The Wimmera HACC Living at Home Integrated Assessment Partnership Project

Memorandum of Understanding

Undertaken by the Wimmera region HACC Assessment Services:

Dunmunkle Health Service
Edenhope & District Memorial Hospital
Hindmarsh Shire Council
Horsham Rural City Council
West Wimmera Health Service
West Wimmera Shire Council
Wimmera Health Care Group
Yarriambiack Shire Council

In-conjunction with Wimmera Primary Care Partnership and the Grampians Region Department of Health, Victoria.

Produced June 2010 and revised 2012 by Janet Hall in collaboration with the Wimmera HACC Partnership Project Team

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1. MEMORANDUM OF UNDERSTANDING

Executive Summary

This Memorandum of Understanding (MoU) is an outcome of the Wimmera Home and Community Care (HACC) Partnership Project; a partnership that is an alliance of the HACC Assessment Services in the Wimmera region. The agencies formed this partnership in-order-to collaboratively implement the Victorian Department of Health HACC Living at Home Assessment (LAHA) Framework and subsequent to the initial 12 month project, the alliance has continued in order to maintain and foster inter agency partnerships and collaboration.

This MoU is an internal intra agency document for HACC Assessment Services (HAS) in the Wimmera region. The MOU sets the framework for LAHA practice and for agencies to work together in order to provide consistent, responsive and collaborative services to the HACC client group.

The aims of the protocol are to:

- Outline the agreed and accepted ways of working together to conduct Living at Home Assessments across this region.
- Clarify the roles and responsibilities of agencies where joint assessments are indicated.
- Promote effective service coordination

It is anticipated this MoU will contribute to the levels of trust and networking between agencies, which will inturn, increase the regions capacity to implement the LAHA framework across the Wimmera with a focus on providing services within a culture of maintaining and improving clients' health and functioning.

Those agencies that were members of the project team that undertook the initial development and subsequent review of this MoU were the Wimmera region Victorian Department of Health HACC Assessment agencies and are the signatories, alongside Wimmera Primary Care Partnership.

Context

This protocol should be read in conjunction with the Victorian Government Department of Health *Framework for Assessment in the Home and Community Care Program*, and the *Victorian Service Coordination Practice Manual*, *Service Coordination Tool Templates (SCTT)*, *HACC National Service Standards* and additional guidelines that have been progressively developed to guide Victorian state-wide practice for HACC Assessment Services.

In relation to undertaking Living at Home Assessments, the agencies agree to implement and comply with the:

Victorian Service Coordination Practice Manual (VSCPM) standards located at http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

Service Coordination Tool Templates (SCTT) user guide located at http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm

HACC privacy resources. In relation to consent, agencies will comply with the Victorian Service Coordination Practice Manual (VSCPM), Service Coordination Tool Templates (SCTT) user guide and privacy resources located at: http://www.health.vic.gov.au/pcps/coordination/privacy.htm

Acronyms

ASM	Active Service Model
DHS	Department of Human Services, Victoria
DH	Department of Health, Victoria
HACC	Home and Community Care
HAS	Home and Community Care Assessment Services are referred to via the acronym HAS or HACC Assessment Services
IC	Initial Contact
INI	Initial Needs Identification
LAHA	Living at Home Assessment
OHS	Occupational health and safety
MAV	Municipal Association of Victoria
MoU	Memorandum of Understanding
SCTT	Service Coordination Tool Templates
VSCPM	Victorian Service Coordination Practice Manual

2. LIVING AT HOME ASSESSMENT

Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer[1]. The Service Coordination Tool Templates (SCTT) are the screening tools used to support and guide the breadth and depth of assessment and to facilitate and support service coordination practice[2].

A Living at Home Assessment (LAHA) is the process of undertaking a broad holistic assessment of general health and wellbeing in the context of active ageing and independent living[3].

A LAHA may include service-specific assessment(s)[4] for service(s) provided by the assessing organisation, risk management and occupational health and safety assessment (OHS).

2.1 The aim of Living at Home Assessment[5]

The aim of undertaking Living at Home Assessments is to enable people with care needs to remain living independently at home in their community by

- building on each person's strengths,
- raising clients functional and social capacity related to their ability to self care and be socially connected,
- delivering services or supports based on what is most important to the client and carer and
- recognising if a clients declining abilities and increasing need for service requires transitioning from the HACC Program to a more suitable care option.

