

Primary Care Partnerships: Better Access to Services

Guideline 4: Developing a Service Coordination Plan

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4. 1 Overview

4.1.1 About the Service Coordination Plan

This is the fourth guideline in the Initial Needs Identification (INI) tool suite and is designed for those completing the Service Coordination Planning tool.

The Service Coordination Plan (SCP) should be used with consumers with both multiple agency involvement and complex needs.

4.1.2 Overview of the tool templates

This document is part of a set of four guidelines for completing the Initial Needs Identification (INI) tool templates. A complementary consumer consent template and guidelines have also been prepared.

Issues relating to assessment (service specific, specialist and comprehensive) are not included. To describe the scope of the activities covered by these tools, the following table is useful. The distinction between the INI and various types of assessment are summarised in this table. These distinctions essentially relate to the depth and breadth of the information sought from the consumer.

Table 1: A tiered screening and assessment model

Activity	Depth	Scope	Used for referral purposes?	Current status
INI:				
Consumer Information	Shallow	Narrow	Yes	Required
Summary and Referral Information	Shallow	Narrow	Yes	Required for all referrals and should be used for intake summary functions
Supplementary Profiles	Shallow	Broad	Yes, where relevant	Optional, to be used at discretion of the professional, except in the case of HACC referrals where the living arrangements and functional profiles should be used (both to make and receive a referral)
Assessment:				
Service specific*	Deep	Narrow	No	Out of scope
Specialist*	Deep	Narrow	No	Out of scope
Comprehensive*	Deep	Broad	Yes, where relevant	Out of scope
Care Plan*	Deep	Narrow	No	Out of scope
Service Coordination Plan	Deep	Broad	Yes, where relevant	Should be used with consumers with both multiple agency involvement and complex needs

* Indicates activity is not covered by the current suite of Service Coordination Project tools.

There are 4 guidelines in this series:

- Guideline 1: Completing Consumer Information as the first step in Initial Needs Identification
- Guideline 2: Completing the Summary and Referral Information step of Initial Needs Identification
- Guideline 3: Completing the Supplementary Profiles as part of Initial Needs Identification
- Guideline 4: Developing a Service Coordination Plan

This introduction and summary of key points is included in each section to make them mostly self-contained. Consent and information disclosure issues are dealt with separately.

Overview of the tools

The Initial Needs Identification tool templates consist of a core set of **Consumer Information** that contains items designed to collect demographic and social details about individual consumers. The **Summary and Referral Information** form is to record a summary of their problems/issues and outline an initial action plan. There is also a 1 page **Consumer Consent** form. The INI tool template also has 5 **supplementary profiles** that allow further information to be collected on those areas relevant to the consumers' circumstances and presenting problems. Not all profiles will be relevant for every consumer and, in some cases, some specific information within a profile will not be required. In these cases, simply record NA (not applicable) or code 99, depending on the instructions on the top of each page. The final form in the series is a **Service Coordination Plan** form.

Each PCP will need to develop its own protocol (who, what, when, how) for collecting and sharing information using the Initial Needs Identification tool template. It is likely that many of the items in the Contact Details component will be collected during the initial contact with the consumer or the person referring the consumer. Some items, however, may not be collected until the first time a consumer is seen by a clinician. The content and purpose of the different components are summarised in the following table:

Table 2: Purpose of the INI Forms

COMPONENT	PURPOSE	Pages
CONSUMER INFORMATION		
p.1	Demographic and social details of the consumer, contact person/s and GP, and how the information was obtained	CI p.1 of 2
p.2	Codes to record source of referral, other demographic information and benefits, entitlements and insurance status	CI p 2 of 2
SUMMARY AND REFERRAL INFORMATION		
p.1	Summary of presenting problems and a text box to record other relevant information.	SRI p.1 of 2
p.2	Describes current services used in last three months, and proposed initial action plan. Completed at the end using information from other profiles if appropriate	SRI p.2 of 2
SUPPLEMENTARY PROFILES		
LIVING ARRANGEMENTS	Codes and comments for living arrangements, legal, financial and employment, carer profile	LA 1 of 1
HEALTH CONDITIONS	Overall health, pain, vision hearing and falls, list of conditions and medications.	HC 1 of 1
PSYCHOSOCIAL PROFILE	Covers mental health, well being, social and family supports and disability criteria	PP 1 of 1
FUNCTIONAL PROFILE		
p.1	Functional screen for activities of daily living and self care	FP1 of 2
p.2	Screening questions for cognitive and behavioural problems, with prompts for further assessments	FP2 of 2
HEALTH BEHAVIOURS	Screen for risk factors, nutrition and physical activity, with prompts for further investigation	HB 1 of 1

