

**Refugee Health
Service Coordination Guide
for Victoria
2009**

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PART ONE – History of the Refugee Health Program

Introduction

Over the past 10 years, Victoria has accepted over 110,000 newly arrived communities and special humanitarian program entrants from Sudan, Iraq, Afghanistan, Burma, the former Yugoslavia, Iran, Central and West Africa, Croatia, Sierra Leone, Ethiopia and other countries.¹

The Victorian Government continues to raise the profile on the impact of the newly arrived communities experience and resettlement on health and wellbeing, the issues surrounding access, and the need for culturally appropriate health assessment and service provision.² Numerous policy and legislative documents have been written to support the integration of newly arrived communities and other immigrants into the state of Victoria.² A current and leading document is the *Refugee Health and Wellbeing Action Plan 2008-2010*. This builds on the initial plan that was launched in 2005 which focused on the often complex needs of people from a newly arrived communities background. From 2005, Victoria has delivered the Refugee Health Nurse Program (RHNP) to support the health of newly arrived newly arrived communities.³

Service coordination improvements across primary and specialist health systems have helped to strengthen Victoria's response to the needs of newly arrived communities.⁴ Selected Primary Care Partnerships (PCP) in which newly arrived communities health nurses (RHN) were situated, received funding from the Primary Health branch of the then Department of Human Services (DHS).⁵ These funds aimed to build on the existing service coordination processes in PCPs and current agency practice, by integrating work between community health services (CHS), general practices (GP), hospitals, primary health providers and newly arrived communities specialist support services with a focus on newly arrived communities health.

In 2008-09, DHS commissioned HealthWest Partnership to work with PCPs, who were recently funded for newly arrived communities' health service coordination, to assist with the development of a coordinated approach to newly arrived communities health service provision. This manual has been developed by HealthWest Partnership to try to reduce duplication of effort and to provide an ongoing resource to assist those new to the area. It is based on the outcomes of HealthWest's initial newly arrived communities' service coordination project in 2007.⁶

How to use this resource

The aim of this resource is to assist local agencies involved in supporting newly arrived communities in the development of processes, protocols and pathways that help streamline services.

In the resource, you will find tips and steps to help in the development of a local response. Depending on your local situation and the previous experience of those involved you might like to skip to the part that best reflects your starting point.

Any or all of these steps can be conducted as part of the process of improving newly arrived communities service coordination.

Sections of the guide will be useful for different audiences. The following sections will be most useful for PCP's, organizations and workers who:

- Are new to newly arrived communities health service provision.
 - *Part One – History of the Refugee Health Program*
- Are new to service coordination principles.
 - *Part Two – Service Coordination Principles*
- Are new to newly arrived communities health service coordination.
 - *Part Three – Refugee Health Service Coordination*
- Wish to implement newly arrived communities health service coordination locally.
 - *Part Four – Implementing Refugee Health Service Coordination*

Other key resources

- Department of Human Services, Refugee Health and Wellbeing Action Plans 2005-2007 and 2008-2010
www.dhs.vic.gov.au/multicultural/
- Charter of Human Rights and Responsibilities Act 2006
www.justice.vic.gov.au/humanrights
- Department of Human Services Cultural Diversity Plan 2008
www.dhs.vic.gov.au/multicultural/
- Overview of the Commonwealth Humanitarian Program
www.immi.gov.au/refugee/migrating/index.htm
- Integrated Humanitarian Settlement Strategy (IHSS)
www.immi.gov.au/media/fact-sheets/66ihss.htm
- Settlement Grants Program (SGP)
www.immi.gov.au/media/fact-sheets/92funding.htm
- Victorian Refugee Health Network website: www.refugeehealthnetwork.org.au
- McDonald B, Gifford S, Webster K, Wiseman J, Casey S 2008 *Refugee Resettlement in Regional and Rural Victoria: Impacts and Policy Issues*. VicHealth, Melbourne
www.vichealth.vic.gov.au/mentalhealthreports/#cs_1487

Refugees – A Priority Client Group

People from newly arrived communities are recognised as one of the most disadvantaged groups in Australia. Newly arrived communities are reported to have higher rates of long-term physical and psychological problems when compared to other migrants. These issues often require specialists, sometimes multiple investigations, and referrals at a time when people are often least equipped to negotiate complex service systems.⁷ Under the Victorian Government's Primary Health Demand Management Framework, (prioritisation approach) newly arrived communities now receive priority of access to all community health services.²

"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 community health services should identify this population group and provide a culturally appropriate service."²

Early settlement period is the crucial time when newly arrived communities can be introduced to health treatment and prevention. Early identification of health problems is vital, as untreated illness may have long-term health consequences for the individual. Timely health assessment also assists delivery of broader public health objectives for newly arrived communities.²

The complexity of the newly arrived communities' experience requires a range of service options be accessible. Currently there are often difficulties for both service providers and newly arrived communities negotiating referral and care pathways for health care. To improve access for newly arrived communities communication, coordination and referral pathways between local primary care and specialist care providers need to be enhanced.²

Refugee Health Nurse Program

The Refugee Health Nurse Program (RHNP) commenced in 2005, to improve health outcomes for refugees. Community health nurses with expertise in working with culturally and linguistically diverse and marginalized communities were recruited to work in the program.

The RHNP supports the provision of a coordinated model for refugee health care with complementary and multiple entry points. RHNs facilitate early health assessment by assisting and referring newly arrived communities to primary and specialist services.²

The RHNP has three aims:

- Increase refugee access to primary health services
- Improve the response of health services to refugee needs
- Enable individuals, families and newly arrived communities to improve their health and wellbeing

The RHNP also includes the use of the refugee health assessment tool to assist GPs has been supported by the provision of Medicare item number. It also acknowledges the cooperative roles of DHS, community health services and the Victorian Foundation for Survivors of Torture in the development of the tool.

The profile of the RHNP includes the role of PCPs⁷ to develop and promote effective service coordination models to support newly arrived communities clients.

The program guidelines for the RHNP can be located at:

www.health.vic.gov.au/communityhealth/downloads/rhnp.pdf

Other key resources

- Western Region Health Centre, 2008 *Refugee health service model evaluation*.
www.wrhc.com.au/images/Refugee_Health_2008.pdf
- Kelly M 2008 *Greater Dandenong Community Health Nurse Project: an in-depth description of the Refugee Health Nurse Program position based at Greater Dandenong Community Health Service*. Refugee Health Research Centre: La Trobe University and Foundation House
www.latrobe.edu.au/rhrc/rhrc_publications.html

Background to Primary Care Partnership (“PCP”) involvement

The PCP strategy was initiated in April 2000, as a means of strengthening, improving and uniting primary health care in Victoria through a partnership approach. Currently over 800 services have come together in 31 PCPs across the state, each comprising a number of local government areas to improve planning and coordination of the local service system.

