speech pathologist if unsure of appropriate service to meet client needs or priority level.
Appendix 9—Dental Emergency Demand Management System (EDMS) triage tool

Towards a demand management framework in CHSs provides the context to this priority tool. It is part of a suite of clinical priority tools and a Generic Priority Tool applicable to all CHS clients.

Introduction
Public dental services provide routine and urgent dental care by teams consisting of dentists, dental therapists, dental hygienists, dental assistants and dental prosthetists. They are responsible for delivery of integrated community-based dental care and oral health promotion.

Dental services provided through CHSs target children and disadvantaged adults, and have strict eligibility criteria. Those eligible are:
- children
- adults with a Health Care Card (HCC) or Pension card.

Instructions for use
This tool should be used where appropriate following use of the Generic Priority Tool. It may be used in conjunction with other clinical priority tools.

People seeking urgent dental care are assessed, triaged and managed using the EDMS. The EDMS triage tool is designed to assess dental emergencies and assign the appropriate triage category for people requiring dental care. A series of questions guides the collection of information required to determine the EDMS category. Intake workers without a background in dental should consult with a dental clinician if unable to determine the level of priority for service.

People who require routine care are placed on a waiting list. The information collected during the INI and the priority level should be recorded on the SCTT, using the Summary and Referral Information and/or Profiles templates.

The EDMS triage tool guides the decisions that are required to determine the priority level of a new client. The tool identifies five groups, and provides advice regarding maximum waiting time for clinical assessment:
- EDMS category 1—see within 24 hours
- EDMS category 2—see within 7 days
- EDMS category 3—see within 14 days
- EDMS category 4—see within 1 month
- EDMS category 5—on waiting list

Urgent Emergency (Category 1) clients include people:
- with a swollen face, neck or mouth
- with bleeding socket following recent extraction
- unable to open their mouth
- with tooth/gum pain that resulted in waking over night
- under 14 who have had an accident leading to problems with teeth or gums
- with swelling or difficulty opening their mouth due to their wisdom teeth
- with intellectual disability or immunosuppression
- over 80.

High priority waiting list clients include:
- children up to 12 years of age, and 13–17 year olds who are dependents of health care or pensioner concession cards
- children and young people up to 18 years of age in residential care provided by the Children Youth and Families division (DHS)
- eligible pregnant women.

These clients should be offered the next available appointment and should not be placed on the waiting list.

References
Appendix 10—Case study examples using the CHS priority tools

The following case studies are presented to highlight how the CHS priority tools can be incorporated into service coordination practice. As CHSs use different service access models to undertake the Initial Needs Identification process, each case study describes the staff involved during each element of the client pathway through a CHSs in both integrated (centralised) and non-integrated (multiple access points) service access models.

Case studies 1 and 2 highlight this process for clients requiring a single service response.

Case studies 3 and 4 highlight this process for clients requiring multiple services. As CHSs use different models to undertake assessment and care planning for clients with multiple needs, each case study describes staff involved during each element of the client pathway through a CHSs for services that provide comprehensive assessment and care planning and those that conduct service specific assessments and care planning.

Definitions

Integrated (centralised): there are two types of integrated service access models:

1. Single access system: a single discrete access point.
2. Parallel access system: a combination of discrete access point(s) for most services/programs and additional discrete program/specialist/service specific access point(s).

Non-integrated (multiple access points): multiple access points.

Reference:

Comprehensive assessment: a face-to-face interaction with a consumer, involving intense level of inquiry, and an advanced dimension of history taking, examination, observation and measurement/testing. It facilitates a more extensive process of inquiry that requires analysis and interpretation of the assessment information and a clinical judgment, diagnosis and differential diagnosis.

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

References
Case study 1—client prioritised on basis of clinical need, single service.

Max is a four year old boy who is experiencing communication difficulties. His mum, Mary, reports that he started to stutter three months ago. Initially she thought he would grow out of it, but recently it seems to be getting worse and Max is now frustrated and embarrassed at kindergarten when the other children can’t understand him. He is sometimes refusing to talk. Mary is worried about how he will manage at school next year.

