HACC interface with other programs

Introduction

A HACC service may be one of several services a person receives in order to live at home as independently as possible.

HACC agencies need to know which government funded programs have specific arrangements in place with the HACC program and, what these arrangements or guidelines are.

This section describes the HACC program interfaces for these programs and services.

For a comprehensive listing of all funded services refer to the Human Services Directory (HSD). The HSD aims to provide practitioners and service providers with access to accurate and up-to-date information about health, social and disability services in Victoria.

Seniors Online Victoria is another comprehensive source of information.

Aged Care Assessment Program

The Aged Care Assessment Program is a national program jointly funded by the Commonwealth and Victorian governments. It is administered by the Victorian Department of Health under a cooperative arrangement with the Commonwealth Government.

The target group is frail older people over the age of 65 and Aboriginal people from age 50. Aged Care Assessment Services (ACAS) also assess younger people with a disability when other age-appropriate services are unavailable.

ACAS conduct comprehensive assessments to determine if a person needs community services or aged care residential services, and assesses for restorative care among other potential options.

ACAS determine whether a person is eligible to access:

- Commonwealth funded residential care
- Residential respite
- Home Care Packages
- Flexible care (Transition Care).

ACAS will accept referrals from any source, including frail older people and their families, general practitioners, hospitals and service providers.

Following the introduction of the Commonwealth Living Longer Living Better aged care reforms, there has been no change to processes for referrals from HACC to ACAS.

From August 1 2013 Home Care Packages are offered at four levels (levels 1–4). For the purposes of ACAS assessment the four packages have been ‘broad banded’ into two bands, the lower band being level 1 and 2 and the higher band being level 3 and 4.

People with a current CACPs approval can be offered a Level 1 or 2 package without another ACAS assessment.

People with a current EACH or EACHD can be offered a Level 3 or 4 package without another ACAS assessment. If no Level 3 or 4 packages are available they may be offered a level 1 or 2 package in the interim.

The *Guidelines for streamlining pathways between ACAS and HACC assessment services* (Department of Health 2011) describe the recommended referral pathways for frail older people to reduce unnecessary duplication of assessments.

The purpose of the guidelines are to:

- make sure that frail older people and their carers get the right assessment at the right time
- minimise the number of times frail older people and their carers have to tell their stories
- reduce waiting times for assessment.

Commonwealth funded aged care packages

The Commonwealth Government *Living Longer Living Better* aged care reforms commenced in August 2013.

Key measures include:

- Additional package care levels so there are now four package levels (levels 1- 4) available.
- a new dementia supplement to provide additional financial assistance to people with dementia receiving any of the four levels of packaged care (10 per cent of the package value).

Commonwealth Home Care Packages

Four levels of Home Care packages have replaced the CACPs EACH and EACHD packages:

- Home Care Level 1 — for people with basic care needs
- Home Care Level 2 — for people with low-level care needs
- Home Care Level 3 — for people with intermediate care needs
- Home Care Level 4 — for people with high level care needs

A Dementia and Cognition Supplement of 10 per cent will be available at all four levels of home care for people assessed as having a cognitive impairment.

For more information about changes to Commonwealth aged care services go to the *Living Longer Living Better* website or *myagedcare* website.

Interface with HACC

General principles relating to access to HACC subsidised services for people in receipt of Commonwealth community aged care packages (CACPs) were developed by the department in 2010. These guidelines will be updated to reflect the new Commonwealth Home Care Packages guidelines.

In the meantime the following principles apply:

- As a general rule, people in receipt of a home care package are not eligible to receive the full range of HACC subsidised services. For example personal care, delivered meals, domestic assistance, respite and property maintenance can be provided through Commonwealth Home Care packages so they would generally not be provided to clients as a HACC subsidised service.
- Level 1 and 2 package clients can receive HACC subsidised nursing and allied health, as a HACC client.

