

Home and Community Care Best Practice Project

Hume Region

Service Coordination for Complex Clients Final Report

September 2005



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Executive Summary

This project builds on the work of the previous HACC Best Practice Project in the Hume Region “Care Coordination, Care Planning & Case Management”¹. In this project, terms that were being commonly used differently by many organisations were defined and pathways that represented ‘usual’ practice were developed into flow charts. One primary recommendation of this project was to develop the role, responsibilities, expectations and principles of a lead agency.

This project, the Service Coordination for Complex Clients, furthered previous work through consulting extensively with practitioners in the field around the possibilities in relation to developing a model that would have at its centre a lead agency to facilitate coordination and ensure service coordination processes such as developing a Service Coordination Plan were integral components of service delivery. The following definition was developed: “The Lead Agency Model is about facilitating service coordination through a collaborative approach to communication and planning.”

Lead Agency Practice Forums were held in each Primary Care Partnership (PCP) area in the Hume Region, focussing on working through case examples and practising decisions such as who would be the lead agency, why, for how long, and, what would they do differently to the usual care coordination and planning approach. These Forums each developed a lead agency flow chart as a process for understanding the role.

The Forums were followed by many service providers volunteering to ‘practise’ being the lead agency, or being involved in a situation where another agency was the lead agency, over a period of three months. Feedback from these agencies was collected monthly on a proforma identifying such issues as how many agencies were involved, how did they decide who would be the lead agency at the time, what was working and not working with the lead agency model, and, their recommendations for further developing the model.

The key recommendations arising from the three months ‘practice’ were that the lead agency model be implemented across the Hume Region, supported by training and resources. The primary difficulty reported was that many service providers had not attended the project Forums and many were not familiar with the lead agency concepts and suggested implementation.

The next stage of the project was a Regional Forum at which there was an outstanding level of debate and resolution in relation to the lead agency model that forms the basis of this report. The principles underpinning the model (developed in August 2003) were refined, as was the definition of the lead agency model, including role and responsibilities. The flow charts depicting ‘usual’ pathways through service coordination and care planning were debated and amended to reflect the views of participants.

¹ Home and Community Care, Care Coordination, Care Planning & Case Management Project Report, Hume Region, Telos Consolidated, June 2003

During the project, many service providers became strong advocates for the model, stating that 'we' must persevere with teaching, supporting and implementing the model. The project has achieved its goals of enhancing service delivery practices in relation to complex clients and making recommendations for developing Lead Agency practice across the Hume Region.

The Reference Group wish to see the practice gains achieved in this project become part of ongoing practice development, supported by Lead Agency practice champions, projects and initiatives with leadership from groups, such as, the Primary Care Partnerships (PCP) Service Coordination Groups, the HACC Best Practice Groups and the Hume Region Service Coordination Reference Committee.

Recommendations

The list of recommendations below was developed by the participants at the Regional Forum (July 2005) and finalised by the Reference Group.

In the drive to continuously improve practice in order to provide the best service to clients, the Reference Group wished to draw the following recommendations to the attention of the HACC Best Practice Groups, the Department of Human Services, all agencies in the Hume Region and any others who are interested in developing quality practices. The recommendations are based on the learnings in the Hume Region as the lead agency model was developed and underwent a period of informal 'practice'.

Recommendations focussed on the need for training, policy changes/developments and the resources to support these, alongside the need for information technology to be at a level where all communication that is currently undertaken in hardcopy or by phone/fax can be transmitted electronically, knowing it is secure. It is recommended that:

- Recommendation 1:** Hume Region DHS provide a program of region wide service provider education in relation to the lead agency model, including training in case conferencing, eg. calling and chairing meetings
- Recommendation 2:** Hume Region DHS provide ongoing education, with agencies being encouraged to attend, in the use of SCTT (Service Coordination Tool Templates), especially the Service Coordination Plan
- Recommendation 3:** The Hume Region Service Coordination Reference Group, through the Hume Region E-referral Project, develop the IT processes to support the lead agency model, being both e-referral and secure messaging component.
- Recommendation 4:** PCP Service Coordination workgroups monitor, support, formally evaluate and review the lead agency implementation framework. That the evaluation data be reported to DHS to inform policies and planning around growth funding
- Recommendation 5:** All PCPs integrate the lead agency model into their Service Coordination Manual. The lead agency expectations, role and overview flow chart be included in any written documentation on the model and future training strategies around Service Coordination, eg Service Coordination Self Paced Training Model
- Recommendation 6:** The PCP Service Coordination workgroups develop a mechanism to identify clients within the lead agency system and who is lead agency, to enable new services to link efficiently to the lead agency

- Recommendation 7:** Through the four HACC Best Practice Groups, that case management services be well informed and that an understanding of the lead agency model be developed, building on existing good relationships between case managers and those who provide direct services
- Recommendation 8:** This project will submit recommendation to the SCTT review panel and suggest that on the Service Coordination Plan form, the wording should be “key worker/lead agency”
- Recommendation 9:** Advise Divisions of GPs of the project and the lead agency model, educating them in how this model will work in practice, especially once further developed and better used in the HACC Sector
- Recommendation 10:** This project Reference Group reconvene in six months to monitor outcomes and consider next steps.

