Framework for Assessment in the Home and Community Care Program in Victoria

2007

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Framework for Assessment in the HACC Program in Victoria

Introduction

The HACC Program enables people with basic care needs to remain living independently at home with relatively low levels of formal service provision. Assessment is a critical factor in managing client pathways in and out of HACC services as well as the broader health and community care system.

The HACC Assessment Framework sets out program policy for Assessment as a HACC funded activity. It describes in detail the requirements for the delivery of a **Living at Home Assessment** which includes a home-based holistic assessment of need and service-specific assessments as key components. In most instances these Assessments will occur wherever the client is currently living in the community.

The Framework also describes related processes such as Client Care Coordination and Supported Access. Both of these processes are critical adjuncts to Assessment for specific client groups.

The policy described in the Framework builds on existing assessment expertise and good practice within the HACC Program. To this end, the Framework will be an important reference point for promoting more consistent assessment processes and practices across Victoria.

The policy is drawn from the *Strategic Directions in Assessment Victorian Home and Community Care Program, Final Report* prepared by consultants Anna Howe and Deb Warren in 2005. The strategic directions recommended in this project came from a synthesis of data and information including a literature review, HACC Minimum Data Set analysis and extensive consultation with the sector. The development of the Assessment Framework was guided by the HACC Assessment Reference Group and by submissions received on the draft Assessment Framework which was released for consultation in September 2006. Organisations that provided feedback on the consultation draft are listed in the Appendix.

The Assessment Framework replaces Section 7.3 'Assessment and Care Management' of the Victorian HACC Program Manual.

Assessment in the HACC Program

The role of Assessment in managing client pathways through HACC and the broader health and community care system is a challenging one. Assessment is the mechanism by which organisations discover what clients, carers and families need and want in order to live as independently as possible. Care planning, monitoring, review and reassessment are processes that ensure that the service system is responsive to client and carer changing circumstances in the context of available resources.

In 2004 Victoria committed to refocussing its model of HACC service delivery away from a 'dependency' model where tasks are largely done for clients, towards a more active model which aims to maintain and improve client independence wherever possible.

In practice this means:
- building on each person's strengths
- improving clients' functional capacity and social participation wherever possible
- delivering services or supports based on what is most important to the client and carer.

Assessment also plays a critical role in recognising if a client's declining abilities and increasing need for service requires transitioning from the HACC Program to a more suitable care option. For frail older people this would include transitioning to Commonwealth funded services such as Community Aged Care Packages (CACPs), Extended Aged Care in the Home (EACH) or residential aged care.

Good assessment processes and strong links with key health and community care organisations are critical to achieving these outcomes.

Client Care coordination

The HACC National Minimum Data Set User Guide Version 2.0 (Victorian modification) describes Client Care Coordination as usually a short term activity involving:
- activities which facilitate access by people from special needs groups such as people from culturally and linguistically diverse (CALD) backgrounds, Aboriginal people, and for people with dementia
- clients who are receiving services from a number of different organisations and require care coordination within and across these organisations.

The role of Client Care Coordination for different client groups was discussed with a range of stakeholder groups as part of the Framework development process. It was agreed that in order to meet the needs of specific client groups, this activity will be divided into two different activities: Client Care Coordination and Supported Access. Client Care Coordination and Supported Access are not mutually exclusive. A client may receive both types of support.

Client Care Coordination occurs for a sub-group of clients following a Living at Home Assessment. This sub group would primarily be people who have complex needs or circumstances and who need a service response from more than one organisation including inter-agency care planning. Clients from all backgrounds and circumstances including CALD and Aboriginal backgrounds will receive Client Care Coordination if required.

Client Care Coordination is described in Section 2.2.2. This activity will be a funded activity.

Supported Access for CALD and Aboriginal clients

All HACC organisations are required to facilitate access to services for all people within the target population. Equitable access to HACC services is recognised as a particular issue for CALD and Aboriginal clients.

'Supported Access' describes the role ethno-specific, multicultural organisations and Aboriginal organisations play in linking their communities into the service system and supporting them to gain access to a range of needed services through the HACC Program or through other funded programs.

Supported Access is described in Sections 2.4.3. The Framework will be updated to include detailed policy guidelines for the Supported Access activity once pilot projects have been carried out.

Access Points for Community Care Services

In February 2006 COAG agreed 'that there be simplified entry and assessment processes for the Home and Community Care Program'. This work is closely linked with work the Commonwealth Department of Health and Ageing is pursuing to simplify entry and assessment for its own aged care programs as set out in 'A New Strategy for Community Care – The Way Forward'.

Currently, people seeking HACC services in Victoria can enter the system and get a service response through *any HACC funded organisation* in the first instance ('no wrong door') and/or be directed to organisations that can meet any other identified needs. This approach to access will remain a feature of the HACC program and the community care sector more generally as a result of the Primary Care Partnerships and the implementation of service coordination.

The high level objective for Access Points is that they should be marketed and visible points where people can go if they are seeking services but do not know what is available or what they may be able to get access to.

From Victoria's perspective this fundamental objective for Access Points complements the work that has been done in implementing the Primary Care Partnerships - *Better Access to Services Policy and Operational Framework.* In Victoria the primary goal of Access Points is to improve navigation of the service system for frail older people, younger people with disabilities, their carers, families and friends and service providers.

Further work

Further work is required to implement the Framework. Part 4 lists key pieces of work that will be carried out over the next two years. Further work includes developing a funding model for Assessment; developing a professional development strategy for HACC Assessment staff; and defining the Supported Access activity for CALD and Aboriginal clients. Access Points demonstration projects will be developed and implemented in two regions.

The Framework will be updated as key pieces of work are progressed and policy positions finalised.

Framework structure

Part 1   Access to Services

This part describes how clients access services in the HACC Program and in the community care sector more generally. Processes for eligibility testing, and assessment are described as part of the client pathway for HACC clients.

Part 2   Assessment as a HACC funded activity

This part describes the revised policy for the delivery of Assessment as a HACC funded activity. Related processes such as Client Care Coordination and Access and Support are also described.

Part 3   Criteria for designating organisations as HACC Assessment Services

This part outlines the criteria that HACC funded organisations will be required to meet in order to be designated as HACC Assessment Services.

Part 4   Further work

This part briefly describes specific projects and provisional timeframes for further work as part of the ongoing Framework development process and implementation.

Part 1   Access to Services

1.1   Service Coordination

Service Coordination is the process by which organisations work together in a seamless and coordinated way with the client at the centre of service delivery. Service coordination elements of initial contact, initial needs identification, assessment and care planning ensure that opportunities for early intervention, health promotion and improved health care are maximised.

All HACC funded organisations are required to work with the model of service coordination described in the *Better Access to Service Framework* (June 2001). The *Victorian Service Coordination Practice Manual*[1] provides clear practices, processes and protocols which support service coordination on a statewide basis. In practice this means that all HACC organisations are required to be alert to the full range of client needs and to refer their clients to relevant organisations if and when they identify needs that are outside of their own service capacity, using the Service Coordination Tool Templates (SCTT).

See the Primary Care Partnerships (PCP) website www.health.vic.gov.au/pcps/coordination for access to the full range of resources that have been developed to support service coordination implementation.