COMPONENT	PURPOSE	Pages
DEVELOPING A SERVICE COORDINATION PLAN		
p.1	Key worker, review date, participants' list, evidence of assessment of need, case conference /date and information given to consumer.	SCP 1 of 2
p.2	Action plan for each goal including dates, action, review date, who is responsible.	SCP 2 of 2

The tools are designed so that the first 2 pages (the Consumer Information form) cover the core consumer information that should be collected on all consumers. The next form (2 pages) is for a summary of the action to be taken. The core INI thus consists of two forms over 4 pages and includes:

- **Consumer information** which information about the consumer, other agents and their GP and information with codes for categories to cover demographic details, benefits and entitlements, and insurance status. The comment box at the top on page 2 has space for comments that can be used for information on risk and urgency.
- **Summary and referral information** to record why the consumer is seeking services, describe the problem or issue as identified by the consumer or referring agency, describe other issues as identified by the consumer or in the initial needs identification process, record current services, and record an initial action plan including listing the agency/health professional to receive the referral, the reason, whether consumer consent has been obtained, the referral method, whether feedback is required and the date.

The Summary and Referral form is informed by any relevant detail from the additional profiles that are used for the particular consumer or from the areas usually investigated by a particular agency or clinician. These are either used or left out depending on the consumer's presenting problems or as a result of any issues arising during the initial contact. As a result this page will usually be completed at the end and is used as a basis (in conjunction with subsequent assessments and care plans) for putting together the service coordination plan (if required).

The Summary and Referral form may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of page 2 for each issue. For example there may be 2 issues – seeing the dentist and getting referred to a sexual assault service – and it may not be relevant or necessary to share all information for both referrals.

The **supplementary profiles** are completed *only* if they are relevant to the client's presenting problems and needs and after the core information has been collected. The core information is recorded in the Consumer Information and Summary & Referral components. The assumption is that the next stages of referral, assessment or care planning, or service coordination, is a continuation of that process, and that the core consumer information will therefore already be available.

There are 5 supplementary profiles. The five supplementary forms cover profiles of living arrangements, health conditions, psychosocial factors, a functional screen and health behaviours. These are domains that can be investigated at the discretion of the contact worker and depending on the nature of the consumer's problem. In some cases, there will be no need to complete any of these supplementary domains. However, for consumers with complex needs, contact workers may choose to use several forms to identify their initial needs.

COMPLETE ONLY THOSE PROFILES THAT ARE RELEVANT FOR THE CONSUMER

The profiles are not a structured interview. Do not ask consumers about issues in the order that they are listed if they are inappropriate in the context. The profiles are designed to be completed based on all sources of information available to the person completing them (observation, information contained in a referral letter, consumer notes or information provided to you by a carer or referring agency). Record NA for any issues that you have either not canvassed or that are inappropriate for the consumer unless otherwise instructed. The design of the set of profiles assumes that children and adolescents will be directly referred for a relevant assessment to be completed.

The profiles are not designed as a diagnostic tool, nor are they considered to be an assessment. They are tools to help determine the consumer's risk, eligibility, priority for service and health promotion opportunities as early in their contact with the service system as possible.

This set of optional domains has been chosen by combining evidence from the literature, a review of the range of forms currently in use, and consultations with the field on different draft versions of data collection tools. They can be used to further investigate the scope of the consumer's needs at the initial contact point.

The Living Arrangements and Functional Profile forms should be completed for all consumers requiring Home and Community Care (HACC) services. These two profiles contain HACC minimum data set (MDS) items and the collection of this information during the INI will mean that the information will not need to be collected at a later time. The remainder of the HACC MDS will be collected at the assessment stage.

The Service Coordination Plan template brings together all the different information that is useful for service coordination for those consumers that require this level of intervention. It covers the contact details of the key worker and other participants, a series of prompts for the collation or collection of evidence of consumer needs, a description of the consumer's problems/issues and associated goals, and the current required approach to consent and information disclosure as part of planning. The Service Coordination Plan is only completed for those consumers with both multiple agency involvement and complex needs.

