PARTNERING AGREEMENT

FOR THE COLLABORATIVE PARTNERSHIP

BETWEEN

GRAMPIANS
AGED CARE ASSESSMENT SERVICE (ACAS)

AND

GRAMPIANS HACC ASSESSMENT SERVICES (HAS)

GRAMPIANS PYRENEES CATCHMENT

EFFECTIVE FEBRUARY 2013

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1. INTRODUCTION

This Partnering Agreement is to document the relationship between Aged Care Assessment Service and HACC Assessment Services (HAS) in the Grampians Region. This document is based on local agreements and written in reference to the Guidelines for streamlining pathways between ACAS and HACC assessment services in Victoria document[1].

The partnership is designed to be mutually beneficial for clients and services by:

- Clarifying pathways for referral and assessment
- Confirming the process for sharing information to reduce duplication in assessments

This Partnering Agreement is endorsed by the Grampians Region Aged Care Assessment Service, Ballarat Health Services and the four HACC Assessment Services Services resident within the Grampians Pyrenees catchment area:

Ararat Rural City Council	East Grampians Health Service
Northern Grampians Shire Council	Pyrenees Shire Council

1.1 Grampians Region Aged Care Assessment Service (ACAS)

There are 18 Aged Care Assessment Services (ACAS) across Victoria. The aim of the ACAS is to assess the care needs of frail older people and ensure the older people who belong to the following groups have equitable access to an ACAS

- Aboriginal and Torres Strait Islander People
- People of Culturally and linguistically diverse (CALD) backgrounds
- People living in rural and remote areas
- People who are financially disadvantaged or socially disadvantage
- Veterans, their spouses, widows and widowers
- People with Dementia
- People who are homeless or at risk of becoming homeless
- Forgotten Australians (includes people who have experience childhood in institutional care or an out of home care environment, or former child migrants. People in this group are also known as care leavers.

Grampians Region ACAS is centralised at Ballarat Health Services but has assessment staff in the following local government areas:

Ararat City Council	Ararat Rural City Council
Northern Grampians Shire Council	Stawell an St Arnaud
Yarriambiak	Minyip
Horsham Rural City Council	Horsham
Hindmarsh Shire Council	Nhill

1.2 Grampians Region HACC Assessment Services (HAS)

Each of the HAS in the Grampians Region are responsible for delivering Living at Home Assessments (LAHA). A LAHA is a person centred assessment, of the individual and their family or carer's needs, which leads to a client specific care plan and individualised service responses.

[1] Guidelines for streamlining pathways between ACAS and HACC assessment services in Victoria, Victorian Government Department of Health, December 2010

HACC assessment services have an obligation to assess people's needs independently of the services their agencies deliver. A LAHA focuses on:

- Providing choices relating to individual strengths and interests
- Encouraging people to do more for themselves by maintaining and/or regaining skills and capacities wherever possible
- Recognising if a clients declining abilities and increasing need for services requires transitioning from the HACC Program to a more suitable care option such as case management.

2. SCOPE OF THE PARTNERING AGREEMENT

The key mutual benefit identified is to streamline pathways for clients between ACAS, and HAS providers in the Grampians region. This will be achieved by both parties practicing within established best practice standards in referrals, joint assessment and case conferencing.

The overarching objectives are to acknowledge and practice within:

- An agreed set of indicators that may prompt a referral for HAS or ACAS involvement
- An agreed process to share ideas, knowledge and resources to negotiate better outcomes for clients
- The existing Victorian Service Coordination Practice Manual[2]
- Clear appeal pathways for services where outcomes are in dispute

Practice protocols have also been included as a guide for partnership members:

- Attachment 1. Indicators for referral between Partners
- Attachment 2: Referral process between Partners
- Attachment 3: Case Discussion/Conferencing
- Attachment 4: Grievance process

2.1 Confidentiality and Consent

It is agreed that all services will treat all client discussions and shared information as confidential.

All services acknowledge that consent needs to be obtained from the client prior to any shared activity or information sharing being undertaken.