1.2   Client Pathways in the HACC Program

The HACC Program provides a broad reach of service to a large client population. The majority of clients receive low levels of service and only a small group of clients receive medium to high levels of service. For this reason, the assessment experience in HACC needs to be tailored to fit client need and circumstances.

Assessment is not a one-off event. It is a continuum, an ongoing process of building a relationship with a client and carer that begins at the first contact and continues through to service delivery, review and reassessment as circumstances change. Assessment is an interactive process between clients and providers, not a one-way communication.

A clear understanding of the different types of assessments that occur along this continuum is important. A clear policy framework and understanding of the purpose and intended outcomes of different types of assessments should ensure that:

- clients with basic, one-off or short term needs are not over assessed
- clients are assessed by assessment staff with the appropriate expertise
- duplication of assessments for the same purpose is minimized; assessments build on each other but do not duplicate
- repetitive information gathering is minimised.

In most cases, clients will receive more than one type of assessment in order to ensure that they get the service that most appropriately meets their need. In many cases different assessment types occur seamlessly (from the same assessor, at the one visit) without repetition of information gathering.

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[1] The *Victorian Service Coordination Practice Manual* Primary Care Partnerships, Victoria 2007.

A description of the different assessment types is provided below in order to promote a clear understanding of the purpose of each assessment type and when they occur.

A **Living at Home Assessment** is the only assessment that is funded by the HACC Program as a separate activity. Funding for eligibility testing and other assessment types (listed below) is included in the unit price for the particular service being delivered. Details of the funding approaches for each HACC activity can be found in section 8.5.9 of the Victorian HACC Program Manual.

Comprehensive assessment is not funded by the HACC Program so is not described in the Framework. However, comprehensive assessments carried out by the Aged Care Assessment Services (ACAS) are an important part of the client pathway for many HACC clients with high and complex needs who need to transition to more intensive levels of service. For this reason there needs to be clear guidelines and protocols between the two programs to minimise duplication and to ensure clients get the right type of assessment at the right time. Section 2.7 describes policy requirements which will enhance links with the ACAS.

1.2.1 Eligibility testing

Eligibility testing is the initial screening that determines if the person is in the HACC target group. All HACC organisations must have a consistent approach which conforms with the HACC Program policy on target group definition, and principles of equitable access (See the Victorian HACC Program Manual Section 4). If eligibility testing determines that the client is within the HACC target group, organisations will identify:

- the person's need and priority for assessment for services delivered by the organisation the client has contacted, and/or
- the need for assessment and/or immediate service delivery from other organisations (including making the appropriate referrals).

Persons not within the HACC target group should be informed of the reason why and provided with information on other relevant sources of assistance or information to meet expressed need. Response times between referral, assessment and service delivery must be appropriate to client and carer need.

Who does this? All HACC organisations
How is this carried out? Eligibility testing is based on information provided by the referrer over the phone (client or family) or information contained in a written/electronic referral. Organisations are required to have protocols and consistent processes in place for testing eligibility and to employ staff with the relevant expertise. A systematic approach to identifying priority of access should be utilised.
Service Coordination Element: Initial Contact and preliminary initial needs identification.
Use of SCTT tools: The SCTT must be used when making an outward referral to another organisation. SCTT tools can be used for client registration and the identification of needs, risks/alerts at intake.

1.2.2 Living at Home Assessment

This brief description of a Living at Home Assessment as the funded activity demonstrates how it fits into the client pathway. The policy is described fully in Part 2.

The **purpose** of a Living at Home Assessment is to gain a broad understanding of the type and range of client and carer's needs for community based services and support. A Living at Home Assessment is a broad assessment of need, *not* limited to a need for the service that the assessing organisation provides or to HACC funded services. A Living at Home Assessment includes Service-specific assessment(s) for service provided by the assessing organisation, risk management and an occupational health and safety assessment (OHS).

Who does this? HACC Assessment Services, that is, those organisations funded to deliver Living at Home Assessments**.**
Assessment mode? Face-to-face assessment, where possible in the client's home.
When? Directly following initial contact or within an agreed time frame following initial receipt of a HACC service.
Service Coordination Element: Initial Needs Identification and Assessment.

Key Outcomes:
A written care plan including:
- service-specific care plan(s) for HACC service provided by the assessing organisation and
- a referral action plan for referrals to a range of other needed services (as necessary)
- information on services or activities including health promotion/social activities that the client chooses to follow up themselves.

1.2.3 Service-specific assessment

The purpose of a service-specific assessment (for example, for Domestic Assistance, a Planned Activity Group or Nursing) is to identify specific service requirements and create a service- specific care plan to meet a client's assessed need whilst also taking into account occupational health and safety. In the case of nursing or allied health, this is a clinical assessment.

Who does this? All HACC organisations, including HACC Assessment staff, service coordinators, nurses and allied health practitioners.
When? Following initial contact or as part of a Living at Home Assessment. Some clients will receive a service-specific assessment without first having a Living at Home Assessment due to the urgency of need for the service or because the service requirement may only be short term. In both cases, the service provider should consider a referral to an Assessment Service for a Living at Home Assessment if the client is identified as having a broader set of unmet needs that may require an ongoing service response from the HACC program.
Assessment Mode? This is a face-to-face assessment in the client's home or a centre based assessment in the case of some allied health services or services such as Planned Activity Groups.
Service Coordination element: Service-specific assessment

Key outcomes:
- A written individualised service-specific care plan which is developed with the client (and carer) and a copy left with the client. The plan details the exact nature of the care provided, when it will be delivered and the fee structure (see below)
- Incorporation of occupational health and safety assessment issues.

1.2.4 Fees Assessment

All clients are required to be informed of the HACC fees policy for HACC services at the time of assessment. Fees can only be determined after consideration of both clients' income and factors which affect clients' ability to pay the fee. Fees are not charged for all services or in all cases. Fees assessment must occur in accordance with the HACC Fees policy. (See HACC Program web site www.health.vic.gov.au/hacc for the most recent Fees Policy update.)

Part 2   Assessment as a HACC funded activity

2.1   Assessment Principles

The principles below are a summary statement of the approach to a Living at Home Assessment as a HACC funded activity. The principles are designed to support clients and their care relationships as well as clients who do not have a carer. The principles are designed to support the Assessment role in targeting and demand management within the HACC Program.[2] As such these principles are relevant to all organisations in their approach to assessment and service delivery in the HACC Program.

Client centred

- Clients are treated with respect and dignity
- Clients receive a timely response: the right assessment, in the right place, at the right time
- Assessment approach is empowering and builds relationships over time
- Approach is client driven, culturally sensitive, flexible and takes a problem solving approach
- Communication with clients during the assessment process is in the client's preferred language utilizing a language service or bilingual assessment staff.
- Clients are well informed of their role and rights in the assessment process, most importantly, their right to determine their own needs and be actively involved in decision making processes.
- Respect for client's right to privacy should be maintained by all staff involved in collecting and storing client information.
- Where there is a carer present, assessment focuses on the care relationship rather than the individual in isolation.