Acknowledgements

This project was initiated by the Upper Hume Best Practice Group submitting for funds for a Hume Region Project and when successful forming a Reference Group inviting other Best Practice Groups to ensure their input and participation.

The Department of Human Services Regional Office has supported the project throughout by participation in the Reference Group, the forums and the debate of the issues.

The greatest acknowledgement is to the workers and managers in the field – to all those who participated in the PCP area Forums, the lead agency model practice and the Regional Forum. Some participated at all levels with staff attending various forums in different locations. The process and the outcomes of this project have only been possible due to the excellent input and the preparedness of all participants to openly and honestly debate practice issues.

The project wishes to pay tribute to the following people and thank you for your time and energy.

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Denise Ritchens	Julyan Howard	Nanette Herry	Trudy Land
Karen Hampshire	David Taylor	Angela O'Meara	

Jill Nicholson

Project Manager

Reference Group

The project was guided at all stages by a highly committed Reference Group who worked both at the 'big picture' level and the micro level in debating lead agency model concepts. Members were tireless in their willingness to look at yet another flow chart and provide feedback or redraw it.

Regional projects require many to travel in order for the group to meet which was essential to the debates. Each member gave time, skill, ideas and energy throughout the project. Members also participated in the Forums and other project activities.

Member	Agency
Sheryl Follett, Chairperson until end July 2005	Upper Murray Family Care
Jenny Buckingham, Chairperson from August 2005	Mitchell Community Health Service
Neil Duggan	Department of Human Services
Pam Tobias	Glenview Community Care
Sigrid van Fondern	Regional Information and Advocacy Council
Jan Kowarzik	City of Wodonga
Fiona McLellan	Ovens and King Community Health Service
Betty Potter	Indigo Shire Council
Simon Rose (resigned after the first meeting)	City of Greater Shepparton

This group was greatly assisted by 3 others who monitored practice and were subsequently invited to attend meetings.

Monitoring lead agency 'practice'	Agency
Daniel Whiting	PCP Service Coordination, UMFC
Jenny Buckingham	Mitchell Community Health Service, HACC services
Simon Rose	City of Greater Shepparton

I would like to express my gratitude to all members of the Reference Group for their absolute commitment to 'making a difference' to lead agency practices in the Hume Region. They have established a path that, through the recommendations in this report, can be followed.

Jill Nicholson
Project Manager

Introduction

Background

The previous HACC Best Practice Project in the Hume Region, Care Coordination, Care Planning & Case Management Project, defined the terms and developed flow charts to guide practice in relation to care coordination, care planning and case management processes. The timing of this was September 2002 to August 2003.

One primary outcome was the need to further the conversation and practice around lead agency when there was not a case manager involved with the client and their situation was considered complex.

As part of the recommendations from this project, some preliminary work was done at a Lead Agency Forum that explored some of the expectations, roles and principles that may be incorporated into the model.² These included:

- Definition of complex as “3 or more services involved with the client, and/or a level of complexity/instability”
- Lead agency expectations and role
- Communication between agencies
- Who takes on the responsibility of being the lead agency?
- Principles that underpin the role of the lead agency
- Reviewing or changing the lead agency
- Referral out of the care coordination system (into other care/systems).

The context in which service providers continue to deliver has some aspects that are worth noting as background to this project. These are:

- The multiplicity of agencies providing assessment, care planning, care coordination and case management services within the Hume Region
- The diversity in models of practice in different local government areas and agencies
- The reluctance of agencies to take on the role of lead agency, fearing an increase in their already full workloads
- The increasing complexity of care support required by clients wishing to remain at home
- The implementation of the PCP Service Coordination Tools
- The Privacy Act and how this is interpreted and translated into practice in each agency
- The role of Primary Care Partnerships in service development and service coordination
- The challenge and fatigue associated with ongoing change.

² Lead Agency Forum, Hume Region, August 2003

A Lead Agency model that incorporated the concept of one agency leading the coordination of services and care planning was proposed as the way forward to assist service coordination with complex clients.

This current project began at the end of 2004, with workers in the Upper Hume HACC Best Practice Group creating case examples that would be used in four PCP area Forums aimed at furthering debate about lead agency practice and the implications.

This project is linked to the field and run by them through representatives on the Project Reference Group.

Purpose of this Project

The aim of this Project is to establish the 'Lead Agency' model of care coordination for complex clients within the Hume Region. The project will develop a 'Lead Agency' model to include clarity re the lead agency role, principles, steps in the process and encouraging the development of communication protocols between agencies (incorporating privacy principles) that will guide the practice of workers in the field. The project outcome will be to enhance service delivery practices in relation to complex clients and to make recommendations for developing Lead Agency practice across the Hume Region.

It is a conscious choice of the Reference Group to refer to the Lead Agency and not key worker. It is the agency that has responsibility to deliver even though it is acknowledged that this usually devolves to a worker.

Many workers are part time or absent from their office to undertake their duties. If required, a duty worker would need to act on the agency's behalf for any of their clients. This applies also to those for whom the agency is the lead agency.

Project Method Overview

The project was undertaken in seven (7) stages, as outlined below, to maximise the input of practitioners in the field and to encourage debate around the lead agency model of practice. At all times the Project was guided by the Reference Group.