In each PCP catchment, a range of service providers (including community health services, hospitals, local governments, divisions of general practice, metropolitan or rural health services, mental health services, women’s health, aged care assessment services, district nursing, ethno-specific services and others) form voluntary alliances to work together in developing a stronger and more integrated community-based health and service sector.⁴ (4).

The *Primary Care Partnerships Strategy 2006-2009*⁸ aimed to:

- Improve the experiences 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.

PCPs are funded recurrently to develop a strategic plan to improve health and wellbeing in their catchment. The PCP strategy includes the following three areas:

1) *Service Coordination*

- Enables service providers to develop protocols and processes to improve the consumer’s experience and provide more streamlined pathways through the service system
- Eliminates duplication and inefficiencies, improves management of waiting lists, provides early identification of client’s needs, improves cross-program coordination and response, and ensures clients receive services according to their needs

2) *Integrated Health Promotion*

- Collaborative work across a catchment aimed at improving the health and wellbeing of local communities, especially those with the most disadvantaged and poorest health status

3) *Integrated Chronic Disease Management*

- 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 disease progression

The PCP strategy guidelines can be located at: www.health.vic.gov.au/pcps/index.htm

PART TWO – Service Coordination Principles

Service Coordination Theory

What is it?

“Service Coordination places consumers at the centre of service delivery, to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes.”⁴

Victoria’s approach to Service Coordination stems from the document, *Better Access to Services: A Policy and Operational Framework*.⁹

Underlying principles⁴

- A central focus on consumers
- Partnerships and collaboration
- The social model of health
- Competent staff
- A duty of care
- Protection of consumer information
- Engagement of other sectors
- Consistency in Practice Standards

Service Coordination Cycle⁴

The service coordination elements are represented in the cycle below (figure1). *Initial Contact, Initial Needs Identification, Assessment and Care Planning* are the key elements. The other processes such as *Information Provision, Consent, Referral, Feedback, Service Delivery and Exiting* can occur at any stage of the process. This cycle can occur within a single agency or over a period of time with a number of different agencies.⁶

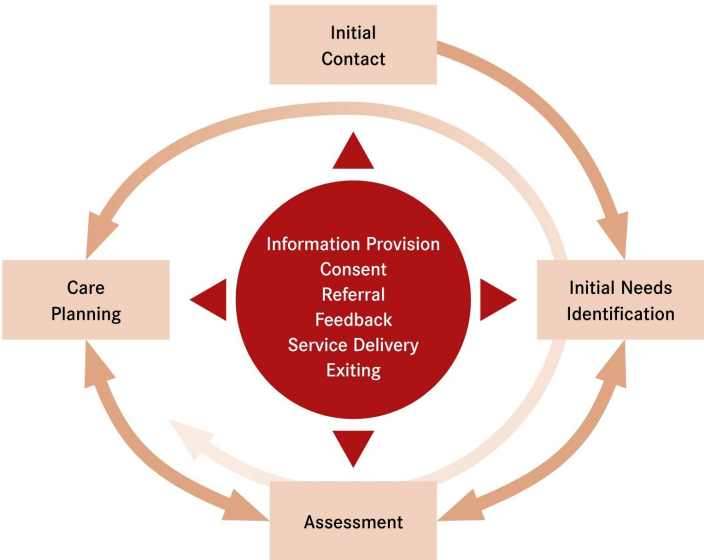


Figure 1. Service Coordination Cycle.⁴

Service Coordination Key Elements⁴

Initial Contact

- Customer's first point of contact with the service system
- Service providers have an obligation to:
 - Provide accurate and comprehensive service information
 - Provide other information like health promotion literature
 - Facilitate access to services to *Initial Needs Identification*

Initial Needs Identification

- Broad, shallow screening process to uncover underlying and presenting issues
- Initial assessment process (not necessarily diagnostic) to identify the full range of consumer needs (including health promotion, illness prevention, early intervention, self-management capabilities and restorative options)
- Determination of consumer risk, eligibility and priority for service
- Tool used to balance service capacity and consumer needs. It is sensitive to the consumer, their needs and the service setting

Assessment

- Decision-making methodology that collects, weighs and interprets relevant information about the consumer
- Investigative process using professional and interpersonal skills to uncover relevant issues
- Process of delivering care and treatment through the development of a care plan
- Service Specific Assessment (for consumers with straightforward, obvious and specific needs), the Specialist Assessment (for consumers presenting with issues that require a specialist service response) or the Comprehensive Assessment (for the consumer with multiple or complex needs)

Care Planning

- Process of deliberation that incorporates care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting
- Judgment and determination of relative need and competing needs
- Assist consumers to make appropriate decisions given their needs, wishes, values and circumstances
- Coordination of service provision for clients with chronic and complex needs

Other Service Coordination Processes

The following processes can occur at any stage throughout the consumer's journey.⁴

Information Provision occurs throughout all parts of the service coordination process.

It is about being:

- Accurate
- Current (up to date)
- In a language that the consumer understands
- Easily understood (simple)
- Culturally sensitive
- Aware of the clients cognitive needs

Consent is required:

- By privacy legislation for protection of an individual's personal information and their right to decide how the information is used or shared with others
- For any secondary purposes (e.g. additional information not directly related to the primary purpose of the referral)

Referral is the:

- Transmission, with consent, of the consumer's personal and health information from one service provider to another, for the purpose of further assessment, care or treatment

Feedback is the:

- Key to good communication between services
- Acknowledgement that a referral has been received and action taken
- Transmission of information between services about a client's progress and assessment outcomes, treatment and care planning, with the client's consent

Service Delivery encompasses all the other service coordination processes that make up the various components of service delivery including:

- Information provision
- Consent
- Referral
- Feedback
- Exiting

Exiting is the:

- Referral out or discharge of a client to other services to facilitate further assessment, care or treatment as needed anywhere along the pathway