Carer focussed

- Carers are treated with respect and dignity.
- Carers receive a timely response: the right assessment, in the right place, at the right time.
- Carer assessment is empowering and builds relationships with carers over time.
- Approach is individualised, flexible and culturally sensitive.
- Carers are well informed of their role and rights in the assessment process for the care recipient and their right to an Assessment of their own needs. Most important is their right to be involved in the assessment and decision making process where appropriate.
- Respect for carer's right to privacy with respect to the collection and storage of carer information.

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[2] See also Section 5 of the Victorian HACC Program Manual for the HACC Program's Statement of Rights and Responsibilities.

Promote independence

- Assessments build on strengths and abilities and improves the client's quality of life and social participation as well as functional independence.
- Clients and carers are assisted to continue living independently at home through improved capacity, therefore minimizing the need for assistance from formal services for as long as possible.
- The Assessment approach advocates and provides information about local prevention and health promotion activities, social and recreational activities.

A partnership approach

- Partnerships, alliances and inter-agency protocols ensure that the assessment process is coordinated around client and carer need, drawing on specific expertise as required.
- Alliances are developed between HACC Assessment Services and other relevant organisations within a defined geographic area preferably the PCP catchment.
- Alliances build trust between organisations, which results in reduced duplication and more timely completion and coordination of assessment, care planning and service delivery.

Care planning and service delivery

- A Living at Home Assessment leads to a care plan which includes service-specific care plans and a referral action plan, and which is individualized and goal oriented.
- Care planning is individualized around supporting the care relationship where relevant.

System focussed

- Assessment and care planning processes take account of demands on the organisation's resources as well as demands on the community care system as a whole. This leads to appropriate targeting of resources and consistent decision making about eligibility, resource allocation and priority of access.
- Assessment processes manage client and family expectations, assisting them to transition to higher levels of care such as packaged care or residential care when the required service response can no longer be met from the HACC Program.

2.2 HACC Assessment Service roles

2.2.1 Client Assessment

HACC Assessment Services are funded to provide a Living at Home Assessment as a funded activity for HACC clients. This activity will usually be carried out in the client's home and incorporates:

- a broadly based, holistic assessment of client and carer need which focuses on opportunities for improving functional capacity and participation in social and community activities; including risk management and identification of occupational health and safety issues
- assessing priority of need for services provided by the assessing organisation
- service-specific assessment and care plans, including identification of occupational health and safety issues for services provided by the assessing organisation
- a care plan which includes service-specific care plan(s) for services provided by the assessing organisation and a referral action plan for referral to other organisations
- implementation of the service-specific care plan(s) and the referral action plan.

HACC Assessment Services will be required to develop Alliances with local key organisations that are involved in client assessment such as HACC Assessment Services, ACAS and allied health services. This will ensure a coordinated and timely response to client need.

2.2.2 Client Care Coordination

All HACC Assessment Services will play a role in client care coordination. Care coordination describes activities undertaken following a Living at Home Assessment for a subgroup of clients with complex needs and circumstances. Clients needing care coordination include clients receiving services from multiple organisations who are not receiving case management as part of a package of care..

Client Care coordination for this client sub-group is an extension of the assessment, care planning and care plan implementation process where there is multi-agency involvement.

Client Care Coordination may include a range of tasks such as facilitating inter-agency care planning due to multiple agency involvement in service delivery; facilitating development and reviews of the service coordination plan; more frequent monitoring and review of the service-specific care plans; or assistance with accessing services from a range of program areas outside the HACC Program.

For effective inter-agency care planning, written protocols and processes will be developed with HACC Assessment Services and other relevant organisations for nominating which organisation will provide the key worker role. The key worker role ensures that people with multiple agency involvement have a single point of contact in the service network. See Section 2.3.3 Care Planning for more detailed information.

Hours of Care Coordination reported in the HACC MDS does not include administrative work (for example, drawing up rosters, processing accounts, or completing time sheets), personnel management, or attendance at staff meetings or training programs.

Care coordination and case management are distinct activities on the same continuum. Client care coordination can be regarded as a less intensive form of case management. Case management includes the roles and tasks described above for care coordination as well as arranging additional services needed by the client by means of sub-contracting, purchase of services, or maintenance of effort agreements between organisations; organising case conferences and actively monitoring care plans for changes in client or carer circumstances (see the HACC Program National MDS User Guide, Victorian Modification November 2005 pp 65-66).

2.2.3 Building alliances and service links

Alliances

HACC Assessment Services are required to build Alliances with key organisations that contribute to client assessment including HACC Assessment Services; organisations providing Supported Access; allied health services; and ACAS.
The purpose of the Alliance is to:

- promote a coordinated and streamlined approach to client assessment
- promote a joint understanding of priority of access criteria for assessment for service and agreement about timeliness of response
- promote a better understanding of assessment processes and enhance capacity to share assessment information
- embed an active service model approach into assessment practice; for example, shared orientation and training programs; identifying local assessor skill mix across the assessment services; promoting the use of secondary consultations; enhancing planning and service development.
- develop lead agency and key worker protocols for clients with complex needs and multi-agency involvement needing inter-agency care planning.

The formation of these Alliances should be developed within a defined geographic catchment, preferably the Primary Care Partnership catchment and will build on inter-agency partnerships already developed as part of PCP membership.

Memorandum of Understandings which document protocols and agreements for inter-agency business related to Assessment, Care planning, Client Care Coordination and Supported Access will be developed as state wide protocols. These statewide protocols will form the basis of local agreements.

This work will build on the Victorian Service Coordination Practice Manual.

Links to Allied Health providers

One of the most important service links for HACC Assessment Services is the link with allied health providers. In 2006-07 the HACC Program has grown its investment in allied health in order to increase the capacity of allied health providers to respond to the needs of HACC clients in a timely manner.

Allied health and nursing providers treating people in the HACC target group develop service-specific care plans for their own clinical interventions. These care plans contribute important clinical information to the development of overall care plans by HACC Assessment Services, assisting in maximising independence and functional capacity.

HACC Assessment Services and allied health providers will need to develop collaborative arrangements and a two way information sharing to ensure that the allied health intervention occurs in a timely manner and the information derived from this clinical assessment and intervention contributes to the person's overall care planning and service delivery goals.

HACC Assessment Services are required to build close working relationships and develop written protocols and agreements with allied health providers that clearly establish a joint understanding of priority of access criteria and timeliness of response. This is particularly important where an assessment for aids and equipment is required prior to the delivery of home based services such as personal care.

Other Service Links

Primary Care Partnerships are the key mechanism for building service links and developing shared protocols and processes. Organisational links can include protocol development, participation in network meetings (formal/informal), secondments, rotations through local organisations and shared training to enhance understanding of program/agency roles and responsibilities.

The new Victorian Service Coordination Practice Manual provides a statewide model and practice standards that will assist in achieving consistency in the implementation of service coordination.

Assessment Services are required to develop local protocols with a range of service providers. The protocols will articulate respective roles and responsibilities for assessment, care planning, care coordination, sharing of client information, and referral processes with specific service providers. Key organisational links would include but are not limited to:

- all local HACC service providers
- Aged Care Assessment Services (Section 2.7)
- Aids and Equipment programs
- Carer services
- Community Health Services, including
  - Allied health (as above)
  - Early Intervention in Chronic Disease Management
- Disability Services
- General Medical Practitioners
- HARP CDM and all sub-acute and ambulatory services
- CACPS, EACH and EACH Dementia programs
- Mental Health services including aged psychiatry services.