2.2 Principles that underpin Living at Home Assessment [6]

- Assessment is interactive and client focused
- Assessment is a continuum
- Assessment is aimed at achieving clients goals
- Assessment is underpinned by the Active Service Model (ASM) and Well for Life approach
- Assessment is undertaken by staff with appropriate expertise and qualifications
- Assessment is responsive to issues of culture, language, belief and identity in the provision of relevant, meaningful and easily accessible services
- Assessment is a collaborative process between one or more agencies and the client and carer
- Repetitive information gathering and the duplication of assessments is minimised with each assessor accepting and building on information gathered in prior assessments
- Clients with basic, one-off or short-term needs are not over assessed
- Clients must provide consent to each stage of assessment and to the sharing of their information.

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[1] Victorian Service Coordination Practice Manual [VSCPM] 2009, p.20
[2] Service Coordination Tool Templates [SCTT] 2009 user guide, p.1
[3] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.7
[4] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.1
[5] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.2
[6] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.5

2.3 Assessment mode

Face-to-face assessment in the client's home.

Who: All new clients should receive a LAHA based on the underpinning philosophy of the Active Service Model, which aims to maintain and improve client functioning, wellbeing and independence[7]. For more information on who should receive a LAHA refer to section 3 of this document.

When: Directly following initial contact or within an agreed time frame.

NOTE* When a clients needs are urgent, a service specific assessment and service provision should take place *prior to* a LAHA. A LAHA should never be an urgent action.

2.4 Referral processes and timelines

The time frame and priority for acknowledging referrals for a Living at Home Assessment and providing feedback to the referring organisation will be determined in accordance with the Victorian Service Coordination Practice Manual (VSCPM). For more information refer to section 4 of this document.

2.5 SCTT templates & profiles for a LAHA

The project team agree that all SCTT profiles will be addressed in order to ensure an holistic assessment. The following templates will therefore be addressed:

Referral cover sheet (including priority of urgency)
Consumer information
Summary and referral information
Consumer consent to share information (to be completed but does not need to be sent)
Living and caring arrangements
Functional assessment summary
Need for Assistance
Health Behaviours
Health Conditions
Psychosocial
Family & Social Network
Palliative Care (if relevant)
Care Coordination Plan (if more then one service/agency involved)
Service provider Home Safety Check List

For more detail on referral profiles refer to section 4 of this document.

2.6 Key Outcomes of a LAHA[8]

A LAHA results in the development of a written care plan that details the clients goals, any services to be delivered by the assessing organisation, and referral to both HACC and non-HACC funded services for needs that cannot be met by the assessing organisation.

Written care plans will be based on a collaborative approach to support the consumer to achieve their goals.

[7] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.1
[8] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.7

A written care plan includes

- an outline of the consumer's stated and agreed goals, based on a collaborative care team approach[9] and

Depending on client need and consent it may also include

- a referral action plan for referrals to both HACC and non-HACC funded services for needs that cannot be met by the assessing organisation (as necessary);
- intra and/or inter agency care plans if more than one service is provided[10](as necessary);
- information on services or activities including health promotion and social activities that the client may choose to follow up themselves.

For more detail on assessment roles refer to section 5 and care planning refer to section 6.

2.7 The agencies agree that:

In relation to the processes, time frame and priority for acknowledging referrals, the agencies agree that with client consent they will:

- send and acknowledge referrals using the SCTT
- use Connecting Care (RIMS or similar) for secure transfer and sharing of client information between agencies
- share relevant information including assessment, care planning, OHS and the Home Safety Check List
- comply with the time frame and priority for acknowledging referrals and providing feedback to the referring organisation as detailed in the Victorian Service Coordination Practice Manual (VSCPM) and section 4 of this document
- complete an Outcome of Assessment report (Appendix 3) and transmit this to the referring agency to provide feedback to the referee.

[9] A care team refers to the care planning and delivery relationship between the assessor/client, assessor/client/carer, assessor/client/carer/other provider or a combination of all.
[10] Victorian Service Coordination Practice Manual [VSCPM] 2009, p. 28-29

3. ACCESS TO A LIVING AT HOME ASSESSMENT

3.1 Who should receive a Living at Home Assessment

The agencies agree that all new clients (who are not brokerage or episodic[11]) should receive a LAHA, based on the underpinning philosophy of the Active Service Model (ASM).

In addition, the following circumstances serve as triggers for undertaking a LAHA:

- A client has changed circumstances e.g. recent social, emotional or functional decline, hospital admission, death of spouse.
- A current HACC client who has not previously had a LAHA is due for their annual review. The review process will be completed utilising the Living at Home Assessment and collaborative team approach to determine potential strategies for increased client independence.
- Other triggers for assessment/reassessment utilising the LAHA and collaborative team approach include when
    - client circumstances change significantly to warrant a LAHA reassessment within the six month period,
    - carer stress is evident,
    - there is differing view points between what the client wants and what carers/other services /referrer believe is needed, and
    - there are multiple clients in the one household with competing needs.