- In Victoria, where a Level 1 and 2 package client was attending a planned activity group prior to going on the package, they can continue to do so as a HACC client in their own right. Similarly where a person is in receipt of a Level 1 and 2 package and not currently a member of a social support group, they can be considered for a HACC subsidised place as a HACC client in their own right.

Being eligible to be considered for a HACC subsidised place does not confer entitlement to service provision. Eligibility means that the person is in the HACC program's target group and is eligible to be assessed and prioritised for service provision. Services may not be able to be provided due to other people being assessed as a higher priority and/or due to resources not being available.

Commonwealth funded residential aged care

HACC funded services are not generally available to people living in residential aged care.

When a person using HACC services moves to residential care HACC services cease. This should be handled sensitively and allowances made for a transition period, for example, through attendance at a planned activity group.

HACC type services may be provided to residents in aged care facilities only:

- on a full cost-recovery basis
- where the HACC service provider has the capacity to service additional people without adversely affecting people in the HACC target group.

The Commonwealth reforms to residential aged care will be introduced in July 1 2014. See the Commonwealth Living Longer Living Better web site for information on residential aged care.

Compensation payments

Where a person has received a substantial lump sum compensation payment intended to cover the cost of care, fees for HACC services should be set at the full cost-recovery rate. If the lump sum is not substantial or a periodic payment has been granted, HACC program subsidies and fee reductions can be applied.

All clients should be assessed as to their ability to pay fees, including those who receive a lump sum or periodic compensation payment.

For further information see Part 1: 'Fees policy'.

Disability services

Disability services provides and funds services for people with a disability, and their families, to meet their disability related support needs.

Disability related support needs include assistance to maintain or increase independence and skills to participate in the local community.

People with a disability and their family or carers can request disability supports if:

- the person has a disability
- the disability impacts on mobility, communication, self-care or self-management
- the support request meets specific requirements related to the service being sought.

Disability supports may not always be suitable. For example, a person with a chronic health issue may have their needs better met through health services.

There is a high demand for disability supports and allocation is prioritised based on each person's circumstances. Requests for disability supports are considered along with all other requests. It is not possible to specify in advance when a support will become available.

Access to disability services

Ongoing supports such as Individual Support Packages (ISPs) and supported accommodation are accessed via the Disability Support Register (DSR).

The DSR is a database of all people who are requesting ongoing disability supports. The DSR enables the department to allocate supports in a fair and efficient manner when resources (funding or vacancies) become available.

People with a disability are eligible to access health services the same way as other members of the community. This includes people accessing individual support packages (ISPs) and people who live in disability-supported accommodation including group homes, congregate care or residential institutions.

Individual support packages (ISPs)

ISPs are an allocation of funding to a person with a disability to purchase supports that will best meet their disability related support needs.

Supports purchased with an ISP are not intended to replace those provided through informal sources or other community or government services. Ideally, an ISP will complement other community and informal supports.

ISPs are allocated in accordance with the *ISP guidelines* with particular reference to a set of funding principles. The funding principles state, among other things, that:

- ISP funding (funding) must be used to purchase supports that are directly related to the person's disability needs and to achieve the goals identified in their support plan
- funding is not provided as income for the person.

When a person is offered an ISP, they undertake a comprehensive planning process to determine:

- what supports they need
- who will provide the supports
- how ISP funds will be managed.

This information is included in a funding proposal that is submitted to the relevant departmental region for approval. Once approved, it becomes the person's funding plan and the person can implement the plan as required. The person may make changes during the life of their plan (usually three years) without seeking further regional approval, provided the changes remains consistent with both the goals of their funding plan and the funding principles.

People may be allocated an ISP based on a notional funding allocation determined at the time of DSR registration. Funding is allocated within four broad bands.

See the *Individual support package guidelines* (Department of Human Services, 2010) for more information.

Supported accommodation services

Long-term disability-supported accommodation may be requested for people who require rostered support. This service is targeted to people with a disability who have the highest support needs.