2.2 Communication

Grampians ACAS and HAS will achieve and maintain good communication and coordinated client care through:

- inviting the relevant ACAS/HAS assessor to in-house and multi-agency case conferences
- ensuring communication channels are maintained in relation to shared clients and any changes in needs or information
- providing relevant referral and feedback documentation including a fully completed SCTT, the Service Provider Home Safety Checklist, client specific care plan (HACC) and ACAS Assessment Outcome Report
- providing opportunities to participate in joint client assessments
- promoting the value of Secondary Consultation where further clarification or advice is sought
- providing an opportunity to participate in joint education sessions
- providing a Manager or Clinical Coordinator to attend network meetings to develop relationships
- providing feedback to each other as appropriate regarding inter-agency relationships
- providing reasonable notice to the other party of any desired proposed change to agreed processes and/or timelines.

[2] Victorian Service Coordination Practice Manual, 2009, Primary Care Partnerships Victoria, August 2009

3. AGREEMENT TIMEFRAMES AND REVIEW

This Partnering Agreement will begin in February 2013, and both parties agree to review the agreement in twelve months.

3.1 Variation to Agreement

- This agreement may be varied at any time in accordance with this clause or at the annual review
- ACAS and any HAS provider can request a variation, the variation must be acceptable to, and agreed upon by all parties
- Any variation will be attached to this Partnering Agreement as a schedule.

4. DISPUTE RESOLUTION

A dispute can be related to either the process of operation between the two service groups or to disputed client outcomes and recommendations.

- In the event that any issue or dispute arises between the services, in the first instance, the assessors will contact each other in a bona fide attempt to resolve the issue or dispute promptly

- If the issue or dispute cannot be resolved to the satisfaction of the parties within 14 days, it is to be referred for resolution to the line managers of the respective assessor

- If the issue or dispute remains unresolved under the preceding steps in this clause, it is to be referred for resolution to the respective management team members, or their nominees

Attachment 1 INDICATORS FOR REFERRAL BETWEEN ACAS AND HAS SERVICES

1.1 From ACAS assessors to HAS Assessors

It is acknowledged that ACAS assessors on completion of their assessment are responsible for all referrals for client specific service delivery. This may still be to a HAS agency where service delivery is available. A completed SCTT referral should be sent to ensure that the HAS agency assessor does not duplicate parts of the assessment already completed.

Clients who can be referred for a Living at Home assessment must be HACC eligible, and include:

- Client's who has been referred for a personal alert Victoria service but do not meet the requirements for an ACAS assessment

- Clients who have family members/carer's who require or would benefit from a Living at Home Assessment to maintain their independence

- Clients who are referred to ACAS but are deemed as unsuitable for an assessment eg are not frail and aged, require no case management, packaged care or residential care is not required and the expertise of a geriatrician is not considered necessary at this time.

1.2 From HAS assessors to ACAS assessors

It is acknowledged that HAS assessors on completion of their assessment are responsible for all referrals for client specific service delivery

<u>Clients who can be referred for an ACAS assessment include:</u>

- Clients who are frail and aged, who require ongoing case management support or residential care or respite

- Clients who can no longer be managed on HACC level services who may be eligible for packaged care or residential care. ACAS assessment for community and residential packages (other than Linkages) is required.

<u>Clients who should not be referred for an ACAS assessment include:</u>

- Clients who require a specialist geriatrician assessment should be referred initially to their General Practitioner

- Younger people (under 65 years) with a disability requiring services beyond HACC level should be referred directly to the Department of Disability Services – ACAS do not assess people under 65 without all alternative support options being explored

- Clients who are suitable for a Linkage Program should be referred directly to your local Linkages Program, an ACAS assessment is not required.

1.3 Pre-Referral Process

Both HAS and ACAS assessors are encouraged to ring the relevant Intake Worker to discuss an assessment referral prior to sending it if that they are unsure it is suitable/appropriate. At this time the discussion can also focus on the value of doing a joint assessment.