- Stage 1: Establishment and Accountability of the Project
- Stage 2: Developing an understanding of existing Hume Region care coordination models
- Stage 3: Develop Lead Agency 'Practice' and Evaluation Processes
- Stage 4: Lead Agency Practice Forums
- Stage 5: Practice monitoring and feedback
- Stage 6: Regional Forum
- Stage 7: Project Report and Recommendations

Project Outcomes

Research of Current Regional Practice

The Project Brief identified existing regional care coordination models that it wished the Reference Group to further understand as they could have implications for this project. These were the Primary Care Partnerships (PCPs), the Multiple and Complex Needs (MACN) model developed at the State level for clients with very complex needs, crossing all service types, and, the Acquired Brain Injury (ABI) strategy. The Australian Coordinated Care Trials were also reviewed. Key findings are presented below.

Current status of Hume Region PCPs in terms of service and care coordination

All four PCPs have listed service coordination as one of their priority areas in their Community Health Plans, as follows:

- All continuing to encourage the use of the SCTTs by member and non member agencies
- They are at various stages with their Service Coordination Practice, Processes, Protocols (3 Ps) and Systems Manuals, ranging from continuing to develop them³, revising them⁴, to encouraging their continued uptake^{5 6}
- The Goulburn Valley PCP priority area is to facilitate the uptake of e-referral options⁴
- The Upper Hume PCP further specifies priorities for service coordination as:
 - Refining 'lead agency' practices for service coordination planning
 - Further involving General Practitioners in service coordination through use of SCTT and feedback processes.⁷

Multiple and Complex Needs Initiative

The Regional Coordinator of the Hume Region MACN described the purposes and benefits of using case conferences as a key strategy in identifying eligible clients and facilitating coordination of the client's care planning process. The Regional Coordinator in the MACN program has clear authority to call and chair the case conference.

³ Central Hume Primary Care Partnership: Planning for Partnership Community Health Plan 2003-2004

⁴ Goulburn Valley Primary Care Partnership: Better Rural Health Community Health Plan 2004-2006

⁵ Lower Hume Primary Care Partnership Community Health Plan 2003-2004.

⁶ Upper Hume Healthy Communities Plan 2002-2005. Revision and Progress June 2003

⁷ Upper Hume Healthy Communities Plan 2002-2005. Revision and Progress June 2003

The purpose of the case conference is to bring together all relevant personnel to:

- Clarify roles and responsibilities – clients/carers/workers –including who will coordinate client care
- Identify key issues/problems which need solutions
- Establish clear protocols and processes for communication – even if a lead worker/care coordinator for the client is not appointed
- Prioritise tasks
- Provide an authorising environment for decisions to be made
- Map pathways of care to assist in identifying whether a client has other alternatives than the MACN Initiative.

Perceived benefits have been:

- Avoiding duplication of effort and services
- Opportunity costs of travel and time spent at the case conference outweigh the costs of lengthy time spent in communicating with a range of people over varied periods of time
- Demystifying situations and making specialist information accessible (eg. reducing jargon)
- Avoiding crisis management
- Reducing the service system and service provider fatigue associated with working with clients with complex needs
- Debriefing workers
- Supporting key worker/s
- The independence of the case conference chairperson.

Considerations for the conducting of case conferences:

- The 'authority' and executive support to convene a case conference
- The skills required to plan and implement a case conference – timing, organisation, who to include, managing a group, chairing, documenting
- Confidentiality
- Templates/tools for recording of meeting details, roles and responsibilities allocated, communications, care plan
- Client attendance and how to encourage and achieve this
- Who will chair and minute the meeting?

Australian Coordinated Care Trials

The key learnings emerging from the Australian Coordinated Care Trials which could have relevance when considering the role of lead agencies in coordinating the services of clients with complex needs are:

- Regular and reliable service coordination facilitated improved client self management of their health and the resources available⁸
- Establishment of clear roles, responsibilities and methods for inter/intra agency communication. A central point of communication reduces the time and effort for multiple service providers in dissemination of relevant information⁹ (also noted by the Regional Coordinator of the Hume Region MACN).
- Adequate resources, technologies and systems within agencies to enable a collaborative service coordination model⁸
- Difficulty estimating the degree of contact, care and/or service coordination clients would need and the mix of face to face and phone contact required to effectively coordinate a client's care, without being intrusive.^{8,9}
- A lack of continuity of service coordination resulted in irregular and infrequent contact
- Minimal follow up by the service coordinators led to difficulties engaging the care coordinators and the client in their own care and facilitating the use of appropriate services⁸
- Planning for coverage of service coordinators for periods of extended leave
- The amount of time needed to perform the role adequately, particularly if there are other competing work responsibilities and commitments⁹

⁸ Markwick M. et al. Coordinated Care – A Southern Perspective from SA HealthPlus in The Australian Coordinated Care Trials - Reflections and Lessons, Section C: Service Coordination
www.health.gov.au/hsdd/primcare/acoorcar/pubs/reflections/secc.htm

⁹ De Clara N. and Bennett T. The value of the service coordinator role in the TEAMCare Health Trial in The Australian Coordinated Care Trials - Reflections and Lessons, Section C: Service Coordination.
www.health.gov.au/hsdd/primcare/acoorcar/pubs/reflections/secc.htm

Developing the Lead Agency Model

During late February and March 2005 four Forums were held, one in each PCP area, to further explore and develop the lead agency model with practitioners from the field. These were very well attended by a range of HACC and other service providers including: local government services, district nurses, allied health professionals, carers services, specialist services, discharge planners, case management services (both DHS and community based), advocacy services, Department of Human Services staff, members of the Reference Group and the PCP Service Coordination Groups.