PART THREE – Refugee Health Service Coordination

Refugee Health Service Coordination

2005-06

In 2005-06, to focus on improving GP integration and service coordination for newly arrived clients, the Victorian Government allocated one-off funds to each of the 8 PCPs in which RHNs were situated. This involved the local government areas (LGA) Hume, Darebin, Greater Dandenong, Moonee Valley/Melbourne, Brimbank, Maribyrnong, Greater Shepparton and Warrnambool.⁵

The aim of the refugee health service coordination projects were to build on the existing processes in the PCPs and current agency practices of CHSs, GPs, hospitals, private primary health providers, and newly arrived communities' specialist support services, in order to deliver better health outcomes for newly arrived communities.⁵

Strengthening the role of CHSs and PCPs in service coordination for newly arrived communities to:

- Respond to the poor health status of newly arrived communities
- Increase the value of partnerships in improving the delivery of primary health care services and programs
- Create more integrated responses to clients with complex needs⁵

2008-09

In June 2008, DHS announced new funding under the RHNP, with additional RHN positions being placed in the 8 metropolitan and rural local government areas of; Greater Dandenong, Maroondah, Wyndham, Greater Geelong, Colac-Otway, Latrobe Valley, Bass Coast and Mount Alexander.¹³

HealthWest's Refugee Service Coordination Model

HealthWest is an alliance of Brimbank Melton PCP and WestBay Alliance that includes the local government areas of Maribyrnong, Hobsons Bay, Wyndham, Brimbank and Melton. These organisations have developed shared operational plans which include developing partnerships with member agencies, integrating health promotion, coordinating services, and integrating chronic disease management.^{10,11}

During 2007, HealthWest Partnership worked collaboratively with the refugee service providers in the Western Region of Melbourne to develop a comprehensive service coordination model to improve newly arrived communities access to health services. The primary aim of the project was to document practices, processes, protocols and systems for the improvement of holistic care for newly arrived communities.

The key objectives were to work in cooperation with GP Divisions and health providers to:

- Progress work on developing care pathways for newly arrived communities across the PCPs
- Improve care coordination between GP practices and health providers
- Support new GPs willing to work with newly arrived communities
- Identify and link with other appropriate services such as Infectious Disease Units

- Encourage the use of the Service Coordination Tool Template and the State-wide GP Referral Template
- Identify and prioritise service gaps, workforce development needs and opportunities for further funding/support¹²

The main outcomes of the project were the:

- Development of a 'best practice' pathway that mapped newly arrived communities access routes to health services, indicating efficient and appropriate pathways of referral and encouraging the use of existing supporting services to facilitate this process
- Development of a newly arrived communities/humanitarian entrant social and clinical screening tool to facilitate the sharing of a single page of accurate client information that was not already included in other screening and referral tools and that would assist in the identification of those newly arrived families who need more intensive support to increase their chances of becoming self sufficient.
- Development of a protocol to guide newly arrived communities service coordination between service providers and outline roles and responsibilities of service providers in newly arrived communities health service provision

In 2008, following the success and adoption of the Refugee Care Pathway developed in the west of Melbourne, the Primary Health Branch of DHS commissioned HealthWest Partnership to work with the PCPs newly funded for newly arrived communities health service coordination to support them in developing locally relevant newly arrived communities service coordination pathways for their areas.

Differences between metropolitan and rural areas

There is recognition that the types of services and resources available for newly arrived communities differ from metropolitan to rural areas. Rural areas tend to have greater secondary settlement, where newly arrived communities move to a rural area after the first 6-12 months of supported settlement. This means newly arrived communities may arrive without any support to assist their access to services in their newly chosen place of residence.¹⁴ In rural areas, there is also a smaller range of specialty services available, fewer staff who are stretched over more programmes and limited resources to support the complex needs of some clients.

This heightens the importance of relationships between and within organisations and therefore the need to approach this work with a good understanding of partnership leadership.

Roles within Refugee Service Coordination

The provision of an integrated newly arrived communities' service response does not mean that one service provider must provide all the services. It requires a high level of collaboration, communication and feedback between service providers. This ensures that assessment and care is coordinated and not duplicated.

Primary Care Partnerships⁴ that are funded to support RHNs:

- Consist of members who are service providers, who have agreed to the PCP goals of improved partnership development, greater communication and cooperation between service providers, improved service coordination and integrated approach Health Promotion and Chronic Disease

- Promote the standard core principles of service coordination which place consumers (e.g. newly arrive communities) at the centre of service delivery
- Through their networks, support service providers to work together and develop local agreements that guide the newly arrived communities service coordination process
- Promote the use of the *Victorian Service Coordination Practice Manual* as a standard approach for more consistent and streamlined service provision
- Promote and support the exchange of communication, ideally electronic information exchange via eReferral, between newly arrived communities service providers
- Provide the platform to facilitate the development and review of newly arrived communities service coordination implementation
- Encourage continuous monitoring and improvement of service coordination implementation with all participating service providers

Refugee Service Providers

- May be members of a PCP and committed to the PCP's values
- May be funded by DHS and so are committed to using the manuals and embedding service coordination principles into their policies and procedures
- Have different but complimentary roles depending on their
 - Nature and level of involvement
 - Program requirements and size
 - Service profile and target groups
 - Funding and resources
- Agree to interface at referral and feedback with other newly arrived community service providers
- Collaborate around newly arrived communities inter-agency care planning

General Practitioners⁴

- Are essential partners and participants in the newly arrived communities service coordination inter-agency team
- Interface at referral and feedback with other newly arrived communities service providers
- Collaborate around newly arrived communities inter-agency care planning
- Provide "*comprehensive, coordinated and continuing medical care, drawing on biomedical, social and environmental understandings of health*"¹
- Access reimbursement through the Medicare Benefits Scheme (MBS) and Practice Incentives Program for the provision of Refugee Health Assessments
- Conduct any of the following
 - Comprehensive health assessments
 - Health checks
 - Care plans and cycles of care
 - Medication reviews

Refugee Health Nurses

The Refugee Health Nurses aim to^{3,7}

- Build the capacity of individuals, families and newly arrived communities
- Improve newly arrived communities health, through health promotion, early intervention, equity of access and disease prevention
- Develop referral networks between health service providers
- Establish collaborative relationships with GPs
- Provide social supports and orientation programs

The RHN conducts an initial health screen and in liaison with the settlement case coordinator, arranges a health assessment with a local GP, or a community health GP. The RHN also provides case management, health service coordination, information and education, links to welfare and social work and advocacy for other services (e.g. housing and employment). When a RHN is not available, the settlement case coordinator arranges a GP appointment for a health assessment and may also refer to a community health nurse.