2.3 Living at Home Assessment

2.3.1 Role and purpose

The **purpose** of a Living at Home Assessment is to gain a broad understanding of the type and range of client and carer's needs for community based services in the context of the person's current living environment in the community. A Living at Home Assessment is a broad, holistic assessment of need, *not* limited to a need for the service that the assessing organisation provides or to HACC services alone.

Key components of a Living at Home Assessment are:
- Understanding the person's and carer's needs in their own right and in their usual environment, as opposed to interpreting their needs only in relation to the responses that can be provided by the assessing organisation.
- Building on the client's strengths and capacities.
- Identifying opportunities for maximising functional capacity, prevention and early intervention in meeting individual support needs in their usual environment, thus reducing the risk of the person's loss of independence.
- Maximizing opportunities for clients to participate in social and community activities.
- Coordination of the assessment process with other organisations in order to access specific expertise as required.
- Providing information and advice about service options available to meet needs.
- Developing and implementing care plans (including making referrals to a wide range of organisations and services) based on needs identified.
- Contributing to a reduction in the occupational health and safety risks for paid staff, volunteers, clients and carers.

Organisations' policies must clearly define the assessor's role in providing a Living at Home Assessment in order to accurately account for this activity from a funding and reporting perspective. Processes, policies and procedures are to include:
- Operational policy and procedure manuals and position descriptions that clearly define the assessor's role in assessment, care planning, risk management and identification of OHS issues.
- Position descriptions that clearly distinguish assessment tasks from other responsibilities such as supervision of community care workers or tasks such as rostering and payments.
- Organisational responsibility for assessment worker orientation, supervision and for supporting access to training and professional development.

2.3.2 Assessment practices

Assessment and the Active Service Model

The aim of the active service model is to increase the Victorian HACC Program's effectiveness in maximising client independence through person centred and capacity building approaches to service delivery.

Through the delivery of Living at Home Assessments, HACC Assessment Services will be key agents in the implementation of Victoria's active service model approach. Whilst the active service model approach is in its early stages of development, some of the key ingredients are described in this Framework. These are:

- Consolidating the funding of Living at Home Assessment to those organisations with the resources and professional expertise to carry out and develop this role.
- An assessment approach that builds on client and carers' strengths and abilities with a focus on improving their quality of life and social participation as well as functional capacity.
- Assessment and care planning focus on opportunities for maximising functional capacity (improving or maintaining), improved self management capacity and minimizing the need for formal services as long as possible.

Some of the expected outcomes from an active service model approach will be:

- Increased referral to a range of allied health professionals in order to improve capacity to undertake domestic and personal care activities. This will involve active collaboration with HACC funded allied health services in order to gain timely access to these clinical interventions to maximize functional gain.

- Increased use of aids, equipment and new products/technologies as an addition and/or alternative to HACC services for low level needs clients.

- Incorporate *Well for Life* principles into assessment and care planning practice; that is, understanding and promoting the inter-relationship and benefits of good nutrition, physical activity and social participation to independence and healthy ageing.

- Increased referrals to GPs and specialist services such as rehabilitation and ambulatory services to investigate clinical/medical issues that may be identified at assessment as impacting on functioning.

- Increased referrals to Early intervention Chronic Disease Management services to enable improved self management for clients with chronic and complex needs.

- Advocacy for client and carer involvement in local prevention, health promotion activities, social and recreational activities.

Assessment tools

HACC Assessment Services are required to use a common standardised assessment tool when carrying out a Living at Home Assessment.

The Commonwealth government together with State and Territory governments is in the process of finalising a national screening tool that can be used across a range of community care services at intake. This tool, known as the Australian Community Care Needs Assessment (ACCNA) was developed by Professor Kathy Eagar from the Centre for Health Service Development at the University of Wollongong. The ACCNA is similar in scope and design to Victoria's Service Coordination Tool Templates.

The ACCNA will represent a national minimum set of data items for initial needs identification at the first point of intake. Once the ACCNA is finalised, a Victorian *assessment* tool will be developed in Victoria which builds on the ACCNA and the SCTT, and meets the policy requirements for the provision of a Living at Home Assessment. This work will be carried out in 2007-2008.

Use of a common assessment tool does not mean a one size fits all approach but should be used as appropriate to client circumstances. The tool will have mandatory fields and domains required for every client, and then optional domains dependent on client type and level of need.

Use of the assessment tool will result in a Priority of Access rating (POA) which will then guide decision making about the relative priority of need for services. The POA rating is not designed to replace professional judgement but to provide a more consistent approach within and across organisations.

Organisations must have consistent processes and procedures for priority setting for access to services provided by the Assessment Service. Clients must be informed of the likely wait for a service and provided with options for alternative sources of care if required.

Whilst a common assessment and POA rating provides consistency in practice, assessor expertise and professional judgement will always guide the use of the tool for any one client. A Living at Home Assessment is a process of relationship building which occurs over time as client and carer needs change, become more evident or the client or carer become more receptive to the intervention of formal services. The tool is only as good as the skills and expertise of the person using it.

Fields/domains to be assessed for all clients are likely to include:
- domestic activities of daily living
- personal care needs screen
- nutritional risk screen
- carer risk screen and need for respite
- screening for aids and equipment
- capacity for functional improvement
- identification of health promotion/prevention opportunities particularly in social participation, physical activity and falls prevention.

Managing occupational health and safety issues

HACC funded organisations are required to adhere to occupational health and safety legislation and regulations in order to provide a safe work environment for both paid staff and volunteers. Achieving this requires an active approach by management, paid staff and volunteers, especially since HACC services by their very nature present challenges to the effective management of occupational health and safety. There are three publications that are available to assist organisations with the management of OHS issues.

Working Safely in Community Services - this document presents a broad overview of OHS requirements and employer and contractor responsibilities and explains the systematic approach to addressing OHS issues.

Victorian Home Care Industry Occupational Health and Safety Guide October 2005 - this document was jointly produced by DHS and Worksafe Victoria.
The guide is required to be followed for home care/domestic assistance, home maintenance, delivered meals (Meals on Wheels), respite, and personal care services funded by the HACC Program in Victoria. The guide contains a very good overview of the current occupational health and safety legislation in Victoria and provides practical advice about how to address frequently encountered OHS risks and issues in the services listed above. The guide covers a large part of the HACC

Program's funded services and much of the information and suggested approaches are also relevant to all other HACC services. This document can be downloaded from the HACC website www.health.vic.gov.au/hacc/projects

Working Safely in Visiting Health Services - this guide covers health services staff including nurses and allied health professionals who home visit and/or work in community venues.