The focus in each Forum was the case examples where a lead agency was indicated by the degree of complexity of the scenario. Participants looked at who would be the lead agency and in this process identified a number of issues, leading to the drawing of a flow chart to map the processes involved visually and clarify them.

There were consistent themes in the discussions, such as:

- The probable need in many situations for a case conference, with the client and/or family participating, to clarify roles and services that would be provided. This was mostly seen as 'new' practice, although it had been current practice in some circumstances
- Some concern about the time involved in being the lead agency but this did not dominate the discussion
- An emergent understanding of the difference between a Service Coordination Plan (SCP) and an agency Care Plan and much discussion about how to achieve a SCP when everyone is so busy
- The urgent need for the SCTT and any other forms (eg. Referral Outcome Form) to be electronic and to be transmitted securely to another agency directly from one computer to another
- The flow charts developed at each of the four Forums were similar, some much clearer re the development of a Service Coordination Plan and the multi-agency process for doing this. The guiding nature of the flow chart was reinforced as was the need to abide at all times by the Privacy Guidelines
- The need for SCTT to be used by Hospitals and GPs as they are frequent referral sources to, for example, District Nurses (some Hospitals are using the SCTT to make referrals)
- In every Forum, participants volunteered to be part of the three month lead agency 'practice'
- Some municipalities have not been involved in these Forums (ie neither District Nursing nor Local Government Services attended).

Practicing the Lead Agency Model

Many service providers volunteered to 'practice' being the lead agency, or being involved in a situation where another agency was the lead agency, over a period of three months. Feedback from these agencies was collected monthly on a proforma identifying such issues as to how many agencies were involved, how did they decide who would be the lead agency at the time, what was working and not working in the lead agency model, and, their recommendations for further developing the model.

The key recommendations arising from the three months 'practice' was that the lead agency model be implemented across the Hume Region, supported by training and resources. The primary difficulty reported was that many service providers had not attended the project Forums and many were not familiar with the lead agency concepts and suggested implementation. Recommendations in detail from those involved in the lead agency practice period were:

- In favour of implementation across the board of the Lead Agency model and strongly encourage all agencies to utilise it
- To effectively implement the model, it must be well supported with resources and training, as have been provided for the SCTT
- Need to develop different scenarios to assist in the recognition of complex clients; eg.
 - tick box on Referral Outcomes Feedback Form indicating current or potential need for lead agency
 - comprehensive screening
 - good referral practice
 - discharge planning
 - at first client meeting, District Nurse (DN) to look through waiting list for Community Aged Care Packages to identify potential complex clients.
- Persevere with the 'practice' phase so that can provide more data for implementation
- Physical meeting of the services is essential
- Protocols need to be established
- E-referral is essential
- Model places an onus on services to provide very good and holistic Initial Needs Identification (INI)/screening. Ideally we would have multifaceted needs identification at initial contact
- Develop a service card identifying lead agency and contact details
- Lead Agency model requires clear parameters
- Clinical case management should not preclude lead agency service coordination model (mental health service)
- Preliminary consultation among services pre case conference may make better use of time at the case conference
- Simplify flow chart, eg. Steps 1 2 3 4.

Lead Agency Practice Model

Following the PCP area Forums and the three month lead agency practice, a Regional Forum was facilitated in July 2005 to bring all the experiences together into the one setting to finalise the lead agency practice model.

The following definitions, principles, roles and communication strategies relating to lead agency practice were developed by HACC service providers at a Regional Forum held in August 2003 and then updated to reflect current thinking and recent learnings from the lead agency practice in July 2005. The flow charts were developed following Forums held in early 2005 and then finalised in July 2005 at the Regional Forum.

Definition of Lead Agency Model

The Lead Agency Model is about facilitating service coordination through a collaborative approach to communication and planning.

Definition of Complex Client

For the purpose of this project, a client is considered complex where three (3) or more services are involved with the client and/or other factors creating complexity/instability present. For the Lead Agency model to be applicable, the client will not usually have a case manager.

Benefits of the Lead Agency Model

The service providers who volunteered to practise the lead agency model and the Project Reference Group identified a number of benefits as follows:

- Client/carer/family benefit by having one identified agency that undertakes coordination of their care, having a holistic picture of the client and the services being provided. This ensures that the client gets access to the services that he/she needs
- Client/carer/family felt that they had an advocate in the care system
- Helped to identify the complexity and the number of services involved, creating an opportunity for one lead agency (instead of multiple agencies doing some coordination) and for all services to be travelling in the same direction, coordinated in both their planning and service delivery
- Appropriate and timely information sharing with agencies and good client outcomes; sometimes taking place at Extended Care meetings
- Greater liaison between services
- Service Coordination Plan meetings (preferably including the client and their family) provided excellent opportunities to identify client needs, clarify client goals and which agency is providing what service(s)
- Documenting the Service Coordination Plan which lists responsible persons/agencies
- Distributing copies of the Service coordination Plan to client, family, GP and other services

- Efficient referrals, with clarity re who was making referral, saving duplicate referrals. Although acknowledged that being the lead agency takes time, it was also considered to save time around referral duplication, multiple phone calls and each agency undertaking some/parts of service coordination
- Provides support for service providers, especially for those in sole positions or isolated areas
- Greater understanding of client progress re issues that have an overall impact on their wellbeing but may not have been the responsibility of most agencies
- When a change of agency/ies delivering services occurred, this could be addressed at a Service Coordination Meeting, allowing input from all agencies and all being informed re change in client care.