Refugee Settlement Services

Refugee Settlement Services (e.g. Adult Multicultural Education Centre – AMES or a rural sub-contractor) coordinate a consortium of agencies that provide newly arrived communities case coordination, information and referral, on arrival reception and assistance, accommodation and furniture packages for the first 6-12 months after arrival. The Victorian Foundation for Survivors of Torture and Trauma (Foundation House) provide short-term torture and trauma counselling services as part of the consortium led by AMES. AMES provide a community guide to assist refugee entrants with their orientation to daily life logistics and essentials (including the bank, Centrelink, Medicare, education, language learning and public transport). AMES also arranges referral to dental services, liaises with the Refugee Health Nurse to organise referral to a GP, and assists with access to specialist appointments.

After the first 6 - 12 months, support is available through the Settlement Grants Program (SGP) in both metropolitan and rural areas for entrants 6 months to 5 years post-arrival. Types of programs include orientation to Australia, practical assistance to promote self-reliance, community development and programs facilitating integration, inclusion and participation. SGP programmes can facilitate newly arrived communities access to health and nutrition education, exercise groups, and other healthy lifestyle choices. Foundation House is also able to provide counselling and related advocacy support to eligible clients through their generalist program after the first 12 months.

Specialist services roles:

Many newly arrived communities arrive with complex health issues due to living in deprived environments, with limited access to health services and nutritious food. After their initial Refugee Health Assessment conducted by the GP, many require referral to specialist services for assessment of more unusual and complicated health problems. Specialist services need to maintain strong links with GPs and Refugee Health Nurses for assistance with the treatment, follow-up and monitoring of complex health conditions.

Other key resources

Department of Human Services 2007 *Victorian Service Coordination Practice Manual. A Statewide Primary Care Partnerships Initiative*
www.health.vic.gov.au/pcps/publications

Department of Human Services 2007 *Good Practice Guide for Practitioners. A resource of the Victorian Service Coordination Practice Manual. A Statewide Primary Care Partnerships Initiative*
www.health.vic.gov.au/pcps/publications

Department of Human Services 2007 *Continuous Improvement Framework. A resource of the Victorian Service Coordination Practice Manual. A Statewide Primary Care Partnerships Initiative*
www.health.vic.gov.au/pcps/publications

Department of Human Services 2006 *Service Coordination Tool Templates 2006 User Guide*
www.health.vic.gov.au/pcps/coordination

PART FOUR – Implementing Refugee Health Service Coordination

Starting Refugee Health Service Coordination locally

Starting Refugee Health Service Coordination in any local area involves a number of important steps.

These steps include:

- Relevant background research into newly arrived community services already existing in an area
- Encouraging, involving and learning about existing service providers
- Mapping a current pathway of newly arrived community health service access
- Utilising change management techniques
- Mapping a proposed/alternative/ideal refugee health service access pathway
- Identifying the decision support tools required
- Developing and using a protocol agreement to guide refugee health service provision

Some or all of these steps can be used in the development of a Refugee Health Service Coordination Model in any local area. More detail about each of these steps is outlined in the following pages.

Relevant Background Research

1. Research policy documents and publications about newly arrived communities settlement, issues and health. A very useful website is the VFST's Victorian Refugee Health Network¹⁵ www.refugeehealthnetwork.org.au
2. Familiarise yourself with the local area where you will be doing service coordination
3. Access Department of Immigration and Citizenship's settlement database for refugee figures in your local area¹ www.immi.gov.au/living-in-australia/delivering-assistance/settlement-reporting-facility/index.htm
4. Identify refugee stakeholders in the area such as:

Government Agencies

- Department of Immigration and Citizenship (DIAC)
- Regional Department of Human Services (DHS)/Department of Health (DOH)
- Refugee Minor Program
- Centrelink and outreach/satellite centres

Primary Settlement Services

- Adult Multicultural Education Services (AMES)
- Local Refugee Settlement Committee

- o Victorian Foundation for Survivors of Torture (VFST) / Foundation House

Health Services

- o Private GP Clinics
- o Local GP Division
- o Local Primary Care Partnership (PCP)
- o Local Community Health Centres (CHC)
- o Local Hospitals and Emergency Departments
- o Tertiary Hospital Specialist Clinics (Infectious diseases and Immigrant clinics)
- o Local Refugee Health Nurse (RHN)
- o Local Diagnostic Centres

English Language Centres

- o English Language Schools
- o Adult Migrant Education Program
- o Local TAFE or University

Local Government

- o Local City Councils
- o Maternal and Child Health Services

Housing Services

- o Department of Housing
- o Local housing authorities
- o Refugee friendly real-estate agents

Employment Agencies

- o Job network agencies

Secondary Settlement Services

- o Local Settlement Grants Provider (SGP)
- o Migrant Resource Centre (MRC)
- o Migrant Information Centre (MIC)
- o New Hope Foundation

Other Agencies

- o Centre for Culture, Ethnicity and Health (CEH)
- o Asylum Seeker Resource Centre (ASRC)
- o Australian Red Cross Asylum Seekers Assistance Scheme (ASAS)
- o Community Legal Centres
- o Women's Health Agencies
- o Local Churches
- o Other newly arrived community service providers

5. Arrange interviews with relevant agencies to identify what services they provide for newly arrived communities. Relevant questions may include:

General Information

- o What is your role?
- o How do you assist refugees to integrate into Australian systems?
- o How are you involved in their settlement process?
- o Who do you receive referrals from?
- o What services do you provide for newly arrived communities or help them to access?
- o How many staff (& what kind) do you have to deal with newly arrived communities issues?
- o How many newly arrived communities access your service in a month/year?
- o What nationalities of newly arrived communities do you see?
- o How to you respond to refugee client language and cultural needs?

- What differentiation is made in regard to service provision, depending on the type of visa held by the newly arrived communities (humanitarian, sponsored, asylum seeker)?

Health Service Access

- How do you assess that a newly arrived communities' client has health needs?
- What are the main health problems you see in newly arrived communities?
- How do newly arrived communities find out about and access these services (especially health services)?
- What health services/agencies do you inform newly arrived communities about?
- How do you refer them to these services?
- Are there any problems with the referral process?
- What areas of newly arrived communities' health do you think are neglected by health service providers?
- What health promotion/illness prevention measures do you provide through your service for newly arrived communities?
- What problems and gaps are you aware of in newly arrived communities' service provision?