Design issues common to all tools

Each page of every form has the same space at the top for an agency-assigned consumer identifier to be recorded and a space at the bottom for identifying the person and agency completing the tool template. There is also a box for recording at a later time that the information on the page has been superseded and has been updated. This allows the superseded information to be kept as a historical record in the file.

Information superseded

Each page has a box on the bottom to record if the consumer's situation has changed. If new issues or problems are identified after a page has been completed, the new issues should be recorded in a new page. The new page is used to record any changes or additions, not to repeat issues recorded on the previous INI. Indicate on the existing INI that the information on the page has now been superseded. This will indicate to other health professionals that a new page has been created. Do not change the original record as the original record forms part of the consumer history and should be stored on the clinical record.

Using the tools

As you complete the templates, consider whether the consumer requires particular types of assessments and/or urgent services that cannot wait for a formal assessment process to be complete. Consumers should be informed about the range of service options that are

available to meet their needs. This is not limited to the services provided by your own agency. Consider the wider range of services supports and resources such as for-profit services, information services, financial entitlements or other alternative services.

The design of the tool templates assumes that most of the supplementary information will not be relevant for children and adolescents. The core information, however, is likely to be relevant. A separate profile for this group is not included because it is assumed they will be referred directly for a more detailed assessment by an experienced agency or professional.

Background on the development of the tools

The selection of the content of the tool templates has been the result of a separate literature review that examined both international and Australian experience. For example, in developing a consumer assessment instrument for the National Long Term Care Demonstration¹, the factors considered important included physical health, mental health, ability to perform activities of daily living, social support and participation, financial and related resources, physical environment and living arrangements, and services.

In a review of published randomised controlled trials of health assessments for older people, Byles² noted the components most commonly included in health assessments. These included the following: height/weight, blood pressure, vision/hearing, teeth or oral examination, balance and gait testing, medications, activities of daily living, instrumental activities of daily living, functional status, medical problems, nutrition, alcohol, smoking, exercise, depression, cognition, social support, service use and home environment.

Detailed references for each item selected have not been included in the guidelines, however the rationale is contained in a separate literature review and a summary statement on the source of each item is included in the guidelines.

The design of the tools to be used at the entry point to services and initial needs identification involved a number of background assumptions:

- that service structures will vary according to the local setting and agency type;
- that the various intervention strategies will also vary according to local needs;
- nevertheless, that the data collected need to be consistent and conform with a number of technical and ethical requirements. As much as possible, information should be recorded in a way that allows for it to be subsequently computer coded;
- that, during the pilot, the INI should be designed for completion by staff. After the pilot, a consumer-completed version would be developed, with both then being available for use; and
- that each consumer will be assigned a unique record number at the initial contact agency, but this is not a common State-wide identifier.

The tools were developed based on a review of literature and current practice and then pilot testing was undertaken using draft tools in order to improve their usefulness. The tools developed in this process are regarded as Generation 1, with further developments and refinements being expected to occur over time.

¹ An initiative to improve care for functionally impaired adults, particularly the elderly. Consumer assessment and case management used to provide care to meets individual need and control long-term care expenditure.

² Byles, J. E. (2000). A thorough going over: Evidence for health assessment for older persons. *Australian and New Zealand Journal of Public Health*, 24(2), 117-123.

4.2 How to use the Service Coordination Plan Template

These guidelines for using the template Service Coordination Plan (SCP) are derived from the work on the content and structure of the INI screening tool templates and from considering examples of other coordination and care planning forms. Examples were gathered from consultations with the field, by discussions with the DHS project managers, together with an analysis of current practice across the 32 PCPs. Documentary evidence was also considered, and in particular attention was paid to what is known from relevant literature and from related projects like demonstration projects and trials of care coordination.

A key requirement in developing the SCP was to ensure that the minimum requirements were met for GPs claiming for relevant items under the Enhanced Primary Care (EPC) program. All 10 minimum requirements are incorporated in the template SCP (see Section 4.3).

The guidelines for using the template are divided into five sections:

1. Who should have a Service Coordination Plan
2. Summary
3. Item descriptions
 - 3.1 Issues/problems
 - 3.2 Goals, action, target date, responsible agents
 - 3.3 Review
 - 3.4 Participants
 - 3.5 Checklist – evidence of need
 - 3.6 Method of planning
4. Consent
5. Further explanations.