Principles

Principles that underpin the Lead Agency Model:

1. The concept of lead agency is underpinned by 'Better Access to Services'¹⁰ and the Service Coordination Tool Templates
2. Agencies will work together in a spirit of co-operation and respect
3. Adopting the role of lead agency is voluntary and can be changed over time as negotiated
4. The role and responsibility of each agency is recognised within their own agency policies, guidelines and capacity
5. The client and/or carer/guardian will be given full opportunity to participate in the development of the Service Coordination Plan
6. Having a lead agency will not be detrimental or discriminatory to the client's access to case management services
7. The lead agency model complements the client's informal support system and respects diversity
8. The lead agency will adopt and adhere to the principles of the lead agency model
9. The lead agency will adhere to client confidentiality and the privacy guidelines
10. All agencies involved have a responsibility for duty of care to the client
11. The role of the lead agency is not case management.

¹⁰ 'Better Access to Services' Principles are contained in Appendix D

Lead Agency Expectations/Role

The lead agency fulfils their usual service provision role and the following:

- Receive and disseminate information
- Facilitate Communication
- Explain lead agency role to client/carer
- Lead agency referral to other services (if in their service provision role they would usually have undertaken this)
- Referral to other service(s) by an agency (that is not the lead agency):
 - a) Another agency identifies a need(s) and contacts lead agency to check whether any agency has made this referral. If not, the agency identifying the need refers as usual to other service(s)
 - b) Notifies lead agency of referral, confirmation of referral will come to lead agency and the referring agency (Referral Outcome Form)
 - c) Lead agency notifies other agencies (as relevant)
- Develop the Service Coordination Plan in consultation with the client and/or ensure a Service Coordination Plan exists
- Notify changes in Service Coordination Plan to agencies involved (as relevant)
- Keep Service Coordination Plan up to date
- Identify the lead agency on the Summary and Referral Form to enable appropriate feedback
- Lead agency is the receptacle of relevant information, ie will have the most up to date information
- Lead agency will hold and access relevant information in relation to client service provision within the Service Coordination Plan
- Prompts and facilitates the review of the Service Coordination Plan. In complex care situations, if a change in care needs occurs, flags the need for a change in Service Coordination Plan, the lead agency may call a meeting for discussion and care planning
- Disseminate information regarding client death
- Notify agencies to which the client has been referred if the client dies/goes into residential care
- Agency will have the capacity to be the lead agency.

The Lead Agency is not:

- Responsible for ensuring that all service provision is meeting the client's needs
- The case manager or a case management service
- To cover gaps in service provision
- To respond to service specific issues/complaints

- To monitor client well-being beyond their usual service specific role
- The agency that makes all the referrals
- A discharge planning service
- A 'fix it' agency
- To replace resources outside the service system that the client has available, eg. family
- The service that addresses family disputes
- Responsible for the client's decisions and actions
- A dispute resolution service
- Responsible for day to day service shifts.

Communication between Agencies

- Clients must know who the lead agency is and understand this role
- Lead agency needs to know all the agencies involved in a client's care
- Clarify roles and agreed understanding through the Service Coordination Plan
- What is communicated with the client's consent within the role of lead agency? Examples listed were: service provision changes, major client status changes
- Determine most appropriate method of communication
- Appropriate staff within the lead agency are aware of this lead agency role, especially in the event of the usually allocated worker being absent
- To be a point of contact for changes in care (eg admission to hospital). All agencies and family are responsible for notifying changes
- Documentation kept by each agency and available to lead agency (if relevant and with client's consent)
- Record at client's house who is the lead agency (where possible)
- Hospital to notify lead agency if patients admitted/discharged/died
- Other services keep the lead agency updated regarding their service provision
- Agency accepting the referral sends feedback to the lead agency and the referring agency (when different).

Who is the Lead Agency?

To decide who is the Lead Agency, including trigger points for needing a lead agency, it is suggested that the following is taken into account:

- Being the lead agency could be a short term or long term role

- The agency being considered as lead agency needs to have ongoing client/carer involvement
- Agency that has regular contact with the client
- Agency that has a relationship with the client
- The client's preference for lead agency, will be considered, however the service system will decide which agency is the lead agency
- An opportunity to distribute the workload of being lead agency
- If the client's situation stabilises/settles, there may be no need for a lead agency or a need to change the lead agency
- The lead agency is negotiated and agreed among the agencies providing service, and, the agency being proposed has the capacity to be the lead agency
- The lead agency will use the Service Coordination Tool Templates.

Who will not be the Lead Agency?

It should not be an agency that the client is not comfortable with.

Service Coordination Meeting

Although not essential, feedback from agencies involved in the practice of the lead agency model and information obtained from the Multiple and Complex Needs (MACN) Project reinforced the positive outcomes for both clients and professionals of a meeting to discuss the client's needs, their goals and subsequently develop a Service Coordination Plan with them. It is advised that the Service Coordination Plan form, which is part of the SCTT, be used as the generic tool to support communication processes within the model.