The majority of supported accommodation services in Victoria support five to six people living in a share house arrangement. Disability support workers support people living in supported accommodation in areas such as household management (for example cleaning and shopping) and general personal care (for example eating, bathing, dressing and preparing food).

Access to HACC services: HACC and ISP interface

Younger people with a disability may access HACC Linkages packages depending on their assessed need, priority and the package availability.

Younger people with a disability cannot access a Linkages package and an ISP at the same time. When a person applies to the Disability Support Register (DSR) for an ISP, ongoing disability supports including existing Linkages supports should be included in the application.

If a younger person has been allocated an ISP and is already using Linkages, the Linkages case manager in collaboration with the ISP facilitator can apply for an increased ISP to cover the cost of Linkages supports. The Linkages supports should continue until the additional ISP funding is approved.

People receiving an ISP are not automatically excluded from HACC services. If a person is receiving or has placed a request for an ISP, then the HACC provider should take this into account when reviewing the services they are providing. The decision to provide HACC services to someone on an ISP should be made on a case-by-case basis and will depend on the level of demand for services within each HACC organisation.

Interface with supported accommodation services

People who live in disability-supported accommodation including group homes, congregate care and people living in Colanda Residential Services (in Barwon South West region) are eligible for HACC funded nursing and allied health services to enhance independence and to reduce the risk of premature or inappropriate admission to residential aged care. Access to these services is based on priority of need as per all HACC clients (see Part 2: ‘Eligibility and access’).

Residents of disability-supported accommodation are expected to transfer to the National Disability Insurance Scheme (NDIS) launch operating in Barwon, from April 2014. Residents of Colanda Residential Services will transfer in September 2014. After they transfer, their on-going support needs will be met through the NDIS, to the extent that they are related to their disabilities.

People living in supported accommodation are not eligible for other HACC services such as delivered meals, domestic assistance, respite and personal care, insofar as services of this kind are expected to be supplied by the supported accommodation provider.

Housing

The HACC program supports people to live in their own homes, which include private rental dwellings, rooming houses, supported residential services, retirement villages, caravan parks and in some circumstances a state government funded residential service.

People in these tenures may be eligible to be assessed and prioritised for a HACC service, but a HACC service cannot be provided if there is a legislative or contractual requirement for the accommodation proprietor to provide that service. For example, a HACC service cannot provide a meal or cleaning service that is the responsibility of the owner of a supported residential service.

Private rental

A person renting a flat or house can be assessed and prioritised for all HACC activities with the exception of some property maintenance. A person in a rented flat or house can access limited property maintenance (with the approval of the landlord) for those costs that are normally the tenant's responsibility, for example installation of ramps and rails, or minor maintenance and repairs.

Rooming houses, private hotels and caravan parks

People living in insecure tenures such as rooming houses, private hotels and caravan parks, excluding recreational users, may experience barriers to access of HACC services. Diversity planning strategies and the use of outreach service models may be required for this group.

These residents usually pay only for accommodation, as per private rental, and are eligible to be assessed and prioritised for all HACC services including limited property maintenance. Property maintenance can be provided, with the permission of the owner, and may include the installation of ramps and rails in areas used by the person, or maintenance work in the resident's room. This maintenance can include a range of activities that are usually the responsibility of the tenant, for example changing light globes and maintenance and repair of the resident's furniture.

Retirement villages

Tenure and contract arrangements for retirement villages may vary widely. For example, in some villages the resident charge includes the provision of activities and transport. Each case needs to be considered and an understanding gained of what services the retirement village is required to provide before a HACC service can be provided.

Supported residential services

Supported residential services (SRSs) are premises where accommodation and special or personal support is provided for a fee. Special or personal support may encompass a range of services including assistance with personal hygiene and meals. SRSs are privately owned and operated but are regulated by the Victorian Department of Health.

SRS residents are potentially eligible for HACC services provided that the activity is not included in the resident's residential and services agreement (the agreement between the resident and the SRS proprietor).