The latter two documents link the process of identifying and addressing OHS issues to the referral process, the assessment process and the development of the client's care plan. This is the appropriate way to operationalise a systematic approach to addressing OHS issues in HACC services along with paid staff and volunteer management and training. Part 2 of the *Victorian Home Care Industry Occupational Health and Safety Guide October 2005* gives the more detailed explanation of these interconnected processes. All three documents can be downloaded from the Worksafe Victoria website www.worksafe.vic.gov.au

The assessment of client and carer needs helps define the type of service required and the risks that may be associated with the service. Good planning to meet client and carer needs also includes planning to ensure that occupational health and safety issues have been considered. Organisations providing HACC services need to work closely with clients and carers and those involved with them to ensure that OHS issues are effectively managed.

2.3.3 Care planning

The overall goal of care planning is to maximise and enhance the client's independence and quality of life. Care planning recognises and supports the client's strengths and abilities, as well as addressing their needs. Care planning occurs in consultation with the client, and with their carers (who can also be clients), family or friends who may have been asked to be an advocate for them or in some cases a guardian if one has been appointed to make decisions on the client's behalf.

Care planning needs to address the needs of both the carer and the person needing care. Care planning needs to be responsive to the cultural requirements of the client and maintain cultural sensitivity.

The care planning process may include:
- Putting together a range of services in a manner that supports informal care arrangements such as family support, and the support of friends and/or neighbours.
- Devising alternative strategies to meet identified client needs when some services are not available, either for the individual or in their local area.
- Negotiating and documenting roles and responsibilities, and with the client's consent, distributing copies of the care plan to the client, carers and service providers involved in the care of the client. If the client has an advocate then they should also receive a copy of the Care Plan. (See below for Inter-agency care planning).

The Care Plan resulting from a Living at Home Assessment encompasses the following:
- Service-specific care plan(s)

This plan details the type and level of each specific service to be delivered by the Assessment Service such as domestic assistance, respite or nursing care. The plan

would include consideration of the OHS assessment as noted above and review dates.

- A Referral Action Plan[3]

The Referral Action Plan translates information collected about the broad range of client needs into agreed referral actions for services not provided by the Assessment Service. The Summary and Referral Template for the SCTT tools contain a template for documenting referral actions.

- Information provision

Information on services or activities that the client chooses to follow up themselves. This may include health promotion/social or active living opportunities in the local area, self management activities/strategies, self-referrals to other services.

Inter-agency care planning

Where there is multi-agency involvement in delivering services to a client, inter-agency care planning will need to occur in order to coordinate the client's care. Organisations involved will need to identify a key worker who will take a lead agency role in the development and review of the Service Coordination Plan (using the SCTT tool template) and be a central communication point between the client/carer and relevant service providers. The objective of the Service Coordination Plan includes:

- providing clarity of roles and communication
- maximising consumer and care involvement in the care planning processes and decisions
- enhancing the sharing and updating of relevant of information between organisations[4].

The decision to appoint a key worker should be made carefully in the light of limited resources for this activity and client need for this service. In many cases clients and carers are capable of, and have a preference for, coordinating their own services. Suggested triggers for needing a key worker are multi-agency involvement in the care plan, having complex needs or circumstances and not receiving a case management service.

GP inclusion in inter-agency care planing is an important issue to consider. For clients with chronic or complex needs consideration should be given to the client's need for a GP Management Plan or Team Care Arrangement. Team Care Arrangements initiated by GPs incur a rebate under the new Medicare chronic disease management items[5].

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[3] The term 'Referral action plan' is used here to reflect the terminology used in the Service Coordination Tool Templates (SCTT) *Summary and Referral* tool.

[4] These objectives for use of the Service Coordination Plan are drawn from the North West Cross Alliance PCPs: Inter-agency Care Planning Protocol Pilot Project Report Nov 2005. This Report is a valuable reference for the development of protocols for care coordination where there is multi-agency involvement.

5 On 1 July 2005 new Medicare Item Numbers for Chronic Disease Management (CDM) were introduced to make it easier for General Practice to manage the health care of patients with chronic medical conditions, including patients requiring multidisciplinary care. These item numbers replace the Enhanced Primary Care (EPC) items for multidisciplinary care planning services which are to be phased out by 1 November 2005. The new item numbers are a result of the Red Tape Taskforce Review and were developed in consultation with GPs. The new items support GPs in proactively developing the best care plans for their patients. They encourage GPs to work in teams with other healthcare professionals where appropriate as patients with chronic conditions often have complex care needs that require a coordinated, team-based approach. The item numbers also increase the assistance that Practice Nurses and others health professionals can provide to GPs. (See Australian Division of General Practice website www.adgp.com.au).

Intra-agency care planning: Sometimes intra-agency care planning is required when clients are receiving services from multiple parts of the one organisation. The Victorian Service Coordination Practice Manual contains more details on this type of care planning.

Future work: As care planning is a complex area of practice, more work will be carried out by DHS and PCP member organisations over the next few years to clarify and refine areas of practice. Learnings from this work will be reflected in future updates of the Victorian Service Coordination Manual.

Referral practices

All HACC Assessment Services are required to have established referral processes for referring clients and carers, with consent, to needed services. Referrals must be made on the state-wide Service Coordination tool templates (SCTT).

When making a referral, HACC Assessment Services are required, as a minimum, to complete the following tools:

- Client Information
- Summary and Referral (2 pages)
- Living and Caring Arrangements
- Supplementary form: Functional Assessment Summary (2 pages)
- Client consent *(this form is not sent with the referral).*

Use of the SCTT Supplementary Form - Functional Assessment Summary:

- In order to reduce duplication of assessment, this form should be used when referring to other organisations that have a role in assessing client level of functioning: for example, local council, nursing organisations, ACAS, HARP CDM, Linkages, Community Health and Disability organisations.
- Other organisations should be sent this form as agreed by local protocols.

HACC Assessment Services must work towards implementation of e-referral in order to streamline referral processes.

2.3.4 Monitoring, Review and Reassessment

Monitoring: Management of the client's service-specific care plans involves formal and informal monitoring of the client and carer's health and well being, and how effectively services are meeting their needs including how OHS issues are being effectively managed. This is the responsibility of all HACC organisations.

Informal monitoring occurs when the community care worker, volunteer or carer reports concerns about the client's health or well being, or concerns regarding the services being delivered.

Review: Regular review is a key element to successful service delivery and achieving the objectives of service-specific care plans. All HACC organisations are required to systematically review their clients to ensure that the service-specific care plan is meeting the assessed need.

Where the organisation has waiting lists, regular client reviews must be carried out in order to reprioritise client need for service and ensure equitable access based on an ongoing appraisal of prioritised need.

Reassessment: Reassessment is an activity carried out by a HACC Assessment Service. A Living at Home reassessment is usually carried out when client or carer circumstances change significantly requiring a complete reappraisal of the client and carer needs. This could be prompted by:

- Changes in client/carer health, or a review of risk management/OHS need, or
- A pre-determined time linked to a review of the service-specific care plan.

Reassessments will require the use of the common assessment tool, and a face-to-face assessment including updating of the HACC MDS functional status data items.

Where there are multiple organisations involved in delivering services to one client, the lead Assessment Service should be nominated for the purposes of reassessment.