Who should have a Service Coordination Plan

The SCP is only completed for those consumers with both multi-agency involvement and complex needs. There is no one definition of 'complex' that is appropriate to all age groups and service types and PCPs will need to develop protocols over time to identify those consumers who would benefit from a SCP. As a general guide, consumers who should have a SCP are those who:

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

Many Service Coordination Plans will be developed for consumers who meet the criteria for payment under the General Practice Enhanced Primary Care (EPC) items. More information about EPC requirements is in Section 4.3. To be eligible for a care plan for which an EPC item can be paid, the *patient must have a chronic disease that has occurred or is likely to occur for 6 months or longer or is terminal.* (from MBS, 1999, 2000, 2001). However, other agencies may develop Service Coordination Plans for consumers who do not meet the EPC criteria.

Summary guidelines for undertaking a Service Coordination Plan

The process for undertaking a service coordination plan will be entirely familiar to most staff taking part in the pilot testing of the templates. These templates are an attempt to see what the potential is for a more standardised approach.

- 1 **Identify all issues/problems** based on the documents indicated in the Evidence of Assessment of Need check box. If new issues or problems are identified, record these in a new document. For example, create a new INI and use it to record any changes or additions. Indicate on the existing INI that the information on the page has now been superseded. Do not change the original record as the original record forms part of the consumer history and should be stored on the medical record.
- 2 **Identify the primary problem or issue** to be addressed in this current service coordination plan and list it first. The primary problem or issue is the one that is expected to be the major focus of the care. In the case of a multi-agency plan, it is the one that is expected to require the most interagency planning and coordination.
- 3 Identify **all other problems and issues** to be addressed in this current service coordination plan. If possible, list them in priority order. Attach additional sheets if necessary.
- 4 If the consumer does not already have a key worker, **identify a key worker**. This will generally be the health professional who accepts responsibility for the primary problem or issue.
- 5 **Identify one or more goals** for each problem or issue. The goal is the best outcome that can realistically be achieved during the period covered by the current service coordination plan. The goal can be recorded in text.
- 6 As an additional aid to making sense of the goal of the consumer and provider's plan, by using one of the following five codes, more generic and mutually exclusive goals can be coded and described:
 - 1 *Safety and protection*
 - 2 *Acute/post-acute* – the goal is restoration of the person's pre-acute level of health and function within a short time frame (weeks to months)
 - 3 *Functional gain* – the goal is to improve (not maintain) current levels of independence and/or optimise (not maintain) current living arrangements (weeks to months)
 - 4 *Maintenance and support* – the goal is to maintain function, quality of life or current health status (required action may be indefinite in some cases)
 - 5 *Prevention and early intervention* – the goal is early identification and intervention to promote health and prevent problems developing.
- 7 **Identify a realistic target date** for achieving each goal. If the goal is maintenance and support or prevention and early intervention, a target date of 'indefinite' may be used.
- 8 **Identify the action to be taken** (this may include self help as well as the services required) to achieve each goal within the period covered by the service coordination plan.
- 9 For each service required, **identify the priority for service relative to other consumers requiring this same service**. Priority for service can be recorded in text or by recording one of the following codes:

Urgent - cannot wait

Routine - attend in date order

Low - hold over during peak demand

- 10 **Identify the individual or service that will be responsible for implementing** or managing the required action and enter the date that the responsible person/agency accepted this responsibility.

Note that the service coordination plan and its goals may differ from recommendations made in the INI or in a previous assessment. If so, the reason for the change should be noted in the service coordination plan by including these as the last item listed under Consumer Issue/Problem.

- 11 Once the SCP is developed, provide a copy to the consumer and to all team members.
- 12 As consumer issues are resolved, record the date under the 'issue resolved date'. The date of consumer discharge from a particular service can also be subsequently recorded under the 'Issue Resolved Date'.

Explanation of the items in the Service Coordination Plan Template

The service coordination plan template is a way of linking the information contained in the INI with a more detailed service coordination planning process. The template is not an assessment tool, but assumes that assessment tools (for comprehensive, service specific or specialist assessments) will be used to inform service coordination planning.

The template is designed to allow consumers and carers to discuss their needs with service providers, GPs and others, and to create an ordered approach to issues of consent, and to agree on plans to meet the consumer's needs. The consent issues need to be explained to all concerned parties in plain language and with suitable assistance available. All the participants to the service coordination plan are listed, and a key worker role is assigned.

The SCP template covers 2 pages of mainly free text and tick boxes. Goals can also be coded into generic categories, and the comment box can be used to indicate risk or service access priority issues.

