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

Towards a demand management framework for community health services
Foreword

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

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

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

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

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

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

Janet Laverick
Director Primary Health
Acknowledgements

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

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

Consumers and other CHS staff have also contributed via workshops and forums to the development of this framework. We thank them for their time and their feedback. We acknowledge the previous work completed by Dental Health Services Victoria (DHSV) and TenSoft Consulting in developing the Dental Emergency Demand Management System (EDMS) triage tool.

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**Appendices**  
Appendices 1–10 contained draft versions of the Community health priority tools, and case studies providing examples of their use. They have been removed from this document as they have been finalised following their trial and evaluation. They are available in a separate document titled Community health priority tools which is available at: [http://www.health.vic.gov.au/communityhealth/downloads/community_health_priority_tools.pdf](http://www.health.vic.gov.au/communityhealth/downloads/community_health_priority_tools.pdf)
Glossary

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

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

In preparing CHSs for their evolving role in delivering health care services, this document aims to improve and consolidate current practices in managing demand. The framework will:
- improve the consistency of practices in measuring and managing demand, providing improved data that can be used for benchmarking, service planning and funding allocation
- support fair and equitable access to services based on equal access across the state for equal needs, with disadvantaged people provided priority access to reduce the inequality in health status
- provide improved access to services for clients by assisting CHSs to provide high quality, efficient, effective, evidence-based services.

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

1.2 Use of this document
This document:
- is referred to as “the framework”
- outlines the basic principles underpinning equitable and timely access to CHSs
- provides tools for prioritising clients requiring services
- identifies systems and strategies to manage clients from initial contact to exit from a service.

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

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

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

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

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

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

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

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


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

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

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

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

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

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

CiYC is particularly important to the community health sector because it articulates the rationale for a greater shift towards ambulatory-based care. Factors influencing the focus on providing health care in community-based settings include:
• recognition that care can be delivered safely and effectively without prolonged inpatient admissions
• development of new technology that enables out-of-hospital care
• pressure on expensive inpatient resources
improved collaboration between Australian and state governments supporting increased community-based care
• recognition of the importance of health promotion and illness prevention.
As the redesign of the delivery of ambulatory services directed by the CiYC policy will impact upon CHS demand, clear access criteria and systems are required to enable appropriate service use by clients requiring community-based care.
This policy is located at: http://www.health.vic.gov.au/ambulatorycare/careinyourcommunity/index.htm

2.2.5 Primary Care Partnerships strategy
The Primary Care Partnerships (PCP) strategy aims to:
• improve the experience and outcomes for people who use primary care services via the service coordination initiative
• reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people’s need for support.
More than 800 services have come together in 31 PCPs across Victoria to progress the reforms. Further information is available at: http://www.health.vic.gov.au/pcps/index.htm
The PCP strategy includes the following:

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

CHSs have developed service access models that reflect local consumer and community characteristics, local circumstances and service availability. This framework has considered the different practices and systems of the range of service access models in CHSs.
There are three main service access models, which are described in the document Service Access Models: A way forward. Resource guide for Community Health (2006). It provides information about how to review, select, implement and evaluate a service access model. This document is located at: http://www.health.vic.gov.au/communityhealth/publications

Integrated Health Promotion (IHP)
IHP refers to collaborative work across a catchment aimed at improving the health of local communities, especially those with the most disadvantaged and poorest health status, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues. Further information is available at: http://www.health.vic.gov.au/healthpromotion/what_is/index.htm
This framework applies primarily to direct service delivery to clients, therefore it is not directly applicable to activities delivered through health promotion funding from the C&WH program.

Integrated Chronic Disease Management (ICDM)
ICDM includes:
• planned and proactive care to keep people as well as possible
• empowering, systematic and coordinated care that includes regular screening, support for self-management, and assistance to make lifestyle and behaviour changes
• coordinated care by a range of health services and practitioners
• care over time through the stages of disease progression.
PCPs work with and support agencies to provide a coordinated approach to the planning and delivery of health services for clients. The Wagner Chronic Care Model (see 6.3.10) has been endorsed as the framework to support service system development to meet the needs of clients with chronic and complex care needs.
2.2.6 Community Health Policy: Community Health Services—creating a healthier Victoria

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

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

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

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

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

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


2.2.8 Improving Victoria’s oral health

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

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

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

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

2.2.9 Medicare Benefits Schedule and chronic disease management

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

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

2.2.10 General Practice Victoria

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

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

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

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

2.2.11 Victorian State Disability Plan 2002–2012

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

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

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

3. Demand Management Framework

3.1 What is demand and demand management?

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

Demand management is not easy. It requires CHSs to:

• continue to address the broader health needs of the community through health promotion and early intervention activities that take a preventative approach to health
• review their internal practices to ensure the services are efficient, of high quality and targeted to the needs of clients.