Community Networks

- What other community groups/agencies do you refer/link newly arrived communities to?
- How do you work together with groups?
- How do you measure the effectiveness of your work?

Refer to South East Healthy Communities Partnership Questionnaire, Appendix 1, for another example of identifying service provision, gaps and barriers.

6. After conducting all interviews, summarise the information according to:
 - Role of agency
 - Incoming referral partners
 - Outgoing referral partners
 - Agency's service provision boundaries
 - Problems, gaps and barriers to service provision
 - Key themes

Other key resources

DIAC settlement database

www.immi.gov.au/living-in-australia/delivering-assistance/settlement-reporting-facility/index.htm

Community profiles

www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-planning/community-profiles.htm

Involving Relevant Agencies

1. Invite 4-5 key agencies to be a part of a newly arrived communities' service coordination steering committee
2. Plan a forum where all key agencies and stakeholders are invited to learn about newly arrived communities' service coordination and care pathways
3. Commit resources for decent venue, catering and handouts
4. Choose a date and suitable venue that can be accessed by all and is culturally appropriate
5. Email invitations to agencies and stakeholders
6. Keep an ongoing invited guests and RSVP list
7. Prime steering group members to encourage participation amongst other agencies
8. Follow-up emailed invitations with phone calls to ensure participation of key stakeholders
9. Consider the use of an external facilitator (depends on the skills, local perceptions of and availability of suitable individuals).
10. Depending on the settlement area, it may be necessary to start from a baseline of 'no understanding' of newly arrived communities health, and build from there. If agencies are very experienced, a certain level of knowledge can be assumed
- 10a. Baseline of 'no understanding':
 - Invite key state-wide refugee players to speak at forum. This may include someone from (AMES) settlement services, Foundation House, Department of Human Services, refugee health nurse, facilitator, service coordination expert etc. Speakers introduce state-wide refugee initiatives and other important information relevant to newly arrived communities service provision
 - Invite a person(s) from a refugee background to speak about their journey as a refugee and their experience of the Australian health system
 - AGENDA EXAMPLE:

Refugee Health Forum

Forum Purpose

To raise awareness about newly arrived communities' health issues
To introduce the Refugee Health Nurse and Refugee Health Service Coordination projects

Program Outline

Welcome and introductions
PCP role in service coordination
Refugee Health and Wellbeing Action Plan
Role of Adult Multicultural Education Services
Role of Foundation House
Overview of the Refugee Health Nurse Program
Victorian Refugee Health Network

Refugee Health Service Coordination Project
Local Refugee Health Nurse Program
Group work: defining pathways for newly settling newly arrived communities
(ensure groups have representatives from a range of agencies)

10b. Baseline of 'newly arrived communities' service provision experience':

- Focus more on service coordination and present a draft of current pathway to discuss and modify
- Invite a person(s) from a refugee background to speak about their journey as a newly arrived communities and their experience of the Australian health system
- Invite key state-wide refugee players to speak at forum about the benefits of service coordination
- AGENDA EXAMPLE:

Refugee Service Coordination Forum

Forum Purpose

Explain PCP Refugee Health Projects
Develop the Refugee Health Care Pathway

Program Outline

Welcome & Introduction to Workshop
Overview of Primary Care Partnership & Refugee Health Project
Current Care Pathways for Refugees
Small Group Discussion on Current Care Pathway (ensure groups have representatives from a range of agencies)
Report Back on Group findings

Mapping a 'Current' Pathway

This can be done by the steering committee, or a group that forms at the initial forum. It is important that key organisations are involved, however it should not be too big that it cannot reach consensus.

The outcome of the work will still need to be presented and amended by the full range of stakeholders involved in your forum(s).

1. Initial pathway mapping can start as a sketch that represents the newly arrived communities' pathways as they are currently occurring. It should include all agencies interviewed or included in the process. These should be positioned on the map according to the service coordination elements (ie. under their headings).
2. Obvious gaps and barriers can also be identified on the map, to indicate areas that need addressing, see figure 2 below.
3. At a forum present map of 'current' pathways to key newly arrived communities' service providers previously interviewed. Include these providers in the pathway development by asking for their comments, adjustments and reasons why changes or inclusions should be made. This process leads to active participation and helps everyone involved understand the complexities of the pathways.
4. Modify 'current' map as required, so that it fully represents the current newly arrived communities' pathway through the service system.
5. The mapping program used was **Inspiration Software Inc**. Inspiration Software Inc¹⁸ is a simple, easy to use and professional looking mapping program. It can be downloaded from the internet or purchased for less than \$80. It can be accessed through www.inspiration.com.au.

Mapping an 'Ideal' Pathway

1. From the previous discussions and interviews with service providers that occurred when developing the 'Current Pathway' map, identify the most efficient pathways recommended or observed. Incorporate comments from service providers about the possibilities that can be utilised within the service system.
2. Discuss some key questions about the current pathway:
 - o Are there any problems with the current care pathway that impede health outcomes for newly arrived communities? What are they?
 - o Are all the steps and players captured?
 - o Can you suggest any improvements to the care pathway?
 - o What are the barriers and enablers to the pathway's implementation?
 - o What changes in the pathway could be made to make it more efficient?
 - o What needs to be put in place to make the care pathway work better?
 - o How will we know that the care pathway is working better?
3. Delegate a smaller working group to work on the pathway development
4. Map the ideal pathway developed by the working group and distribute to agencies for comment or preferably present it at another forum for their input
5. Ask agencies to again discuss and contribute to the pathway with their comments, adjustments and reasons why changes or inclusions should be made
6. Discuss some key questions about the proposed/altered pathway:
 - o Will the proposed/altered care pathway improve health outcomes for newly arrived communities?
 - o How?
 - o Have we captured all the steps and players?
 - o Can you suggest any improvements to the care pathway?
 - o What are the barriers and enablers to the pathway's implementation?
 - o What needs to be put in place to make the care pathway work?
 - o How will we know the care pathway is working?
7. Come to a consensus on the pathway's appearance and re-modify the pathway to include all relevant points raised
8. Email the pathway around to relevant agencies for their further comments and contributions
9. Trial the pathway for effectiveness. Can agencies realistically follow the pathway?
10. Re-assess the pathway after a trial of 3-6 months. What improvements and changes need to be made? The reassessment can be part of a PDSA (Plan, Do, Study, Act) process on the pathway development
11. Make the necessary changes and agree on its readiness for implementation
12. Develop protocol for signing by agency heads, regarding the use of the pathway
13. Evaluate pathway effectiveness as a guide to referral and service coordination

Use of Other Decision Support Tools

A decision support tool was developed in the HealthWest project to identify clients with a high level of complexity who might need extra or ongoing support. It is important that the tool incorporates social as well as health factors to obtain a holistic perspective.