ITEM	Data type	Code set
Consumer name	Alphanumeric	No
Key worker	Alphanumeric	No
Whole Review date	Alphanumeric	No
Participants – Consumer + list	Alphanumeric	No
Checklist – evidence of need	Tick box	Yes
Case conference	Tick box	Yes
Issues/problems	Alphanumeric	No
Goals, goal target date	Alphanumeric	No
Actions, responsible agents	Alphanumeric	No
Proposed start date, review date	Numeric	No
Issue resolved date	Numeric	No
Copy to consumer and team members	Tick box	Yes
Case conference/date	Tick box	No

The template is not meant to imply any particular structure should be in place. The tool templates are not for introducing new structures or micro managing processes of reform. The assumptions about structures in the design of the forms do not go beyond the

separation of initial screening from further assessment. The forms are not expected to closely direct the local processes and roles around assessment and care. The assumptions in the template are about using the tools for information sharing and making information on initial needs more standardised and useful.

Service Coordination Planning follows the process of initial needs identification and may sometimes lead into a more detailed assessment if required. It should be undertaken on the basis of the full range of material gathered to inform decisions on meeting the consumers' needs. Many tools will be useful and the recommended and built-in tools in the field test have been assembled from the best evidence of what works, and from examining the purposes for which information is being collected.

The participants in the service coordination planning process are listed on the template. It also is expected that the consumer will be given the opportunity to have the respective roles of the different participants explained and clarified. If there is agreement at this point, then the negotiation over the goals of service coordination should be straightforward and can be summarised in the recommended format.

The final step is to address consent issues at three levels – to share information between providers, to consent to the planning process, and to consent to the actual plan of care. Service Coordination Planning must also assess individual needs in the context of competing demands upon service providers so as not to generate expectations that are inequitable or cannot reasonably be met. Comments can be made about relative risk and urgency in the comments box on SCP page 1 of 2.

Consumer name, key worker and review details

The first page contains the consumer and key worker names so that information is not lost (this is an EPC requirement). The plan may be documented by someone other than the key worker (see Office Use Only section).

The review may be for the plan as a whole or in part, may be reviewed by someone other than the key worker, and a date for review should be recommended last (another EPC requirement). A decision about who will review the whole plan, and when, will be recorded here. This decision will depend upon the goals of care identified in the Service Coordination Planning process. If only part of the plan is to be reviewed, this will be recorded for each issue on SCP page 2 of 2 and the 'whole plan to be reviewed' will be recorded as 'no' on SCP page 1 of 2.

Consumers with acute or post acute care needs may have short term goals of care and providers may expect that care will be completed within weeks or at most months. Consumers whose goals are of the maintenance and support type will have goals that cover a much longer time scale and may be indefinite, since no change is anticipated until their condition changes. Setting a regular review date of 3 months, 6 months or when a person's needs change is common practice.

Particular goals may require review before the whole Service Coordination Plan is reviewed. Note the problem and the goal, the name of the person reviewing and the date recommended for the review.

Participants in the Service Coordination Planning Process

In normal circumstances the consumer would be involved in the Service Coordination Planning Process. This is indicated by circling either Yes or No. If the consumer is a family unit or more than one person then the plan is based on the person with the existing unique identifier and completed core INI forms. Make a new INI for additional consumers covered by a common plan.

The **consumer**, or the person representing the consumer, eg a substitute decision-maker/carer / family member / friend should be involved in the discussion of consent issues. A separate consent section is covered in a form and guidelines developed by DHS. A **carer** or family friend who attends should be noted as part of the core INI content. See the Living Arrangements profile which will indicate whether there is a substitute decision-maker or legal guardian authorised to act on the consumer's behalf.

The service **providers** who attend should be listed under provider giving name, designation/agency, and contact phone, and email or fax number. List the key worker first and other providers in order of importance. All providers who take part should be listed and an additional sheet should be inserted in the service coordination plan if necessary.

Evidence of assessment of need

The checklist in this section is designed to prompt for the type of information that will be useful for service coordination planning, and goes through the items typically needed before starting. It is expected that the service coordination planning process will have all the relevant information to hand, and that the type and extent of that information will differ between services and service types, and depend also on the goal of care. Evidence of need is an Enhanced Primary Care requirement for GPs (see Section 4.3).

Working through the checklist requires a review of the consumer's file(s) and a search to ensure that current or previous service coordination plans and other relevant documents are available. This should take place before service coordination planning begins and the checklist completed before discussions commence.