<table>
<thead>
<tr>
<th>Service access model</th>
<th>Initial contact</th>
<th>Initial needs identification</th>
<th>Assessment</th>
<th>Care planning</th>
<th>Service delivery</th>
</tr>
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<tbody>
<tr>
<td><strong>Integrated</strong>&lt;br&gt;(centralised)</td>
<td>Phone call by parent. &lt;br&gt;&lt;strong&gt;Receptionist:&lt;/strong&gt; • determines that phone call is a new referral • directs phone call to &lt;strong&gt;intake worker&lt;/strong&gt; if available, or • takes client details (this may include completion of the Consumer Information template of the SCTTs).</td>
<td><strong>Intake worker:</strong> • conducts phone interview with parent to determine current needs • uses SCTTs to assist with broad inquiry regarding needs • establishes that client does not belong to the priority population groups in the Generic Priority Tool • identifies that Paediatric Speech Pathology is the only current need • uses Paediatric Speech Pathology Priority Tool to guide interview and obtain information to determine priority level • documents information and priority level on Summary and Referral Information template (SCTT) • determines client is a Priority 1, and offers the next available appointment.</td>
<td>Speech pathologist</td>
<td>Service specific treatment plan developed.</td>
<td>Speech pathology—this may include a home program, parent education and support, individual or group sessions.</td>
</tr>
<tr>
<td><strong>Non-integrated</strong>&lt;br&gt;(multiple access points)</td>
<td>Phone call by parent. &lt;br&gt;&lt;strong&gt;Receptionist:&lt;/strong&gt; • determines that phone call is a new referral • directs phone call to &lt;strong&gt;speech pathologist&lt;/strong&gt; if available, or • takes client details (this may include completion of the Consumer Information template of the SCTTs).</td>
<td><strong>Speech pathologist:</strong> • conducts phone interview with parent to determine current needs • uses SCTTs to assist with broad inquiry regarding needs • establishes that client does not belong to priority population groups in the Generic Priority Tool • identifies that paediatric speech pathology is the only current need • uses Paediatric Speech Pathology Priority Tool to guide interview and obtain information to determine priority level, • documents information and priority level on Summary and Referral Information template (SCTT) • determines client is a Priority 1, and offers the next available appointment.</td>
<td>Speech pathologist</td>
<td>Service specific treatment plan developed.</td>
<td>Speech pathology—this may include a home program, parent education and support, individual or group sessions.</td>
</tr>
</tbody>
</table>
Case study 2—client prioritised by Generic Priority Tool, single service.

Dan is a 35 year old Aboriginal man who presents requesting a dental appointment. He is anxious about seeing a dentist following a bad experience as a child, and he hasn’t been to a dentist since. Dan moved to the area three months ago to live with his cousin. He has since developed a good relationship with the Koori access worker who has been encouraging him to join in some of the activities of the local Koori community, and to address some of his health concerns. Dan decided that getting his teeth fixed would be good as he has two chipped front teeth.