Given the rural nature of the Hume Region, it is often time consuming for service providers to travel to one place; therefore it was suggested to hold telephone conferences instead - if this is suitable for the client and their family. This could include one service provider or more being with the client with others linked by phone.

One service provider involved in the lead agency model practice recommended that a 'physical meeting of the service providers is essential.'

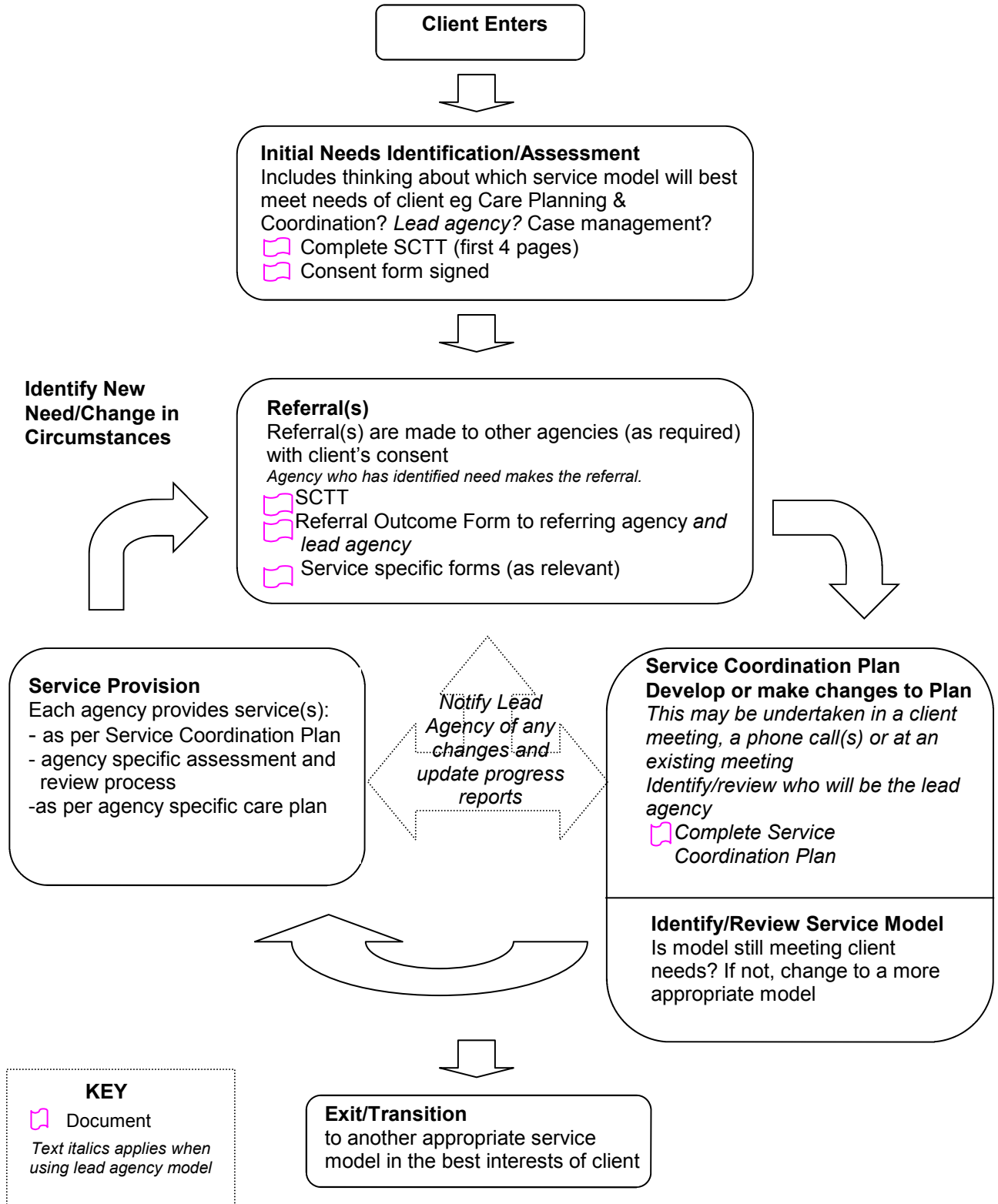
The reference group wish to highlight the benefits of the Service Coordination Meeting as follows:

- Gathers all involved in the one place (or if by phone at the one time) for the client/family to have their needs clarified and then be involved in a discussion of how the service team could work together to meet their needs. This gives the family and service providers a much greater sense of cohesion and they are then more likely to notify each other of relevant changes. There is an ownership of the Service Coordination Plan and the 'parts' of the care delivered by different agencies will result in holistic care

- Opportunity costs of travel and time spent at the case conference outweigh the costs of lengthy time spent in communicating with a range of people over varied periods of time
- Making specialist information available, accessible and ensuring the family and services have understood the information and its' implications
- If the General Practitioner is one of the services involved, their involvement in the meeting can support other agencies in their understanding of the medical/health needs of the client and in turn the GP can understand what is being provided by the agencies
- Avoiding crisis management, duplication of effort and services
- Reducing the service system and service provider fatigue associated with working with clients with complex needs
- Supporting the lead agency in their role and other services in theirs.