2.4   HACC Program target group and special needs groups

2.4.1 Assessment Service requirements

All HACC Assessment Services must develop the capacity to respond to the diversity in the HACC client group. Where specific expertise is required but not located within the HACC Assessment Service, organisations must develop formal protocols in order to coordinate the assessment and care planning process around individual client need.

For **CALD clients**, HACC Assessment Services are required to implement:
- Processes and protocols for ensuring equitable access to assessment by CALD groups, for example, intake and eligibility testing processes are culturally sensitive
- Processes and protocols to support the use of interpreters as required
- Appropriate strategies, policies and processes for providing culturally sensitive assessments to meet local needs (beyond the need for an interpreter). This may include but not be limited to:
    - recruitment of bilingual and bicultural assessment staff
    - inclusion of cultural competence skills training for assessment staff in order to meet the needs of particular communities
    - other elements of culturally appropriate practice demonstrated through CEGS.

For **Aboriginal clients**, mainstream HACC Assessment Services are required to implement:
- Appropriate strategies, policies and processes to support culturally sensitive assessment. This may include:
    - employing an Aboriginal assessment or liaison officer
    - developing processes and processes with Aboriginal organisations funded for Assessment in order to establish agreed practices for achieving culturally sensitive assessment, care planning and care coordination for Aboriginal clients. This will include identifying assessment practices that build trust and confidence in mainstream services.

- Good working relationships with Aboriginal organisations in order to encourage referrals to occur both ways between Aboriginal organisations and mainstream HACC Assessment Services.

2.4.2 Current Initiatives for CALD and Aboriginal clients

Current initiatives in the HACC Program to improve access and equity for CALD and Aboriginal clients are described below.

Culturally Equitable Gateways Strategy

The Culturally Equitable Gateways Strategy (CEGS) aimed to enhance the capacity of local councils to better meet the needs of CALD clients by focusing on access issues, culturally sensitive assessment and enhancing relationships between ethno-specific and multicultural organisations, and local councils. CEGS was launched in December 2003 to allow as much time as possible to establish and develop partnerships and improve service-delivery practice. CEGS funding was made available to a number of local councils, ethno-specific organisations and Migrant Resource Centres. The MAV and the Ethnic Communities' Council of Victoria (ECCV) were also funded as part of the CEGS Strategy.

From December 31 2007 the CEGS funding will cease. Future work on maintaining and improving CALD access to services will be conducted within the context of the HACC Assessment Framework. This includes the policy requirement that HACC Assessment Services must implement appropriate strategies for delivering culturally sensitive assessments and the development of 'Supported Access' as a new HACC funded activity.

Strengthening HACC in Aboriginal communities

In 2005, DHS engaged consultants to develop a resource to assist DHS and Aboriginal organisations to determine the most appropriate option(s) for funding and delivery of HACC services to Aboriginal communities.

The *Aboriginal and Torres Strait Islander HACC Funding Model Project Report May 2006* findings highlight the need for a more coordinated approach to HACC funding and service models in the areas of Assessment/Client Care Coordination activities, planning for the longer term, and enhancing the relationships between HACC funded Aboriginal organisations and the broader service system.

Following consultation with DHS Regions, Aboriginal stakeholders including Victorian Indigenous Committee for Aged Care and Disability (VICACD), HACC Aboriginal Networks, and organisations that receive HACC Aboriginal funding, DHS is developing a project to progress the findings.

The project will be aligned to the Assessment Framework and any development in the role of Aboriginal organisations will be considered in consultation with key stakeholders with the aim of providing the most appropriate HACC services to Aboriginal communities.

Assessment, care coordination and supporting access to services

The role of Aboriginal organisations in providing assessment, care coordination and supporting clients to access to the broader service system was clearly communicated through the Strategic Direction in Assessment Framework consultation process, and in the Aboriginal and Torres Strait Islander HACC Funding Model Project.

A key issue is the level of complexity of Aboriginal clients and their family situation which leads to assessment, ongoing care coordination and support roles that, in many cases, are more time consuming than for non-Aboriginal clients as the service response crosses program boundaries. For Aboriginal clients and carers, this means that:

- Assessment and care coordination are closely linked in practice and should be delivered, where possible, by the same person.
- The length and intensity of assistance that the family needs may result in a need for short term case management, rather than care coordination.
- There is a need to enhance the existing skill level and expertise of Aboriginal staff in the assessment and client care coordination function.
- Partnerships with mainstream HACC Assessment Services need to be built to ensure that Aboriginal clients have equitable access to Living at Home Assessments and are provided with sufficient support to enable them to access services recommended as part of the assessment and care planning process.

Use of a common assessment tool by Aboriginal organisations

In 2004 VICACD initiated a process with Aboriginal HACC organisations to develop an assessment tool (called the Aboriginal and Torres Strait Islander CIARR) for use by Aboriginal assessment staff. A review process for this tool would offer the opportunity for refinement of the assessment questions, and ensure that the data collected in the tool met the requirements of the new SCTT tools and the new HACC MDS functional status data items, as well as mapping to data elements in the ACCNA. Any review process for this tool and the timing of a review would occur in consultation with VICACD.

2.4.3 Supported Access

Ethno-specific services, multicultural organisations and Aboriginal organisations play a very important role linking their communities into the service system, assisting clients to gain access to needed services and supporting them, as required, through the assessment, care planning and service implementation processes.

In recognition of this role and the fact that most ethno-specific and multicultural organisations are mainly funded for provision of Planned Activity Groups, Respite and Volunteer Coordination (that is, not Assessment or home-based services) the *Strategic Directions* report recommended that a separate activity from Assessment be created. This enables CALD organisations and Aboriginal organisations that will not have the capacity to be designated as Assessment Services to be funded for their role in supporting client access to services.

The role, activities and criteria for funding organisations to provide Supported Access still needs to be determined in consultation with the sector, together with the development of a funding model. The role and function of current Aboriginal Liaison Officer positions, and Access and Equity workers in facilitating access to HACC services also needs be taken into account. The Framework will be updated once there is an agreed policy on this activity.

2.4.4 Younger people with disabilities

Particular attention was drawn in the *Strategic Directions* report and consultation process to the complexities of assessment of families with children with disabilities when a number of different organisations are providing needed support. There is a common view that children under 18 and their carers have less access to

appropriate assessment than is required on the basis of relative need. The *Strategic Directions* report identified necessary additional skills and expertise required for assessing younger people with disabilities as:

- identification of a diverse range of needs arising from physical and behavioural causes
- development of appropriate responses by way of personal care and/or respite care
- addressing OHS issues for community care workers, and
- dealing with complex medical issues which may pose critical issues for assessment and care planning.

Where joint assessments are required, HACC Assessment Services should develop formal protocols for assessment and care planning processes with specialist organisations which might include:

- use of specialist assessment tools
- involvement of family members and other organisations providing service to families
- need for inter-agency care planning.

2.4.5 People with a psychiatric disability

People with a mental illness may be linked to a range of health and community services including community health centres, GPs, private psychiatrists, psychologists and the public mental health system. HACC services can be an important adjunct to the specialist services, with the potential to significantly improve quality of life and assist with self-management and recovery.

Functional limitations of people with a mental illness are likely to be primarily related to impaired motivation, cognition, organisational skills or judgement, and these may fluctuate over time. Serious mental illness often manifests in late teens or early adulthood.