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<thead>
<tr>
<th>Service access model</th>
<th>Initial contact</th>
<th>Initial needs identification</th>
<th>Assessment</th>
<th>Care planning</th>
<th>Service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated (centralised)</td>
<td>Dan and Koori access worker arrive at reception. Receptionist: • determines this is a new referral • directs phone call to intake worker if available, or • takes client details (this may include completion of the Consumer Information template of the SCTTs).</td>
<td><strong>Intake worker:</strong> • conducts interview with Dan and Koori access worker to determine current needs • uses SCTTs to assist with broad inquiry regarding needs • establishes that client is Indigenous and is a Priority 1 as identified by the Generic Priority Tool • identifies that dental care is the only service Dan currently wants to access • uses Emergency Dental Management System to guide interview and obtain information to determine eligibility for emergency appointment • documents information and priority level on Summary and Referral Information template (SCTT) • client does not meet criteria for emergency appointment, but is a Priority 1 for general care and is offered the next available appointment.</td>
<td>Dentist</td>
<td>Service specific treatment plan developed.</td>
<td>Dental care provided, including education to promote good oral health.</td>
</tr>
<tr>
<td>Non-Integrated (multiple access points)</td>
<td>Dan and Koori access worker arrive at reception. Receptionist: • determines this is a new referral • directs phone call to <strong>dental receptionist</strong> if available, or • takes client details (this may include completion of the Consumer Information template of the SCTTs).</td>
<td><strong>Dental receptionist:</strong> • conducts interview with Dan and Koori access worker to determine current needs • uses SCTTs to assist with broad inquiry regarding needs • establishes that client is Indigenous and is a Priority 1 as identified by the Generic Priority Tool • identifies that dental care is the only service Dan currently wants to access • uses Emergency Dental Management System to guide interview and obtain information to determine eligibility for emergency appointment • documents information and priority level on Summary and Referral Information template (SCTT) • client does not meet criteria for emergency appointment, but is a Priority 1 for general care and is offered the next available appointment.</td>
<td>Dentist</td>
<td>Service specific treatment plan developed.</td>
<td>Dental care provided, including education to promote good oral health.</td>
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Case study 3—client prioritised by Generic Priority Tool, multiple services.

A written referral from a GP is received requesting a physiotherapy assessment for Joan. Joan had a stroke 18 months ago and has some residual deficits that make it difficult for her to walk long distances. Her husband bought her a walking frame last month as Joan fell while they were at the local supermarket.

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<tr>
<th>Service access model</th>
<th>Initial contact</th>
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</table>
| Integrated (centralised) | Receptionist:  
• determines that written referral is a new client  
• provides referral to intake worker. | Intake worker:  
• makes initial contact with client, and conducts INI during the same phone call. | Key worker conducts comprehensive assessment. Service specific assessments by:  
• physio  
• OT  
• counsellor  
• council assessment worker. | Key worker coordinates and documents care plan, and communicates with GP.  
Service specific treatment plans developed by:  
• physio  
• OT  
• counsellor  
• council assessment worker. | CHS:  
• Physio  
• OT  
• Counselling.  
Council:  
• Personal care.  
GP:  
• medical management and advice. |
|                      |                 |                             | Agencies without key workers:  
Service specific assessments by:  
• physio  
• OT  
• counsellor  
• council assessment worker. | Agencies without key workers:  
Service specific treatment plans developed by:  
• physio  
• OT  
• counsellor  
• council assessment worker. | Communication strategy (including GP) and coordination of services required. |
### Case study 3 (continued)

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<th>Service access model</th>
<th>Initial contact</th>
<th>Initial needs identification</th>
<th>Assessment</th>
<th>Care planning</th>
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<tr>
<td>Receptionist:</td>
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<td>Physiotherapist:</td>
<td>Key worker conducts comprehensive assessment. Service specific assessments by:</td>
<td>Key worker coordinates and documents care plan, and communicates with GP. Service specific treatment plans developed by:</td>
<td>CHS: • physio • OT • counselling. Council: • personal care. GP: • medical management and advice.</td>
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<td></td>
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<td>• determines that written referral is a new client • provides referral to physio. Physio: • makes initial contact with client, and conducts INI during the same phone call.</td>
<td>• physio • OT • counsellor • council assessment worker.</td>
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<td>Physiotherapist:</td>
<td>Key worker conducts comprehensive assessment. Service specific assessments by:</td>
<td>Key worker coordinates and documents care plan, and communicates with GP. Service specific treatment plans developed by:</td>
<td>CHS: • physio • OT • counselling. Council: • personal care. GP: • medical management and advice.</td>
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<td>• conducts phone interview with Joan to determine current needs • uses SCTTs to assist with broad inquiry regarding needs • determines that in addition to the initial request for physiotherapy the client requires other supports as she is not coping well since the fall, and refers to counsellor and OT • determines client is a Priority 1, according to the Generic Priority Tool, as she requires multiple services that need coordination to meet her needs • an assisted referral is made to the local council for assessment for personal care • documents information and priority level on Summary and Referral Information template (SCTT) • offers the client the next available appointment.</td>
<td>• physio • OT • counsellor • council assessment worker.</td>
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<td>Counsellor:</td>
<td>Agencies without key workers: Service specific assessments by:</td>
<td>Agencies without key workers: Service specific treatment plans developed by:</td>
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<td>• uses the Counselling Priority Tool as client expressed a high level of anxiety and vulnerability in accessing the community now that she is walking with a frame • documents information and priority level on Summary and Referral Information template (SCTT) • offers the client the next available appointment.</td>
<td>• physio • OT • counsellor • council assessment worker.</td>
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<td>Occupational therapist:</td>
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<td>• uses Occupational Therapy Priority Tool to further explore Joan’s needs, as she expressed difficulties using the walking frame to access the bathroom • documents information and priority level on Summary and Referral Information template (SCTT) • offers the client the next available appointment.</td>
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*Non-Integrated (multiple access points)*
**Case study 4—client prioritised on basis of clinical need, multiple services.**