Interviews and discussion in the west identified a high risk for some newly arrived communities to “fall through the cracks” after their six month settlement period. Our response was to develop a decision support tool to identify these clients early on in the process.

You may discover differing needs in your community that require different responses (e.g. a geographical map of local services for newly arrived families or an easy reference guide).

Decision support tools can serve a number of specific purposes

- For all consumers, including newly arrived communities, a holistic approach to health and wellbeing needs to be applied. This includes an understanding of not only their health needs, but also their living, employment, economic and social situations. All of these factors are essential and play a significant role in the management of a client’s health and wellbeing.
- The Decision Support Tool can be a supplement to the SCTT tool for cases where the service providers require extra information than what is already provided in the SCTT.
- Where agencies do not use the SCTT and e-Referral methods, the Complexity Screening Tool gives a single page summary of the newly arrived communities and the pertinent areas of their lives that must be taken into consideration by service providers.
- Sharing this information with other service providers involved in their care saves the newly arrived communities the painful process of having to tell and re-tell their ‘story’ and details over and over again to every new service provider. It will also hopefully prevent the newly arrived communities from having to fill and re-fill forms that are difficult for them to read and understand because they are in English, which is not likely to be their first language.

See an example of a Complexity Screening Tool on page 23

Example: Refugee/Humanitarian Entrant Complexity Screen

Purpose of Tool:

AMES Referral Already Sent

1. To ensure **timely access to health services** for refugee and humanitarian entrants with the **greatest needs**.
2. To be used by the **AMES Case Coordinator (CC)** after referring to an initial point of contact into the health service.
3. To be **included in referral information** to Refugee Health Nurses (RHN), General Practitioners (GP), Community Health Nurses, or any other **initial point of contact** into the health service.
4. To **measure the level of complexity and urgency** in a **refugee or refugee family situation**, to ensure **appropriate levels of support are provided** for access and efficiency of further assessment.

GENERAL INFORMATION

Principal Applicant's Surname / Family Name					Principal Applicant's Other Given Names					
Refugee Visa	200	204	SHP Visa	202	Other Visa		Date of Arrival in Australia		Date of Assessment	
Interpreter required for any family member?						Yes / No				
Principal Applicant's Preferred Language?										
Principal Applicant reads Preferred Language?						Yes / No				
Case Coordinator's Name						Phone:				
Community Guide / Proposer's Name						Phone:				

NOTE: This tool assumes that the following have **already or are in the process of being addressed** for the entrant or any member of their family.

Yes/No	Red Alert Case – Any case requiring immediate medical attention on arrival (within 24 hours), who may or may not have had a medical escort for flight. See Manifest attached.
Yes/No	General (Yellow) Alert Case – Any case requiring follow-up medical attention (within 72 hours) after arrival, or any cases with serious medical conditions. See Manifest attached.
Yes/No	Health (TB) Undertaking – Signed agreement to undergo follow-up tests after arrival in Australia. Case Coordinator has contacted Western Hospital Yes/No Awaiting Appointment Yes/No

Criteria	Complexity Rating		
	Lo	Me	Hi
A. Education Level of Principal Applicant (Circle Applicable)			
Unknown Yes / No	None Yes / No	Primary Yes / No	L M H
Secondary Yes / No	Tertiary Yes / No	Post Grad Yes / No	L M H
B. Pre-Arrival Experience (Indicate number)			
Number of Months in Refugee Camp?			L M H
Number of years as a refugee in a transitional country?			L M H
Is there immediate family left in Refugee Camp?	Yes No		L M H
C. Family Composition (Indicate number)			
Number of Adults in Family			L M H
Number of Children / Dependents in Family			L M H
Number of Unaccompanied Minors in Family			L M H
D. Living Situation (Circle Applicable)			
Is the family living in temporary accommodation?	Yes No		L M H
Is the family living in long term accommodation?	Yes No		L M H
Are facilities difficult to access due to location (transport, shops, banks, health etc)?	Yes No		L M H
Is there someone involved with the family (e.g. Com Guide, Proposer, Volunteer) who can negotiate these facilities?	Yes No		L M H
Does the family have social connections close by?	Yes No		L M H
Is living situation crowded?	Yes No		L M H
Is there conflict within the living situation?	Yes No		L M H
Does the family have to repay airfares?	Yes No		L M H

Criteria	Urgency Rating			
	Lo	Me	Hi	
E. Health Situation - relating to whole family (NB: Alerts have already been addressed) (Circle Applicable)				
Has any family member had an acute medical situation since arrival (vomiting, diarrhoea, fever etc) or after first 72 hours?	Yes No		L M H	
Is anyone reliant on daily medication?	Yes No		L M H	
Does anyone have a chronic or long term medical condition?	Yes No		L M H	
Is anyone pregnant?	Yes No		L M H	
Does anyone show signs of emotional or psychological disturbance or distress?	Yes No		L M H	
Are there any children under 5?	Yes No		L M H	
Are there any older people (50+ yrs)?	Yes No		L M H	
Does anyone have an obvious physical disability?	Yes No		L M H	
Is the family already linked with a GP?	Yes No		L M H	
OVERALL RATING (Circle Applicable)				
Complexity Rating	Overall	L	M	H
Urgency Rating	Overall	L	M	H
ACTION Taken by Case Coordinator				
Referred to Refugee Health Nurse	Yes No	Nurse's Name:	Phone:	
Referred to GP?	Yes No	GP's Name:	Phone:	
Comments / Professional Judgement				

Developing a Screening Tool

There are several steps and considerations involved in developing a screening tool. Below are some steps you may like to follow:

1. Collect all referral information forms used by different agencies that see the same clients
2. Identify key relevant and generic, useful and helpful information
3. Design a user-friendly form, simple to fill out and easy to read (see example on page 24)
4. Present form/tool to key stakeholders for comment, modification and input
5. Re-develop tool with appropriate adjustments from the inputs
6. Trial the tool for effectiveness
7. Re-assess use of tool after trial, first individually and then in a larger consultation format such as a forum.
8. Develop protocol for signing regarding use of tool
9. Evaluate tool effectiveness as a guide to referral and service coordination

Use of a Protocol Agreement

A protocol is a written guide about a method of practice in use by a particular agency or agencies.