Care Planning and Coordination Overview Flow Chart

This flowchart is purposefully only an overview (ie not covering all steps) and assumes the client is appropriate for community based HACC services and privacy guidelines are followed. As this is a continuous flow, all steps may not be undertaken in each cycle. *Lead Agency tasks are shown in italics.*



Appendices

Appendix A: Glossary of Terms

ABI	Acquired Brain Injury
ACAS	Aged Care Assessment Service
BATS	Better Access to Services
CACP	Community Aged Care Package
CRIS	Carers Respite and Information Service
DHS	Department of Human Services
DN	District Nurse
HACC	Home and Community Care
INI	Initial Needs Identification
LA	Lead Agency
MACN	Multiple and Complex Needs
PCP	Primary Care Partnerships
PPPs	Protocols, Processes, Practices & Systems
SCP	Service Coordination Plan
SCTT	Service Coordination Tool Templates

Appendix B: Definitions

The definitions below were arrived at in the previous HACC Best Practice Project.¹¹

Care Planning

Care Planning is a dynamic, consultative process that includes the client, the family and appropriate service providers in the identification and assessment of client needs, from which a care plan is developed, that includes goals and actions aimed at achieving desired/optimal outcomes.

Key tasks include:

- Assessment of short term and long term client needs
- Prioritising of client needs and goal setting to meet such needs
- Exploring the most appropriate and cost effective way of meeting client needs
- Developing a Care Plan specific to the services of the agency, noting other agencies involved. The circulation of this Plan will depend on current individual agency practices
- Implementing the Care Plan
- Ongoing assessment and review of client needs and appropriate revision of the Care Plan.

Care Coordination

Care Coordination is a process that implements the care plan to ensure that the specific service(s) in the plan are implemented in a client focused, flexible and timely manner. It is acknowledged that some clients will choose to coordinate their own care. The care plan is dynamic in response to the client's needs and may alter during the work with the client.

Care Coordination includes:

- Implementation of the Agency's Care Plan, particularly through each agency involved coordinating their own service(s)/program(s)
- Agencies ensuring that the care is meeting client needs through effective monitoring and review of the Care Plan
- Liaising and communicating with other service providers and client/carer
- Planned exit to other services/systems, eg. ACAS, case management or residential services.

¹¹ Home and Community Care, Care Coordination, Care Planning & Case Management Project Report, Hume Region, Telos Consolidated, June 2003

Case Management

Case management encompasses the tasks and roles of Care Planning and Care Coordination and as such is based on a comprehensive assessment of the client's complex needs. The Case Manager, as a central point of contact and identified key worker, liaises with the client and services to provide holistic care, problem solving and advocacy on behalf of the client. This process will proactively respond to and plan for client needs, activate appropriate resources in consultation with the client, carers and other service providers, and, ensure that the client is aware of all options and is able to make informed choices.

Key tasks include:

- Being the lead agency
- Assessing client and carer/family needs using the social model of health framework
- Developing/updating the Care Plan and developing future goals
- Problem solving, trouble shooting, responding to crises
- Negotiating and facilitating service provision
- Liaising with service providers
- Monitoring the client's well-being, needs, care and the effectiveness of services
- Advocacy and mediation
- Planning of care within available resources, sourcing additional funds
- Empowering clients and/or their families to make informed choices
- Referrals to other agencies
- Identify the need for specialised training that may arise due to a client's specific needs
- Develop a Client Exit Plan.

Lead Agency Model

The Lead Agency Model is about facilitating service coordination through a collaborative approach to communication and planning.

Complex Client

For the purpose of this project, a client is considered complex where three (3) or more services are involved with the client and/or other factors creating complexity/instability are present. For the Care Planning and Coordination: Lead Agency model to be applicable, the client will not usually have a case manager.

Appendix C: Lead Agency Practice Feedback Summary

This report is a summary of all the feedback forms received from each PCP area during the Lead Agency practice, April – June 2005. Staff at the agencies who volunteered to be part of the practice were interviewed at the end of each month, i.e. April, May and June 2005.

Responses are in the survey format, with those listed more than once accompanied by a number in brackets () at the end of the statement.

Interviews

Completed: 29

Agencies: District Nursing
CRIS
Home Based Outreach
Local Government Services
Health Services
Vision Australia
Rural Allied Health

Number of clients with whom practising the lead agency model:

Varied across the months, between 6 and 11 clients

Number of agencies involved at the time of this practice:

The number of agencies involved varied from 2 to 11, with many instances having 3, 4 or 6 agencies involved with the one client.

1. Why did you decide to use the lead agency model in this situation?

The most commonly ticked responses were multiple agencies and complex medical condition. The other responses - many relapses, need to prioritise for service and complex family, complex social needs - were only occasionally marked.

2. How did the services decide which agency would be lead agency at this time?

Responses ranged from defacto/by default lead agency selection to a choice based on the complex medical needs of the client. This decision was also sometimes based on the rapport agencies had with clients or the agency in the home the most.