Identify all issues and problems based on the documents indicated in the check box. If new issues or problems are identified, record these in a new document and add it to the existing INI. Do NOT duplicate the whole INI. Simply record new issues and add to the existing document. Do not change the original record but note any new findings or confirmation or evidence discounting old findings.

The person convening the service coordination planning process should ensure that existing plans are made available before the process begins. It should be possible to discover whether a hospital discharge plan exists by an inquiry to the relevant hospital department.

For consumers in residential care an inquiry needs to be made to see whether there is a residential care plan. For consumers who meet the Enhanced Primary Care MBS item requirements, an inquiry should be made to the consumer's GP. For consumers taking part in coordination trials or demonstrations, relevant negotiations may need to have taken place before plans are finalised.

These inquiries are routine and may be made by the appropriate support staff on instruction from the person convening the service coordination planning process. The agencies asked to provide care plans will need to assess whether consumer consent has been obtained to share the contents of the care plan.

It may also be helpful to ask the consumer and the carer where appropriate whether other service coordination plans exist.

All the relevant care plans that are made available should be ticked (EPC requirement).

The 'care plan' refers to a plan to provide a single service, eg a physiotherapy program, or a nursing care plan while the SCP is a plan to provide a multidisciplinary and multi-agency service.

Case Conference

Tick a box to indicate whether or not a case conference was held and, if so, record the date.

Copy to:

Circle to indicate that copies of the completed SCP have been provided to both the consumer and other members of the team (EPC requirement).

Service Coordination Plan documented by:

This would normally, but not always be the person who convenes the process of planning.

Consumer Issues/Problems

SCP page 2 of 2 starts with the consumer name. Identify all issues and problems based on the documents indicated in the Evidence of Assessment of Need check box. If new issues or problems are identified, record these in a new document and add it to the existing INI. Do NOT duplicate the whole INI. Simply record new issues and add to the existing document. Do not change the original record but note any new findings or confirmation or evidence discounting old findings.

Normally the Issues/problems would be listed in order of priority, particularly where some goals and actions are contingent on prior goals being achieved or implemented.

Consumer Goals

The goals relate to the consumer issue or the problem being addressed in the SCP, and are not specific to each service or agency. Note that service-specific goals will logically relate to these but would not be recorded here. Instead, they would be recorded in agency-level care plans.

A consumer issue or problem may have more than one goal. **The goal is the best outcome that the consumer can realistically achieve during the period covered by the current service coordination plan.** Assessing progress against the agreed goals is a fundamental step in measuring consumer outcomes.

Goals may be coded as suggested below or they may be written in text form. A target date should be inserted for those goals that have clear outcomes which can be dated. It may be necessary to write indefinite for some support/maintenance goals.

Coding the Goal of Care

As well as, or in addition to, writing in the goals, the following codes can be used:

- 1 Safety and protection
- 2 Acute/post acute – the goal is the restoration of the person's pre-acute level of health and function, within a short time frame (weeks to months)
- 3 Functional gain – the goal is to improve (not maintain) current levels of independence and/or optimise (not maintain) current living arrangements (weeks to months)
- 4 Maintenance and support – the goal is to maintain function, quality of life or current health status (required action may be indefinite in some cases)

- 5 Prevention and early intervention – the goal is early identification and prevention to promote health and prevent problems occurring

Alternately the goal can be recorded in text form. The time scale and rationale of the goals will determine when the full Service Coordination Plan should be reviewed.

Actions to be undertaken

Action to be taken should be clearly stated. One would not expect the action to be an assessment. The assessment should be reported in the INI and the action should be something designed to improve or maintain health and/or quality of life.

Identify the action to be taken (services required) to achieve each goal within the period covered by the plan. Actions such as reviewing, monitoring, reassessment and feedback to the consumer, referral agencies, GP, family, carer should be listed as specific actions as appropriate. List as many actions per issue as required.

Identify the individual/s or service/s responsible for the required action. Finally, enter the proposed start date and review date. The last section under each issue/problem is the 'Issue resolved (date)'. This is completed at a subsequent review if the issue has been resolved and no further action is necessary. The date of consumer discharge from a particular service can also be subsequently recorded under the 'Issue Resolved Date'.

4.3 Minimum requirements for GPs in claiming EPC items

The 10 key minimum requirements for a Care Plan Proforma are shown in the following box. All 10 criteria must be satisfied for an EPC item to be claimed.