- ACAS Intake Worker is available on 53203740 before 9am and after 3pm
- HAS Intake Worker is generally available but they will ring back if unavailable.

Attachment 2 REFERRAL PROCESS BETWEEN PARTNERS

This process applies to all parties to this agreement. Referrals are made using the Service Coordination guidelines and standards of practice and in accordance with each agencies organisational policies and procedures.

2.1 Referral between ACAS and HAS

- Both ACAS and HAS require a completed SCTT tool – this should include:

  - SCTT templates: core, optional and relevant supplementary profiles. Please ensure that each template has a response on it, even if it is 'not applicable at this time' so that everyone else knows that it has been included in the assessment.

    The SCTT 2012 templates are as follows:

    Core referral templates
    - Consumer Information
    - Referral cover sheet and acknowledgement
    - Summary and referral information
    - Consent to share information
    - Single page screener for health and social needs
    - Need for assistance with daily living
    - Accommodation and safety arrangement
    - Health and chronic conditions
    - Social and emotional wellbeing
    - Care relationship, family and social network
    - Alcohol, smoking and substance involvement screening

    Supplementary templates
    - Functional assessment summary
    - Palliative care supplementary information

  - Details of client pension numbers, Medicare numbers, etc,
  - Client medical history – include the date and source (eg doctor, client, family)
  - Details of client services already being received – including frequency and duration
  - A copy of either the Assessment Outcome report (ACAS) or the Outcome of Assessment form (HAS) - NB if the client has been referred at the INI or Intake level an Assessment Outcome report or Outcome of Assessment form will not be available.

- When referring a client ensure that you note any potential benefit for joint visits. (eg client difficult to engage, visits coincide, potential risk issues)

- Either assessor is encouraged to seek further details/history of the client if required

- All referrals are to be made using the Service Coordination Template Tool (SCTT) and must be accompanied by a copy of the Service Provider Home Safety Checklist.

- The service provider sending a referral is expected to:

  - send urgent referrals within no more than 1 working day of obtaining consumer consent
  - send low or routine referrals within no more than 7 working days of obtaining consumer consent
  - send referral information using the SCTT

- make immediate referrals (for example, over the phone when a consumer is in crisis), and follow this up with a more detailed referral using the SCTT

2.2 Receipt of referral and expected follow up

- The service provider receiving a referral is expected to:

  - transmit acknowledgement of the referral, using the SCTT Confidential Referral Cover Sheet, Referral Acknowledgement section, to the initiating service, stating that the referral has been received and the estimated date of consumer Assessment, or the reason why the referral is not proceeding. Connecting Care will be used as the acknowledgement tool if the referral has been electronically mailed through the secure message acknowledgement section.

  - urgent referrals should be acknowledged within no-more-than 2 working days of receipt

  - low or routine referrals should be acknowledged within no more than 7 working days of receipt

  - referral outcome information should be transmitted to the initiating service provider within no more than 14 working days of the consumer being assessed

2.3 Post assessment and care planning

- Should the client capacity or needs change it may be appropriate to review the levels of care required. Some triggers could be:

  - Improved confidence and activity levels

  - Improved mobility and physical status

  - Change in living arrangements which increases levels of support available or required

All of these, and other triggers, could be suggestive of a need for change in the client's care level.

- When the client's care plan has been reviewed consideration should be given for a referral back to ACAS and a review of the level of care required. The outcome of this may be that the client is returned to a lower level of long term care eligibility or may have an increased urgency for care.

2.4 Requesting assessment for packaged or residential care from ACAS

HAS assessors are asked to ensure that when working with the client you do not predict the level of care that will be approved by ACAS. Always discuss care options and opportunities with the client but acknowledge that ACAS are the appropriate body to make the decision as to appropriateness and eligibility.

The types of issues which can sometimes present as a barrier to access, but do not determine eligibility include:

- HACC cannot maintain current levels of client services and client is at risk of declining a package due to the client’s preference for the existing HACC services or main worker

- Cost of the package

2.5 Requests for client information between HAS and ACAS

In instances where either agency is assessing a client and they believe that the client may already have been assessed by HAS or ACAS the rules for accessing client information are:

- Client consent to sharing information must be documented using the SCTT consent tool – this does not have to be signed by the client – it is sufficient that we confirm that a verbal/signed consent to share information has been received and noted on the SCTT consent tool.