John is a 56 year old man who requests a podiatry assessment to review the need for orthotics to manage a foot condition he has recently developed. He would also like to see a dietitian to discuss how to best manage his high cholesterol.

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<tr>
<th>Service access model</th>
<th>Initial contact</th>
<th>Initial needs identification</th>
<th>Assessment</th>
<th>Care planning</th>
<th>Service delivery</th>
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</table>
| Integrated (centralised) | Phone call by John. | **Intake worker:**  
  - conducts phone interview to determine current needs  
  - uses SCTTs to assist with broad inquiry regarding needs  
  - establishes that client does not belong to priority population groups in the Generic Priority Tool  
  - identifies podiatry and dietetics as current needs  
  - uses podiatry and dietetics priority tools to guide interview and obtain information to determine priority level  
  - determines that while John requires more than one service, the issues are discrete and can be managed by each discipline individually  
  - documents information and priority level on Summary and Referral Information template (SCTT)  
  - determines client is a Priority 3 for Podiatry and a Priority 2 for Dietetics. He will be offered appointments as soon as they are available. | Podiatrist | Service specific treatment plan developed. | Podiatrist—this may include a home program, individual or group sessions. |
| | **Podiatrist:**  
  - conducts phone interview to determine current needs  
  - uses SCTTs to assist with broad inquiry regarding needs  
  - establishes that client does not belong to priority population groups in the Generic Priority Tool  
  - uses Podiatry Priority Tool to guide interview, obtain information and determine priority level  
  - determines that while John requires more than one service, that he has two discrete issues that can be managed by each discipline individually  
  - documents on Summary and Referral Information template (SCTT)  
  - determines client is a Priority 3 and will be offered an appointment when available. | Dietitian | Service specific treatment plan developed. | Dietitian—this may include a home program, individual or group sessions. |
| | **Dietitian:**  
  - conducts phone interview to determine current needs  
  - uses SCTTs to assist with broad inquiry regarding needs  
  - establishes that client does not meet belong to priority population groups in the Generic Priority Tool  
  - uses Dietetics Priority Tool to guide interview, obtain information and determine priority level  
  - determines that while John requires more than one service, that he has two discrete issues that can be managed by each discipline individually  
  - documents on Summary and Referral Information template (SCTT)  
  - determines client is a Priority 2 and will be offered an appointment when available. | Podiatrist | Service specific treatment plan developed. | Podiatrist—this may include a home program, individual or group sessions. |
| | **Dietitian:**  
  - conducts phone interview to determine current needs  
  - uses SCTTs to assist with broad inquiry regarding needs  
  - establishes that client does not meet belong to priority population groups in the Generic Priority Tool  
  - uses Dietetics Priority Tool to guide interview, obtain information and determine priority level  
  - determines that while John requires more than one service, that he has two discrete issues that can be managed by each discipline individually  
  - documents on Summary and Referral Information template (SCTT)  
  - determines client is a Priority 2 and will be offered an appointment when available. | Dietitian | Service specific treatment plan developed. | Dietitian—this may include a home program, individual or group sessions. |