CARE PLAN PROFORMA CRITERIA FOR GPs	
Proformas used for care planning should include:	
1. Reminder to check for previous and current care plans	<input type="checkbox"/>
2. Patient's name	<input type="checkbox"/>
3. Patient's consent to share information with other service providers (this presents an opportunity to determine if patient has any preferences for which service providers to include in care plan)	<input type="checkbox"/>
4. Patient's agreement to goals at end of care plan	<input type="checkbox"/>
5. Evidence of biopsychosocial assessment of patient and their care needs as documented by identification of needs and goals	<input type="checkbox"/>
6. Assessment of the treatment the patient will require as documented by tasks	<input type="checkbox"/>
7. Specify medical and care personnel that can provide the above treatment	<input type="checkbox"/>
8. Evidences that other health providers have been involved eg signature	<input type="checkbox"/>
9. Review date	<input type="checkbox"/>
10. Patient to be offered a copy of the record.	<input type="checkbox"/>
Optional	

The SPC meets these 10 criteria, but two require additional comment:

Consumer Consent

In addition to requirements that apply to consumer consent in general, the EPC requirements regarding consent includes a requirement to inform patients about costs. The consent rules for EPC are:

"A.21.15 When discussing the preparation of the plan with the patient, practitioners should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other members of the EPC multidisciplinary care plan team;
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
- Inform the patient of any additional costs he or she will incur." (MBS)

Biopsychosocial Assessment

The template has provision to indicate that relevant assessments have been undertaken and that the required information is available (thus it meets the EPC requirement). This is based on the assumption that relevant assessments are completed prior to the development of a Service Coordination Plan (and not during it). Relevant biopsychosocial

assessments that meet EPC requirements should be available during the development of a SCP.

EPC-specific guidelines

The following information is from the May 2002 MBS supplement.

Preparation of an EPC multidisciplinary care plan

- A.21.9 For items 720, 722, 724, 726, 728 and 730 preparation of a care plan means the preparation of a written plan in collaboration with all of the members of a multidisciplinary care plan team, describing the following matters:
- an assessment of the patient that considers their current and future health and care needs (refer to note A.21.4); and
 - management goals with which the patient agrees; and
 - an assessment of the kinds of treatment, health services and health care that the patient is likely to need; and
 - an assessment of any other kind of services and care that the patient is likely to need (for example, home and community care services); and
 - arrangements for giving the treatment, services and care referred to in paragraph (b); and
 - arrangements to review the plan by a day specified in the plan (if this review is to be claimed as an EPC care plan review item it must be done in collaboration with all of the other members of the EPC multidisciplinary care plan team; if the review is undertaken by the GP alone it should be claimed as a normal consultation item).

A.21.106 Preparation of the plan must also include:

- a meeting with the patient (and the patient's carer, where appropriate in the practitioner's view and with the patient's agreement) to discuss the preparation of the plan; and
- telling the patient who will be included in the multidisciplinary care plan team; and
- collaborating with all of the other members of the multidisciplinary care plan team to identify the patient's needs, the management goals that should be documented in the plan, the ongoing care and services to be provided by each member of the team, and any other services that may be required from other health and care providers to achieve the management goals in the plan;
- recording the plan and the patient's agreement to the preparation of the plan; and
- giving copies of relevant parts of the plan to the other members of the multidisciplinary care plan team and to any other persons who, under the plan, will give the patient the treatment, service and care mentioned in the plan; and
- offering a copy of the plan (and evidence of the contribution made to the plan by members of the team) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer).

Frequency

- A.21.17 It is recommended that a community care plan be prepared only once per year. However, a new plan may be prepared if in the judgement of the patient's usual medical practitioner there have been significant changes in the patient's clinical condition or in the patient's care support arrangements which have significantly affected their clinical condition since the previous plan, but

not within 6 months of the previous plan. Any changes to the plan required after 3 months of the plan being prepared would attract a benefit under the review item 724 (see paragraphs A.21.21 and A.21.22).

- A.21.18 Ongoing implementation and maintenance of the plan by the medical practitioner will be covered under normal consultation items.

General requirements

- A.21.28 In circumstances where the patient's usual medical practitioner, as defined in A21.8, is not a member of the EPC multidisciplinary care plan team, a copy of the care plan should be forwarded to that medical practitioner (subject to patient's agreement).
- A.21.30 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided (see general notes section 7).