With inter-agency collaboration, a documented protocol assists to guide implementation of a shared process (e.g. referral process). Implementing agencies use the shared protocol to guide any new staff in the process for which the protocol was developed (e.g. referring newly arrived communities).

The Victorian Service Coordination Practice Manual is an over-arching state-wide protocol on which to base Refugee Health Service Coordination upon. When service providers have been included in the whole process of pathway and decision tool development, they should not be surprised about being asked to sign a protocol that guides the process.

Developing a Protocol Agreement

This may be an activity for your steering committee or a group formed at an initial forum:

1. Write protocol explanation about why it is important for agencies to agree to a unified process of referral
2. Develop the protocol for signing in regard to referral pathway (map) use and/or screening tool use by including:
 - Signatory Agencies / Agreeing Partner Agencies
 - Context and rationale for the protocol
 - Explanation of Pathway / Tool
 - Agency Roles and Responsibilities
 - Principles underlying success
 - Links to other documentation
 - Implementation guide
 - Review, Feedback and Change Mechanisms
 - Appendices
 - Protocol agreement for signing
3. Ask agencies to each sign their agreement and collect signed pages
4. After agency signing and agreement, implement referral process according to protocol
5. Evaluate protocol effectiveness and implementation of pathway and/or tool after at least a year of implementation

See an example of a Protocol on page 26.

Example: Protocol Agreement

Note: Appendices have not been included.

This Protocol represents the commitment by refugee settlements and health service providers to work together to achieve better access, services and outcomes for refugee and humanitarian entrants into Australia. It aims to compliment and streamline current refugee work, through the implementation of the Refugee Care Pathway and Refugee Complexity Screen across the 5 Local Government Areas (LGAs) within the HealthWest Partnership catchment (Maribyrnong, Hobson's Bay, Wyndham, Brimbank and Melton).

Signatories

Signatories are committed to implementing and promoting the Refugee Care Pathway and Refugee Complexity Screen. Representatives from the majority of these agencies were participants in the development and refinement of the two tools, and are supportive of their implementation. The signatory page can be found in Appendix D.

Agencies include:

- Adult and Multicultural Education Services (AMES)
- Western Region Health Centre (WRHC)
- ISIS Primary Care
- Western Melbourne General Practice Division
- Westgate General Practice Network
- Western Health
- Royal Children's Hospital
- Royal Melbourne Hospital
- Victorian Foundation for Survivors of Torture and Trauma

Context and Rationale

Over the past five years, Victoria has annually settled almost a third of Australia's newly arrived refugee and humanitarian entrants. Of these entrants, a third has consistently settled within the five LGAs of HealthWest Partnership. This is a total of over 4,600 such entrants into this catchment area, over the past five years. Although some health agencies have been providing services to refugee for more than eight years, the number of refugee with complex needs has increased, as many are coming out of lengthy war and refugee' camp situations.

In 2005, the Department of Human Services (DHS) commenced a Refugee Health Nurse Initiative to support and facilitate refugee access to health services. DHS also released funds to develop refugee health service coordination. Following interviews with many refugee health service providers in the catchment, barriers affecting refugee access to health services were identified. These included difficulties speaking English, negotiating health and public transport systems, organising the logistics of large families, and insufficient or duplicative services. With the input of relevant stakeholders, a number of tools to aid decision making were developed in an effort to address these barriers.

The Care Pathway and Complexity Screen are the result of the service coordination work in the HealthWest catchment. The tools aim to build on the positive collaboration of services in this catchment, and facilitate the development of functional integration. They will enable agencies to remain independent of each other, but still work in a cohesive and coordinated way, so that consumers experience a seamless and integrated response to their health needs. Consumers are placed at the centre of service delivery, to ensure they have access to the services they need, and opportunities for early intervention, health promotion and improved health and care outcomes. This will correspondingly result in improved inter-agency communication and more efficient use of limited time and resources.

Refugee Health Care Pathway

The Care Pathway describes a model of best practice that can be used to guide current practice and orient new refugee service providers. Variations and adjustments are possible within the framework, as appropriate to different Local Government Areas and regions.

Purpose of the Care Pathway:

1. To map a more efficient and streamlined process of health access that is streamlined, structured and supportive of the newly arrived refugee
2. To highlight each service provider's responsibilities and show how their services compliment and align with others in the pathway
3. To reduce duplication of services and information gathering, and facilitate improved communication and information sharing between partners involved in refugee health service provision
4. To outline specific pathways according to the refugee's individual needs and complexity, and ensure every effort is made to respect and accommodate cultural diversity

Please refer to Appendix A for a copy of the Refugee Care Pathway and a full description of each service provider's role in the pathway.

Refugee / Humanitarian Entrant Complexity Screen

The Complexity Screen is a tool based on the social model of health, and aims to describe the many factors that influence and impact on a new arrival's life. It includes information such as basic client details, preferred language, health alert information, education level, pre-arrival experience, family composition, living situation and health situation. It is an information sharing tool that aims to highlight to the settlement and health provider, the other integral factors impacting on the entrant's life during the settlement period.

Purpose of the Complexity Screen:

1. To ensure timely access to health services for refugee and humanitarian entrants with the greatest needs
2. To be used by the AMES Case Coordinator (CC) prior to referring to an initial point of contact into the health service
3. To be included in referral information to Refugee Health Nurses (RHN), General Practitioners (GP), Community Health Nurses, or any other initial point of contact into the health service
4. To measure the level of complexity and urgency in a refugee or refugee family situation, to ensure appropriate levels of support are provided for access and efficiency of further assessment

Please refer to Appendix B for a copy of the Refugee / Humanitarian Entrant Complexity Screen.

Roles and Responsibilities

In the 5 LGAs of the catchment, there are key agencies and staff who work with refugee. They have an integral role in the successful settlement and integration of refugee into the health care system. These agencies are listed below, .

- Department for Immigration and Citizenship (DIAC)
- Adult Multicultural Education Services (AMES) – Settlement Case Coordinator
- AMES Community Guide / Access Worker / Volunteer support
- Refugee Health Nurse (RHN) / Community Health Nurse (CHN)
- General Practitioner (GP) / Clinic Nurse / GP Receptionist
- Tertiary Hospital Clinics
- Specialist and Allied Health

These agency's individual roles and responsibilities in regard to refugee and the Refugee Care Pathway are outlined on the back of the pathway (Appendix A).