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

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

3.2 Measuring demand

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

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

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

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

3.2.1 Maintaining an 'open' waiting list

Services funded through the C&WH and Dental programs must not close waiting lists to new referrals.

3.2.2 No geographical restrictions

Services funded through the C&WH and Dental programs must not restrict services on the basis of where people live. People are free to choose which CHS they will attend, and CHSs must not restrict access to people living or working in a specified catchment area. This includes people living across state borders but near service sites in Victoria.

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

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

3.2.3 Communicating about available services

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

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

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

3.3.1 Integrated area-based planning

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

3.3.2 Current demographic profiles

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

3.3.3 Emerging issues

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

3.3.4 Staffing and service provision

Not all CHSs provide the same services. Certain services may be unavailable at some CHSs or there may difficulty filling some positions.

Services unavailable due to temporary staff vacancies should maintain a waiting list. An active waiting list management system (see section 5.1 below) should be in place to monitor clients as time extends. CHSs should communicate with the local community and referring bodies to inform them about this process. Alternate models of care and service delivery should be explored to be able to address these clients’ needs, in consultation with like organisations and the regional PASA.

3.4 Elements of managing demand

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

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

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

A comprehensive demand management model needs to address these elements

Health promotion
Prevention and population-based approaches

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

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

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

Referral out
4. Health promotion

The Ottawa Charter (1986) defines health promotion as:

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

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

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

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

Further information is available at:
5. Inflow

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

5.1 Service Access Models

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

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

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


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

5.2 Initial needs identification (INI) and priority of access

INI is the initial screening process that explores the presenting and underlying issues of a client and assists with determining the need for referral to other services. **The INI is not a diagnostic process or detailed assessment.** It aims to identify the client’s needs, and determine their level of risk and priority for service. A number of resources assist with the INI process:

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

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

The priority tools included in this document are:

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

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

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

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

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

Information provided by clients and/or referral sources during INI, including the priority level, should always be documented, using the SCTT. This provides clinical staff with baseline client information to inform their specialist assessment and intervention.
Community Health Service Priority Tools and the Consumer Pathway through Service Coordination

Service coordination places consumers at the centre of service delivery, to ensure they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes. 

Service Coordination is underpinned by the following 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 with other sectors

Initial Needs Identification (INI)
INI is an initial assessment process where the underlying issues as well as presenting issues are uncovered to the extent possible. It is not a diagnostic process but is a determination of the consumer’s risk, eligibility and priority for service and a balancing of the service capacity and the consumers need.

Service Coordination Tool Templates (SCTT)

Service Delivery
The structure, frequency and delivery of services should be timely to suit the client.
Service delivery should be:
- Beliefs based
- Evidence based
- Client focused (client-centred)
- Encourage and support self management and client empowerment

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

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

Assessment processes depend on agency structure

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

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

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

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

Care Planning

Inter- or Intra-agency Case Plan

Service Coordination Plan

Team Intervention and Care:
- Individual disciplines
- Service Coordination Plan

References:
2. Department of Human Services (2003). Service Coordination Tool Template
5.3 Generic Priority Tool
A Generic Priority Tool applicable to all clients presenting to CHSs has been developed in consultation with the sector (see Appendix 1). It reflects the philosophy and policy directions outlined in section 2.2, especially the Community Health Policy which prioritises service delivery for people with the poorest health status and the greatest economic and social need for service. It values the multiple determinants that influence the health of individuals and communities (social model of health).

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

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

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

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

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

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

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

5.3.3 Prioritisation based on population health
Indigenous people (see Appendix 1 for definition)
There are significant inequalities in the health status of Indigenous Australians compared to non-Indigenous people. Therefore they should be considered a priority group for access to services.

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

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

Refugees (see Appendix 1 for definition)
Refugees have been identified as having unique and greater health needs than the general population. As a result this client group should be prioritised.

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

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

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

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

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

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

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

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

5.4 Clinical priority tools

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

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

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

The Clinical Priority Tools developed are:

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

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

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

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

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

### 5.5 Case studies

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

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

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

6.1 Waiting list management

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

6.1.1 Providing information to the client

Clients should be provided written information at the time they are placed on a waiting list. This should include:
- the anticipated waiting time
- advice that the client can initiate a review of their level of urgency if their condition changes (either improvement or decline)
- who to contact, and how to contact the service, if required
- advice to update the agency if their contact details change
- options available for interim management while awaiting individual care.

6.1.2 Maintaining current client information

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

6.1.3 Reviewing the client’s level of urgency

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

6.1.4 Removing the client from the waiting list

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

6.1.5 Communicating with referral source

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

6.2 Appointment processes

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

6.2.1 Appointment diary

To allocate appointments in a way that reflects the level of services available, and the demand for services, CHSs require information about the number and type of referrals they receive. This can be obtained through an audit of current practices which includes:
- number of new referrals for each discipline
- number of appointment times available in each discipline
- length of time required for each appointment
- number and/or percentage of priority 1, priority 2 and priority 3 clients
• number and/or percentage of clients who require an ongoing course of care
• number and/or percentage of clients who have complex needs and require intervention by more than one discipline.