HACC assessment staff need to understand how a mental illness impacts on the person's functional capacity and how HACC services can best meet their needs. With the client's consent, receiving relevant information from mental health practitioners, and in some cases joint assessment, care planning and ongoing support is important for effective provision of services. This is particularly important for clients receiving psycho-social rehabilitation.

For clients with a psychiatric disability HACC Assessment Services are required to develop inter-agency agreements with mental health agencies in order to access additional specialist assessment expertise when required. Agreements may include the extent and type of information provided on referral; joint assessments; case conferencing and care planning.

Further work required: Assessment processes for children with disabilities, and people with psychiatric disabilities needs considerable cross program discussion with DHS program areas to ensure the relevant expertise for assessment of these client groups can be accessed when needed. The Framework will be updated once these discussions and agreed policy directions have been determined.

2.5   Assessment for personal care

The introduction of the HACC Assessment Framework will **not** make any immediate change to the current Victorian HACC Program Personal Care Policy on the delivery of assessment for personal care, or on the definitions and requirement for the delivery of personal care to clients. For information on personal care as a HACC funded activity see Section 7.6 of the Victorian HACC Program Manual.

Current Policy:
- Section 7.6.12 states that *assessment* for a client's need for personal care is to be undertaken by staff with adequate skills and training.
- Where the client's health may be unstable and/or where the client has complex needs, the personal care assessment will be undertaken by a Registered Nurse Division 1, or other relevant health professional.
- In other cases where the client does not have unstable or complex health needs, personal care assessment is undertaken by HACC Assessment staff as part of the overall assessment process.

Issues

Where a client has unstable or complex needs, the policy gives clear assessment requirements which are followed in the field. However, with regard to clients with **stable health needs** issues have been raised by the sector in the light of the development of the HACC Assessment Framework and the HACC Active Service Model approach.

Concern has been expressed that assessors who are not clinically trained may not have the experience and background in health management to identify and manage risk in the delivery of personal care. This means that the assessment and the resulting service-specific care plans may limit opportunities for client independence through lack of assessor confidence in client capacity for functional improvement and an overriding concern for risk management. The resulting care plan may end up with more tasks being done for the client than is optimal from a capacity building approach.

Active Service Model
The Active Service model evidence base suggests that client motivation to maintain or improve their capacity to undertake personal care tasks independently is very high**.** Research from Silver Chain in Western Australia has shown positive results with short term clinical interventions which are goal oriented around regaining independency in this activity.

Currently some local councils are moving towards Division 1 nurses for **all** personal care assessments unless another health professional's assessment is also needed. In rural areas, it is common practice for district nursing organisations to carry out all personal care assessments. In some cases local council employs registered nurses, or contracts a nursing organisation to undertake all the personal care assessments.

Further work required
The development of the HACC Assessment Framework and the Active Service Model initiative presents an opportunity to review the present policy, gather evidence about the current situation, and then consider whether there is a case for change.

2.6   Carer assessment: supporting the care relationship

Carers are acknowledged as critical to enabling people with care needs to remain at home. Carers are also identified as a specific needs group requiring access to support services and information in their own right. A key issue for a Living at Home Assessment is that it assists in meeting the needs and rights of both carers and those being provided with care, in the context of the *care relationship* rather than individuals in isolation.

Living at Home Assessments must be client and carer focussed, and meet the needs and rights of both carers and those being provided with care, in the context of the *care relationship*.

This approach is described in DHS policy frameworks *Recognising and supporting care relationships (DHS, August 2006)* and *'Recognising and supporting care relationships for older Victorians: A Department of Human Services policy framework (DHS, July 2006)* [6]. These policies recognise that:

- Care relationships are multidimensional, occur in a dynamic context, and can change over time.
- Care relationships are diverse and depend on factors including the age, gender and health of both the carer and care recipient, cultural expectations, and the resources available to the family unit or care network.

A Living at Home Assessment should incorporate the following principles when assessing clients and carers [7]:

- Carers are treated with respect and dignity.
- Carers get the right assessment, in the right place, at the right time.
- Carer assessment is empowering and builds relationships with carers over time.
- Approach is individualised, flexible and culturally sensitive.
- Carers are well informed of their role and rights in the assessment process for the care recipient, and their right to a Living at Home Assessment. Most important is their right to be involved in the assessment and decision making process where appropriate.

The need for greater consistency and training in carer assessment was identified in the *Strategic Directions in Assessment* report.

As part of the broader work being undertaken to develop standardised eligibility and intake assessment across community care, the Commonwealth government has engaged Professor Kathy Eagar from the Centre for Health Service Development at the University of Wollongong, to develop a Carer Eligibility and Needs Assessment tool (CENA). The ACCNA has been designed to link to the carer eligibility and needs assessment tool (CENA) by providing carer screening questions that will trigger the need for a CENA.

Further work
Victoria will finalise its policy on the use of CENA and its links to the ACCNA as part of the HACC assessment tool development and trialling.

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[6] The documents can be downloaded at www.health.vic.gov.au/agedcare

[7] See also Section 5 of the Victorian HACC Program Manual for the HACC Program's Statement of Rights and Responsibilities

2.7 Links to the Aged Care Assessment Service (ACAS)

As frail older clients' needs increase or become more complex, HACC organisations refer to ACAS for a comprehensive assessment. At least half of ACAS clients assessed at home are receiving a HACC service at the time of assessment.

HACC Assessment Services are required to develop formal protocols that articulate assessment pathways for:

- existing HACC clients needing an ACAS assessment, and
- new HACC clients where the need for an ACAS assessment is identified at referral.

For existing HACC clients, protocols would articulate:
- circumstances/criteria under which HACC Assessment Services refer existing HACC clients to ACAS
- mechanisms for ACAS assessments to build on HACC Assessment Services' familiarity with the client, including their knowledge of client and carer need and level of functioning
- mechanisms for sharing assessment information between ACAS and HACC assessors when the person is recommended to continue receiving HACC services in the community
- mechanisms for inter-agency care planning, and effective communication about the assessment and care coordination roles and responsibilities whilst the client is on waiting lists for services such as CACP, EACH, or residential care.

For new HACC clients: Where an ACAS assessment results in the need for HACC services, protocols should ensure minimal duplication of effort by both assessment services and maximum benefit to the client eg. minimum wait times for HACC assessment and commencement of HACC services.

Part 3   Criteria for Designating Assessment Services

To be designated as a HACC Assessment Service, HACC organisations should meet the following minimum requirements with respect to their organisational, IM/IT and assessment capacity:

- The organisation is funded to deliver a range of HACC services including home-based HACC services.

- Assessment staff play a dedicated role in delivering Living at Home Assessments as described in this Framework, including the collection of MDSV2 functional status data, and that this role is clearly defined in operational policy and procedure manuals and position descriptions.

- The organisation agrees to use a common statewide HACC assessment tool that meets the requirements for a Living at Home Assessment.

- The organisation is currently meeting or is well progressed towards meeting the Victorian practice standards for IC, INI and Referral as detailed in the Victorian Service Coordination Practice Manual (Primary Care Partnerships, 2007).