Principles Underlying Successful Implementation

The following principles were agreed upon by the representatives of the participating agencies, as being integral to the successful implementation of the Refugee Care Pathway and Refugee / Humanitarian Entrant Complexity Screen. They can be found on the back of the Care Pathway (Appendix A).

Services:

- Focus on the client and are empowering
- Obtain informed consent from clients, using an interpreter when necessary
- Ensure privacy of client information
- Along with staff are culturally sensitive and respectful of the client
- Ensure appropriate and adequate information is provided and shared to both the client and other service providers
- Work in partnership with client and other agencies for efficient and effective service provision
- Ensure collaboration between agencies and client for a successful service coordination process
- Attempt to share responsibility with client and other agencies to promote empowerment
- Promote the strengths of the refugee and each other
- Aim to be proactive in their approach
- Aim to reduce duplication
- Provide effective communication and feedback to the client and other service providers
- Provide appropriate training and education for staff regarding refugee issues

Links to other documentation

The design of the pathway is based on the service coordination principles outlined in the *Victorian Service Coordination Practice Manual, DHS 2007*. It aims to unify and complement the appropriate use of other documents and current refugee information data collection forms, including the following:

- International Organisation for Migration (IOM):
 - Pre-Departure Medical Screen (PDMS)
 - Health Undertakings and Health Manifests
- Department of Immigration and Citizenship (DIAC) immigration and visa forms
- Relevant Department of Human Services (DHS) web-links (see Appendix A)
- Adult Multicultural and Education Services (AMES) holistic assessment
- Medicare Benefits Scheme (MBS) Refugee Health Assessment Tool
- Service Coordination Tool Templates
- Medical Director 3 Program used by most GPs
- GP Referral Template, Management Plan and Team Care Arrangement
- Refugee Health Nurse Health Screening Tool
- Hospital admission and medical records
- Specialist and Allied Health records

Implementation of the Pathway and Screen

Each signatory agency is responsible for the adoption and implementation of the Pathway and Screen. This includes such measures as:

- Communicate and distribute the pathway and tool to relevant and appropriate staff
- Train current staff in pathway and tool use, and incorporate into orientation processes for new staff
- Facilitate practice changes in regard to refugee health provision
- Raise awareness of roles and responsibilities of providers
- Emphasise adoption of underlying principles to guide practice
- Facilitate effective communication within and beyond each agency, for enhanced and efficient service access for refugee
- Provide supportive policy and procedures for implementation

Review / Feedback / Change Mechanism

HealthWest Partnership will be responsible for the coordination and reviews of the pathway implementation, although this can be prompted by a written request from signatory agencies. The implementation process will be for an initial 12 month period, with the first review occurring towards the end of 2009. Members from the signatory agencies will be called for feedback and monitoring, to ensure service gaps are being addressed and to redefine boundaries. The service coordination continuous improvement framework will be used as a guide for monitoring and evaluating the pathway's progress.

Other Relevant Refugee Health Service Providers

The following providers will be informed of the Refugee Health Service Coordination Protocol, although they will not initially be included in the Protocol signing process.

Individual Private GPs

Testing laboratories

Specialist medical services not connected to a hospital in the west

Maternal and Child Health Nurses

Relevant City Councils

Private Allied Health Practitioners

Specialist women's health services

Sexual health services

Other mental health service providers

Private Dental health services

Community Support Groups

Protocol Agreement

This protocol is based on the trust, professionalism and goodwill of the signatories.

It provides a framework for the implementation of better practice in Refugee Health Service Coordination, and has been developed for the mutual benefit of consumers and the participating agencies/service providers.

Participating agencies/service providers commit themselves to implementing and promoting the Refugee Care Pathway and Complexity Screen. The implementation process will be for an initial 12 month period, with the first review occurring towards the end of 2009.

The following party agrees to participate in this protocol for Refugee Health Service Coordination.

Agency's Name: _____

Signatory's Name: _____

Signatory's Position: _____

Signature: _____

Date of Signing: _____

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Appendix 1



SEHCP Refugee Health Service Coordination Survey

Introduction

The Refugee Health Service Coordination program is funded by the Department of Human Services (DHS) and will be implemented by [South East Healthy Community Partnerships](#) in the City of Dandenong. The project will involve working with service providers in refugee health to develop a service coordination model to guide refugee health service provision. The model developed will outline the most efficient ways for newly arrived refugee to access health services, improve their health and successfully settle into their communities. It follows on from the [HealthWest: Refugee Health Service Coordination](#) program.

Questions

1. What services do you provide for refugee clients?
2. What type of refugee clients do you work with mainly? Are you limited to working with certain refugee classifications in your criteria?
3. What percentage of your clients is from refugee backgrounds?
4. What regions are these clients coming from?

<input type="checkbox"/> West and Central Africa (Sierra Leone, Liberia, Ghana, Zimbabwe, Democratic Republic of Congo)	<input type="checkbox"/> Middle East (Iraq, Iran, Afghanistan, Pakistan)
<input type="checkbox"/> East and Horn of Africa (Burundi, Rwanda, Sudan, Somalia, Kenya, Ethiopia, Eritrea)	<input type="checkbox"/> South East Asia (Myanmar, Thailand, Laos, Cambodia, Vietnam, Malaysia)

5. Which agencies do you make referrals to and approximately how many referrals you make to these organisations per week.

Referrals to (Agency Name)	Type of referral (eg. electronic, telephone, fax, written letter, transport client)	How many? (per week)

6. Which agencies do you receive referrals from and approximately how many referrals you receive from these organisations per week.

Referral From (Agency Name)	Type of referral (eg. electronic, telephone, fax, written letter, transport client)	How many? (per week)

7. Do you use the Service Coordination Tool Templates (SCoTT) Yes No
If yes in which stages?

- Initial contact
- Initial Needs Identification
- Assessment
- Care Planning
- Referral
- Feedback

8. What organisations do you link in with around refugee' services? (What is the nature of the interaction? How often? Driven by?)

9. What barriers/ challenges do you face in providing services to refugee clients related to service coordination? (Internal / external challenges?)

10. How have you addressed them?

11. If not addressed how do you think they can be tackled?

12. Do you have mechanism to gain client feedback? If so what are they?