Before assessing an SRS resident, HACC assessors should obtain a copy of the agreement. Relevant HACC services might include podiatry or other allied health services, nursing or planned activity groups.

In the pension-only SRS sector, a resident's entire income may be going towards accommodation and support costs. In these circumstances HACC fees may need to be waived.

Personal Alert Victoria

Personal Alert Victoria (PAV) is a daily monitoring and emergency response service funded by the Victorian Government through the Department of Health. The PAV program interfaces with the HACC program in two ways:

- HACC assessment services and community health services are designated PAV assessment agencies. PAV assessment is designed to be part of a broader assessment process, where the person is assessed in their home for a range of services, of which PAV may be one option.
- A response service which acts as the incident contact for people using PAV who do not have family or other contacts who can respond to an incident.

For further information refer to *Personal Alert Victoria guidelines.*

Veterans' Home Care program

The Department of Veterans' Affairs (DVA) Veterans' Home Care (VHC) program is designed to assist those veterans and war widows and widowers who wish to continue living at home and who need a small amount of practical help. Services may include domestic assistance, personal care, safety related home and garden maintenance, respite care and limited social assistance.

Interface with HACC

With regard to domestic assistance, personal care, safety related home and garden maintenance, and respite care, veterans can choose to receive either VHC services or HACC services, but cannot receive both.

Veterans who are receiving HACC services may choose to transfer to VHC or continue to receive HACC services.

Eligible veterans may access HACC planned activity groups and delivered meals. These are funded by DVA through the Victorian Department of Health, based on assessed and prioritised need and service availability. DVA contributes to the HACC program to facilitate veterans' access to these services. Providers are required to report on usage through the HACC minimum data set (MDS).

Continuing Care program

The Victorian Department of Health's Continuing Care Unit funds a range of clinical, community and home-based programs for people who:

- are at risk of hospital admission
- are experiencing chronic health issues or functional decline and require multidisciplinary interventions to assist them to live independently at home
- have experienced an inpatient episode of care and are eligible for services to support their care pathway to return home.

People using HACC who have had an inpatient admission may receive support from a Continuing Care program as part of their inpatient or post-acute care pathway.

These services are usually provided in the person's home, and include:

- Hospital in the Home (HITH)
- Post-acute care (PAC) services
- Transition Care Program (TCP).

In addition, there are continuing care services which HACC may refer to including:

- Hospital Admission Risk Program (HARP)
- palliative care
- Subacute ambulatory care services (SACS) comprising community rehabilitation services and a range of specialist clinics.

With the exception of SACS, these services provide home-based nursing and other HACC-like services. When this occurs it is important that the person experiences continuity of care and coordinated care.

Working together

The following principles should guide the integration and continuity of care when people are receiving both HACC and continuing care services at the same time or as linked episodes of care.

- The continuing care service provider and the HACC service provider should work collaboratively to develop the care plan and identify who will be the primary care coordinator during the episode of care.
- Wherever possible, the person's care provider should be continuous across these episodes of care. Who pays for that care and who delivers the care are issues that need to be clarified early in the discharge process to enable continuity of care. However there will be some circumstances in which HACC service providers will not be able to provide continuity of service because they are unable to provide services on a full cost-recovery basis.
- Based on a review by the HACC service provider, any pre-existing HACC services, such as domestic assistance, respite or delivered meals, should continue during the continuing care episode, such as PAC, HARP, HITH and palliative care.
- Nursing will usually be provided by the continuing care provider. The interface between each of the continuing care programs and HACC is described below.

Hospital in the Home

Hospital in the Home (HITH) is the provision of acute care to public hospital patients in the person's own home or other suitable environment. HITH provides an alternative to hospital admission or an opportunity for earlier relocation home. Many HITH patients are elderly and chronically ill.

Interface with HACC

When HITH and HACC are both providing care to a person, the HITH service is the primary care coordinator and will contact the HACC service provider to discuss the care plan. People receiving HACC services prior to a HITH episode should continue to receive the services at the same level (particularly for services like home help and meals) during their HITH episode.