- Staffing composition, qualifications and expertise will transition towards the following:

  - Assessment staff with relevant tertiary qualifications, such as nursing or social work. Transition includes considering options for current staff upgrading their qualifications, and dedicating future recruitment to employing staff with relevant tertiary qualifications.

  - Assessment staff with a mix of expertise creates a 'team' approach. The team would include staff from a range of expertise, backgrounds and qualifications as relevant to the local HACC target population.

- The organisation has the capacity to access health professionals and specific expertise as required, either through their own organization or through the development of formal protocols with other organisations. This would include but not be limited to:

  - Division 1 nurses or other health professionals for personal care assessment for individuals with complex and unstable health needs

  - allied health professionals including occupational therapists, physiotherapists and dieticians

  - cross cultural expertise to assist with assessment of CALD and Aboriginal clients

  - expertise required to assess younger people with disabilities, and people with a psychiatric disability

  - expertise to assess carer needs for 'at risk' carers.

- Operational infrastructure that has the capacity to provide:

  - a quality assurance program to meet the National HACC Standards

  - an appropriate structure, which provides for professional supervision, mentoring and peer support

  - ongoing opportunities for professional development and training in Living at Home Assessments

  - IT/IM systems that support efficient practices in data collection and data management during the Living at Home Assessment processes. Use of mobile computers is highly recommended

- IT/IM systems that are currently or will soon be enabled to send and receive e-referral using the SCTT tools
- IT/IM systems that will meet DHS standards for HL7 compliance in order to send and receive electronic referral messages.

- Agreement to operate within an Alliance of HACC Assessment Services and other relevant assessment organisations. The Alliance will facilitate the development of local agreements based on Statewide protocols for assessment, care planning, and supported access.

Part 4   Further Work

Funding model for Assessment

Assessment in the HACC Program is currently block funded. A new funding model for Assessment is being developed. This work will be carried out in 2007 in consultation with HACC Assessment Services.

Professional Development

Professional development is a shared responsibility between the HACC Program, employers, assessment staff, the higher education sector and the vocational education and training system.

The Strategic Directions in Assessment Report, December 2005 outlined issues regarding professional development and qualifications for HACC assessment staff and identified the need for a professional development strategy. It also suggested the establishment of a Working Group.

A HACC Assessment Professional Development Working Group was convened in November 2006 and aims to identify short, medium and long term needs and plan a professional development strategy in line with the requirements of the HACC Assessment Framework.

The Working Group includes DHS staff, peak bodies, members of the HACC Assessment Reference Group and HACC Regional Training Coordinators.
The Working Group will produce a draft professional development strategy statement in the second half of 2007 which will be the first stage in addressing professional development issues. Following consultation on the draft further work and next steps will then be determined.

Supported Access

'Supported Access' broadly describes the assistance provided to clients that have difficulty accessing the service system. Many CALD and ATSI clients require support through the initial access, assessment and service implementation processes for mainstream service provision. The role, function and funding for this activity and the relationship with Assessment Services will be explored through pilot projects in 2007-08. The role and function of current Aboriginal Liaison Officer positions and Access and Equity workers in facilitating access to HACC services will also be taken into account as part of this project.

Access Points

In Victoria the primary goal of Access Points is to improve navigation of the service system for frail older people, younger people with disabilities, their carers, families and friends and service providers. Two key pieces of work are currently underway to progress this goal:

      i. a Mapping Project, and
     ii. the development of 2 Demonstration Projects.

The objective of the Mapping Project is to provide a reasonable overview of the community care access pathways and infrastructure in Victoria by analysing existing data sources.

Two demonstration projects (one metropolitan and one rural) will be testing the proposed Victorian model for Access Points that is presently being developed by the Department of Human Services and the Department of Health and Ageing.

Development of a HACC Assessment Tool

The HACC Program will fund a project to review the national minimum data requirements contained in the ACCNA in the context of the Victorian HACC Assessment Framework and the requirements of a Living at Home Assessment. A statewide HACC Assessment tool will need to map to the ACCNA, the SCTT, the HACC MDS requirements and include priority of access criteria.

Timing of this work is dependent on the completion of the ACCNA project.

Personal care assessment

The HACC program will fund a personal care assessment project which will investigate current practice in personal care assessment and the case for changing or maintaining current policy. This work will occur in 2008-09.

The introduction of the Framework will **not** make any immediate change to the current HACC Program Personal Care Policy on the delivery of assessment for personal care or on the definitions and requirement for the delivery of personal care to clients. For information on Personal Care as a HACC funded activity see Section 7.6 of the Victorian HACC Program Manual.

Assessment of people with special needs

Assessment processes for children with disabilities, and people with psychiatric disabilities needs considerable cross program discussion with DHS program areas to ensure the relevant expertise for assessment of these client groups can be accessed when needed. This work will occur in 2008-2009.

Glossary of terms

Key worker: is the nominated person who works with the client/carer and other organisations to facilitate inter-agency care-planning and care coordination.[8]

Living at Home Assessment: Incorporates all the features of a broad, holistic needs-based assessment which occurs in the client's home. The care plan resulting from the Living at Home Assessment includes a referral action plan to both HACC and non-HACC funded services for needs that cannot be met by the assessing organisation. A Living at Home Assessment includes service-specific assessment and a service specific care plan(s) as needed, for the range of HACC services delivered by the assessing organisation.

Referral Action Plan
The Referral Action Plan translates information collected about the broad range of client needs into agreed referral actions for services not provided by the assessing organisation. The Summary and Referral Template for the SCTT tools contain a template for documenting referral actions.

Service Coordination Plan: A plan which documents issues/problems for a client, goals, actions that will be taken to achieve these goals, and identifies a key worker responsible for liaising between organisations. A Service Coordination Plan is only developed for clients with complex and/or multi-agency involvement.

Service-specific assessment: An assessment for a specific service type such as domestic assistance, delivered meals, nursing or allied health.

Service-specific care plan – a care plan for a specific service type eg domestic assistance, personal care or nursing.

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[8] Definition drawn from the North West Cross Alliance PCPs: Inter-agency Care Planning Protocol Pilot Project Report Nov 2005.

Appendix:

Submissions received on the Consultation Draft: September 2006

Local Councils

Municipal Association of Victoria (MAV)
Mornington Peninsula Shire
City of Monash
Shire of Casey
City of Manningham
Macedon Ranges Shire Council
Bass Coast Shire Council
Glenelg Shire Council
Baw Baw Shire Council
South Gippsland Shire Council
Greater Shepparton City Council
City of Darebin
City of Melbourne

Other organisations

Primary Health Branch, DHS
Victorian Healthcare Association
Latrobe Community Health Services
Manningham Community Health
Ovens and King Community Health
LINK Community Transport
Aged and Community Care Victoria
Ethnic Communities Council of Victoria
North West Migrant Resource Centre
Royal District Nursing Service (RDNS)
St Vincent's Home and Domiciliary team
Brotherhood of St Laurence
Royal Children's Hospital
Croatian Catholic Welfare Association
Jewish Care
Care Connect
Robyn Raine, Wodonga
St John of Kronstadt - Russian Welfare