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

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

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

6.2.3 Recall and review

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

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

6.2.4 Cancellation and Failure To Attend policies

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

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

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

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

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

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

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

6.3.1 Goal-focused intervention

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

6.3.2 Evidence-based practice

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

It is important that clinicians keep informed of new developments and research that identifies best practice. Professional development and networks, journals, books and the Internet should be used to access this information. Best practice should be considered across the components of service delivery, including appropriate assessment, informed consent, appropriate diagnosis and treatment, regular monitoring of management to determine efficacy, and exit.

6.3.3 Information sessions

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

6.3.4 Individual intervention

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

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

6.3.5 Single session work

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

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

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

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

Clients with complex conditions and/or complex care needs may benefit from a comprehensive assessment. Agencies can use a range of staff and structures to provide comprehensive assessments, such as:

- a key worker or care plan coordinator with this designated role
- a multidisciplinary team
- individual clinicians who incorporate the additional elements involved in a comprehensive assessment to their service specific assessments.

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

6.3.9 Multi- or inter-disciplinary collaboration
Multi- or inter-disciplinary collaboration with clients can lead to improved client outcomes. The communication between professionals and clients allows them to bring different perspectives and skills to identifying needs and working together to achieve goals. Communication is required to ensure clarity of roles, responsibilities and client goals. Providing structures and processes that facilitate multi- or inter-disciplinary management will enable staff to use this best practice approach.

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

Development of an intra- or inter-agency care plan can provide a basis for the ongoing multi- or inter-disciplinary work. Further information about care planning is available at: http://www.health.vic.gov.au/pcps/coordination/care_planning.htm

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

The components of the Wagner Chronic Care Model are:

- self-management
- decision support
- delivery system design
- clinical information system
- organisation of healthcare
- community.

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

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

The components of the Expanded Chronic Care Model are:

- self-management/develop personal skills
- decision support
- delivery system design/re-orient health services
- information systems
- build healthy public policy
- create supportive environments
- strengthen community action.

Reference:

6.3.12 Workforce

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

6.4 Roadblocks

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

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

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

Developing an exit or discharge policy can assist clients to achieve an appropriate exit from services. An exit policy may be appropriate for your agency as a whole or individual programs may need to develop their own policies.

Safe and appropriate exit from services will ensure appropriate use of resources and allow CHSs opportunities to see new clients.

Most clients can exit a service upon resolution of their presenting need, or after an appropriate management period; others may require ongoing monitoring and reassessment.

The conclusion of service needs to be planned and tailored to suit each client’s needs.

Strategies that may assist with maintaining throughput include:

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

7.1 Exit preparation

To ensure good client outcomes, service providers should discuss with clients the expected course of management during the early stages of contact. This is likely to occur during the service specific assessment.

Exit from services should be linked to client needs, goals and progress. Clients’ expectations regarding the length and type of services they receive should be discussed when they first access the service. Clients should be involved in the process of planning for exit from the service. This may include referral to other services, programs or self-support groups. This ensures clients are informed and involved in the management of their needs.

7.2 Exit processes

Readiness for exit should be determined by the client and clinician in collaboration.Clinicians are encouraged to use achievement of goals and potential to achieve outstanding goals as a point of reference for instigating discussions about exit. Referral to other programs to support clients to maintain health outcomes is encouraged, for example, self-management programs and self support groups.

During the course of intervention it may become evident that the client’s needs may be addressed more appropriately through another part of the service system, for example, Hospital Admission Risk Programs Chronic Disease Management (HARP CDM), or Early Childhood Intervention Services (ECIS). These clients should be provided with information about the alternative service and with support and encouragement to accept referral and transition to the other service.

Referral sources should be informed about client exit from services. This is considered best practice in terms of ensuring any ongoing client needs are met and other providers are informed about changes in the client’s condition.

Clients who exit a service may access services again if their needs change. If this change is the result of a new issue or a change in circumstances the client should be considered as a new referral to the service and the client’s level of priority should be determined on the basis of this new presentation. If issues arise as a result of poor management of the exit process the client’s needs should be addressed immediately.
8. Next steps

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

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

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

Working to improve demand management is an ongoing process requiring regular monitoring and evaluation to ensure it is adapting to the future needs of both the community and individual users of CHSs.
Appendices

Appendices 1–10 contained draft versions of the Community health priority tools, and case studies providing examples of their use. They have been removed from this document as they have been finalised following their trial and evaluation. They are available in a separate document titled Community health priority tools which is available at: http://www.health.vic.gov.au/communityhealth/downloads/community_health_priority_tools.pdf