3. What is working with lead agency practice?

Those interviewed listed the following:

- Client benefits from having an advocate in the system (2)
- Provides family with central communication liaison agency (2), one central contact point, easier for all agencies and the family
- Lead Agency (LA) has the holistic picture of client and services going in
- Linking client and providing client with information on other services. Additional medical needs discovered due to LA involvement
- Appropriate information sharing with agencies and good client outcomes
- Helped to identify the complexity and number of services involved
- Greater liaison between services
- Case meeting and Extended Care meetings good opportunities to identify client needs and services involved, clarify who is providing service
- Documenting the plan. Copies to client, family, GP and other services. This lists responsible persons/agencies
- Explanation to the family was good, family happy with lead agency model
- Setting up referrals
- Feedback from other agencies is consistent
- Greater understanding of client progress (eg. housing, equipment)
- Felt that the lead agency had a greater authority (and responsibility) to delve deeper into more information about the client from other agencies
- Preliminary meeting occurred with peer support and advice provided re lead agency
- One agency withdrawing, case meeting held, discussed ongoing client support needs, services negotiated capacity and priority for meeting client needs.

4. What is NOT working with lead agency practice?

Those interviewed listed the following:

- Other agencies and staff in agencies (those not involved in the Forums) not understanding nor involved in the LA model (3)
- Time involved in getting everyone together (2), eg. time required to set up a meeting (6 other agencies, not familiar with lead agency practice)
- Selecting appropriate clients; not clear who may need lead agency model and how they can be identified (2)
- Clear procedure – needs to be as straight forward as possible (2)
- Nothing (i.e. working well) (2)

- Need regular liaison over the phone and phone reviews
- Faxing client information, too time consuming
- SCTT cumbersome, too slow when working with immediate risks and priorities
- Need to clarify the question: Does the LA need to know what everyone is doing?
- Not being able to coordinate care via a lead agency when the client is clinically case managed as this focuses on clinical condition and not necessarily service coordination (Mental health service)
- Client not present at case conference. Services concerned re appropriateness of having client present whilst discussing capacity/budgets (especially if no service can be provided)
- Getting information back from others in the same organisation and coordinating 'in house'.

5. Issues arising as you practise the lead agency model

Those interviewed listed the following:

- Requires all agencies to participate to be fully effective. Other agencies have no ownership of the lead agency model (3). They are happy to be involved, but when it comes to feeding back information, they forget because it is not a project/model they are thinking about
- Need clear processes for identifying and prioritising complex clients (2), current Protocols, Processes, Practices & Systems (PPPs) doesn't lend itself to recognising complex clients for whom LA model would be useful
- Getting everyone together for meetings was problematic, many part time workers which delays meetings thereby offsetting the relevance of using the model and being able to act quickly (2)
- Agency is not funded for lead agency practice and there is no resourcing for the model or the 3 months 'practice' (2)
- HACC agencies take a natural lead agency role in most situations (2)
- Model relied too much on individuals, when worker left the practice ceased (2)
- Framework was good, especially as a floating model that mediates different constraints (eg. funding, service capacity)
- In larger organisations, more challenging as have to train and educate all staff. All staff need to have common knowledge re the model and how to use it
- Hard to know what services are involved as begin to decide re lead agency practice
- Need to remember to enter into client progress notes all feedback and updates
- No additional work involved, except informing others of LA model

- Repetitive to the service plan that is already undertaken
- Need to ensure family understands the role of lead agency
- Need good time management, LA model involves extra tasks but it is going well
- Time involved in lead agency practice
- Client needs became too complex (during the practice) therefore referred to case management
- Multiple e-mails
- None (2)

6. Recommendations

Those interviewed suggested the following:

- If this model is to be implemented, it needs to be well supported with resources and training to implement it to the same degree as the SCTT (6). For the model to be effective, needs to be well resourced and supported by the wider service system, ie all agencies
- In favour of implementation across the board of LA model, encourage all agencies to utilise (3); must persevere with this model and the practice with information available to all agencies re the model and how to practice within it
- Different scenarios to recognise complex clients need to be highlighted; eg. tick box on Referral Outcomes Feedback Form indicating current or potential need for lead agency, comprehensive screening, good referral practice, discharge planning, at first client meeting, DN to look through waiting list for Community Aged Care Packages to identify potential complex clients
- Persevere with the practice phase so that can provide more data re implementation
- Physical meeting of the services is essential
- Protocols need to be established
- E-referral is essential
- Model places an onus on services to provide very good and holistic INI/screening (2). Ideally we would have multifaceted needs identification at initial contact
- Service card identifying lead agency and contact details
- LA model requires clear parameters
- Clinical case management should not preclude lead agency service coordination model (mental health service)
- Preliminary consultation among services pre case conference may make better use of time at the case conference
- Simplify flow chart, eg. Steps 1 2 3 4.

Appendix D: 'Better Access to Services' Principles

Fundamental requirements underpinning Service Coordination¹²

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

1. A central focus on consumers
2. Partnerships and collaboration
3. The social model of health
4. Competent staff
5. A duty of care
6. Protection of consumer information
7. Engagement of other sectors.

In practice this will mean that:

- Consumers will only have to tell their story once
- The needs of consumers will be identified and responded to as quickly as possible
- Service providers will know what other services are available to support consumers
- There will be improved feedback on referrals between agencies
- When consumers have a number of complex issues or there are two or more agencies involved, services will be delivered in a coordinated way
- Services will focus on the strengths consumers
- Information collected about consumers is confidential and protected by the law.

¹² Primary Care Partnerships, Better Access to Services. A Policy and Operational Framework, DHS page 9