The HITH service will provide all nursing care, regardless of whether HACC nursing has been provided prior to the HITH episode. However, on rare occasions HACC nursing may continue to be provided on HITH leave days if the process is coordinated and is in the best interests of the person.

Personal care needs will be assessed by the HITH program to ensure no additional risk is placed on existing HACC providers. If the person is at their usual level of acuity and function, existing HACC personal care can continue. However, if the person requires a greater level of assistance or staffing competence during the HITH episode, the HITH program should provide that care.

If the acute condition requiring HITH admission necessitates an increase in HACC services, HITH is responsible for planning, funding and monitoring the additional services. Where possible, the HITH service is encouraged to use providers that promote continuity of care.

Where no HACC support services have been in place HITH will arrange and fund the services required during the admitted episode and refer to HACC as appropriate for continuing care at the end of the HITH episode.

Post-acute care

Post-acute care (PAC) services support people discharged from a public hospital including emergency departments, acute services and subacute services, who have been assessed as requiring short-term, community based supports to complete their recuperation in the community when hospital services are no longer needed. PAC provides flexible in-home services to enact safe discharge.

Interface with HACC

For people using HACC services:

- PAC provides additional short-term support relevant to the inpatient episode. Prior to the person's discharge, PAC and HACC providers need to plan for and determine the continuity of care arrangements.
- Pre-existing HACC services that are not impacted by the hospital episode, for example delivered meals or domestic assistance, should resume as soon as possible once the person returns home. HACC needs to prioritise these clients for service resumption.
- HACC service providers may need to reassess the person's need for services such as personal care prior to the end of the PAC episode to determine ongoing needs.

For people not receiving HACC services prior to the hospital episode:

- PAC provides short-term care in the home where there is an assessed need for the person to complete their recuperation at home. HACC service providers need to assess the person prior to the end of the PAC episode to determine any ongoing need for services.
- Where there is a HACC need identified that is not related to the hospital episode, HACC needs to assess the person's needs as soon as possible post discharge.
- Where there is an unavoidable delay in HACC being able to provide services, PAC may provide services immediately post discharge until HACC can commence provision of the needed services.

Transition Care Program

The Transition Care Program (TCP) is funded jointly by the Commonwealth and Victorian governments. It aims to minimise the number of older people experiencing inappropriate extended hospital lengths of stay or being prematurely admitted to residential care. The *Transition Care Program guidelines 2011* (Department of Health) govern the provision and operation of the program.

Aged Care Assessment Services (ACAS) determine initial TCP eligibility. The TCP provides short-term support and active management for older people at the interface of the acute/subacute and community/residential aged care sectors. TCP can be provided as a bed-based service, either in low or high-level residential aged care or as a home-based service.

By offering case management, low-intensity therapy and personal support, the program allows older people more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and finalise and access long-term care arrangements.

Interface with HACC

TCP staff work closely with a range of community and residential service providers including HACC, to ensure timely referral, assessment and access to support during and after the TCP episode of care. It is likely that some people receiving the TCP will already be using HACC services.

In such instances, the TCP case manager will liaise with the HACC service provider to negotiate whether the HACC service continues, including consideration of continuity of care, or is suspended during the TCP episode of care.

Where there is no service agreement between TCP and the HACC service provider, an alternative service is utilised. Where there is agreement for the HACC service to continue, the TCP case manager will advise the HACC provider on the invoicing process.

The duration of the TCP episode will be determined by the person's goals at TCP admission, so the length of stay will not necessarily be 12 weeks.

For services required beyond the TCP episode of care, TCP will refer to HACC as soon as it is evident that a particular service is necessary to support an ongoing care need. Information will include notification of the expected TCP discharge date. A TCP extension cannot be granted on the basis of a service not being available, so it is essential that good communication and planning facilitate timely referrals, assessment and transition between TCP and HACC.