- Once this consent has been documented either party can ring the other to request confirmation that the client has/hasn't been assessed. A copy of the consent form should then be sent via Connecting Care or RIMS.

- If you want to receive a copy of either the ACAS or HAS Assessment Report then a copy of the SCTT consent tool documenting client consent to sharing information must be sent by the requesting agency.

Attachment 3 CASE CONFERENCE/DISCUSSION

3.1 Client Case Discussion - in-house between HAS and ACAS

Can be initiated by either the HAS or ACAS agency and may result in changes to the clients individual service specific care plan and inter-agency care plan. These case discussions should be documented in the client's agency file and should include:

- acknowledgement of client consent for the sharing of information,
- clear agreements of the outcomes of the discussion and
- who will follow up on any recommendations made

This discussion can also be shared with other service providers using the encrypted processes available in Connecting Care or RIMS.

3.2 Case Conference - multi-agency care planning

Case Conferences are important in facilitating appropriate care for consumers with multiple or complex needs and those who are likely to experience a better outcome if the care and services they receive are coordinated.

- A case conference can be initiated by any agency involved in the client's care and support.
- These discussions should be documented in each client's agency file
- Outcomes need to be documented using the SCTT multi-agency care plan tool for the group of agencies involved and the client and shared using the appropriate encryption process
- The key/lead agency is responsible for organising the Case Conference
- The key worker is responsible for following up outcomes of recommendations and organising client reviews as agreed

Attachment 4 GRIEVANCE PROCESS

Purpose
To ensure program staff have access to a clear pathway to express a grievance, at any point of the referral, assessment or transition through the HAS/ACAS process.

Scope
This procedure applies to HAS and ACAS

Process
This grievance process relates to programs eligibility, outcome of the assessment and acceptance onto the program.

When an individual (HAS/ACAS staff member) is dissatisfied with a decision regarding the outcome of a referral the following steps should be taken.

HAS
Initial contact is to be made with the main member of staff involved in the referral/assessment. Alternatively the Team Leader/Program Coordinator or the manager of the specific local HACC program can be contacted.

ACAS
Initial contact is to be made with the ACAS Clinician involved in the assessment. Alternatively the ACAS manager can be contacted.

ACAS has an appeal process within the Aged Care Act and if any client or person affected by the decision is not satisfied with the decision, they can write to the Secretary of the Department of Health and Ageing. They must write within 28 days of receiving this advice and give reasons why they think the decision should be changed to:

The Secretary
Department of Health and Ageing
C/- State Manger
Ageing and aged Care Division
GPO Box 9848
MELBOURBNE VIC 3001

Attachment 5 REFERENCE MATERIAL

Guidelines for streaming pathways between ACAS and HACC assessment services in Victoria, December 2010

Strengthening assessment and care planning, A guide for HACC assessment services in Victoria, March 2011

Attachment 6 HAS AND ACAS ENDORSEMENTS

Partnering Agreement between Grampians Region Aged Care Assessment Services (ACAS) and Grampians Pyrenees Home and Community Care Assessment Services (HAS)

This Partnering Agreement is to document the relationship between Aged Care Assessment Services and HACC Assessment Services in the Grampians Region. This document is based on local agreements and written in reference to the Guidelines for streamlining pathways between ACAS and HAS in Victoria.

The partnership is designed to be mutually beneficial for clients and services by:

- Clarifying pathways for referral and assessment
- Confirming the process for sharing information to reduce duplication in assessments.

Signatories to this agreement are:

- Grampians Region Aged Care Assessment Service
- Ararat Rural City Council HACC Assessment Service
- East Grampians Health Service HACC Assessment Service
- Northern Grampians Shire Council HACC Assessment Service
- Pyrenees Shire Council HACC Assessment Service