In TCP the cost for HACC-delivered meals and home modifications is borne by the person, at the HACC-subsidised rate, unless otherwise advised by the TCP.

Hospital Admission Risk Program

The Hospital Admission Risk Program (HARP) prevents readmissions to emergency departments and acute hospital settings by using evidence-based approaches delivered in a community or ambulatory setting including:

- care coordination
- access to specialist medical care
- self-management support
- complex psychosocial issues management.

HARP targets people who present frequently to hospital or are at imminent risk of doing so, and who have complex needs related to chronic disease or psychosocial factors, and where intensive care coordination and specialist care are required in addition to usual care.

HARP works across the hospital and community interface and links people into appropriate hospital or out of hospital care pathways.

HARP services have access to hospital systems that enable early recognition and prompt referral and links either into appropriate hospital or out of hospital care pathways. HARP is governed by the *Health independence program guidelines*.

Interface with HACC

HARP care coordinators work closely with specialist, subacute and community services to address immediate short-term needs, and to develop an integrated multi-organisation plan for ongoing care in the community setting. People receiving HACC services prior to a HARP episode should continue to receive the HACC services at the same level.

HARP may augment these services in the short-term, particularly with specialist medical or allied health assessment and intervention. HACC agencies refer to and receive referrals from HARP organisations.

Palliative care

The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care in Victoria is delivered in a number of settings, from people's homes with primary health and general practitioner support, through to acute health services and highly specialised settings. Palliative care is flexible to meet the needs of the person and their family.

Referral to palliative care services can be made by clinicians including general practitioners, acute health professionals, community health services, HACC services, aged care services and so forth, or by self-referral.

Interface with HACC

Collaboration in assessment and care planning between the HACC service provider and the palliative care provider is considered best practice. A collaborative approach allows both services to benefit from the other's skill and knowledge.

HACC services should continue when the person is referred to palliative care.

Pre-existing HACC services should be reviewed and a coordinated care plan developed with the palliative care service in order to provide the most appropriate support to the person and their family.

HACC and palliative care providers need to discuss the person's future care needs, possible transition to more intensive levels of care and make the appropriate referrals. A referral to ACAS may be required.

HACC funded nursing should continue on the basis of the nursing need relating to a pre-existing health condition. In some cases, HACC services may provide generalist nursing and the palliative care service may provide concurrent specialist palliative care nursing as well as other specialist palliative care.

Some people requiring palliative care services may not already be receiving support from the HACC program. In these instances palliative care should refer to or contact the local HACC assessment service to discuss the person's circumstances and determine the most appropriate assessment and/or care pathway.

Links

Victorian health and aged care services links

Health independence programs guidelines (Department of Human Services 2008)
http://health.vic.gov.au/subacute/hip-manual08.pdf

The Human Services Directory: http://humanservicesdirectory.vic.gov.au/

Personal Alert Victoria guidelines: http://www.health.vic.gov.au/agedcare/policy/pav.htm

Palliative care services in Victoria: www.health.vic.gov.au/palliativecare

Commonwealth funded aged care

Aged care review measures
http://www.health.gov.au/internet/main/publishing.nsf/Content/aged-aged-care-review-measures-techdoc

Commonwealth Home care packages information and guidelines: www.livinglongerlivingbetter.gov.au

myagedcare: http://www.myagedcare.gov.au/

Guidelines for streamlining pathways between ACAS and HACC assessment services: improving the client journey (Department of Health 2011)
http://www.health.vic.gov.au/agedcare/downloads/pdf/acas_has_guidelines.pdf

Residential aged care
http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Residential-care

Seniors Online Victoria: http://www.seniorsonline.vic.gov.au/Home.aspx

Disability services links

Centre for Developmental Disability Health Victoria: http://www.cddh.monash.org

More information about disability services:
http://www.dhs.vic.gov.au/for-individuals/disability

Veterans home care links

Veterans' Home Care program:
http://www.dva.gov.au/benefitsAndServices/home_services/vetshomecare/Pages/