3.2 Supported access

In general, HACC funded agencies such as Wimmera Volunteers undertake service specific assessment but not Living at Home Assessment. However, if a non HAS agency assessor believes a client would benefit from an holistic assessment and/or believes the client may have a broader set of unmet needs than can be met by their own organisation, they should consider referral to a designated LAHA service.

Agencies who are referring a client for a Living at Home Assessment are urged to make initial phone contact with the local HACC Assessment Service (HAS) to check if the client has recently been assessed to avoid the potential duplication of services. By undertaking this action and/or using a secondary consultation approach when appropriate, the practitioner can reduce the time-delay for a client and provide a more efficient service response (rather than making a referral and waiting for a response).

3.3 Service Specific assessment

Service-specific assessment can be defined as *a face-to-face interaction with a consumer who has a straight forward and distinct need for a specific service* (such as home care, nursing, podiatry, etc). This assessment is conducted by the service provider responsible for delivering the service and leads to the development of a service specific care plan.

[11] Episodic may be a one off or time limited service provision.

4. REFERRAL PATHWAYS AND PROCESSES

4.1 Referring to a HAS agency - SCTT profiles

Agencies referring to a HACC Assessment Service (HAS) should provide the following SCTT profiles:

- Confidential referral cover sheet
- Consumer information
- Summary and referral information
- Consumer consent to share information
- Service Provider Home Safety Check List
- Any other templates considered appropriate

4.2 Undertaking a LAHA - SCTT profiles

The agencies agree that all SCTT profiles should be addressed in a LAHA in order to develop an holistic assessment. The agencies therefore agree to address the following:

Core Templates:

- Consumer information
- Summary and referral information
- Consent to share information
- Service Provider Home Safety Check List

Profiles:

- Accommodation and safety arrangements
- Need for assistance with activities of daily living
- Single page screener of health and social needs - Service provider administered
- Single page screener of health and social needs - Consumer administered
- Health and chronic conditions
- Social and emotional wellbeing
- Care relationship, family and social network
- Alcohol, smoking and substance involvement screening (ASSIST)
- Functional Assessment Summary

And as relevant:

- Palliative care supplementary information
- Shared support plan
- Information exchange summary
- General practice referral
- Ambulance Victoria referral

4.3 HAS out going referrals - SCTT profiles

Any referral from a HACC Assessment Service (HAS) will be based on consumer consent to share and 'need to know', unique to each referral. The *minimum* profiles to be forwarded are:

- Confidential referral cover sheet
- Consumer information
- Summary and referral information
- Consent to share information
- Service Provider Home Safety Check List
- Functional assessment summary

Accommodation and safety arrangements…plus other templates or information considered appropriate

4.4 Service Coordination

The agencies agree they will follow the Victorian Service Coordination Practice Manual guidelines and

- send and acknowledge referrals using the SCTT templates;
- use Connecting Care (RIMS or similar) for secure transfer and sharing of client information between agencies;
- share relevant information including assessment, care planning information, OHS and the Service Provider Home Safety Check List - as appropriate and with client consent - when referring the client to another organisation, within case conferences and inter-agency care plans;
- support and promote the implementation of intra and inter agency care planning and care coordination; and the associated roles of Lead Assessor and Key Worker;
- indicate on the Referral Cover Sheet if a Living at Home Assessment has been completed and the date completed;
- indicate on a referral whether the service initiating the referral has been and/or is continuing in a care co-ordination and/or Key Worker role;
- provide feedback and referral outcome information to the initiating service provider within 14 working days of the client being assessed. Feedback should be provided on the Outcome of Assessment form;
- adhere to the Good Practice Indicators for referral detailed in the Victorian Service Coordination Practice Manual.

5. IMPLEMENTING COLLABORATIVE ASSESSMENT

Assessment is an ongoing cyclic process in care delivery that incorporates collecting, weighing and interpreting relevant information about the consumer[12].

Joint assessment and secondary consultation approaches are opportunities to gain a fuller understanding of consumer circumstances and need, to enhance the coordination and continuum of care, and avoid duplication and/or a multiplicity of individual assessments.

5.1 Joint assessment

Joint assessment refers to staff from two or more agencies conducting an assessment together. whereby an Assessment Officer determines that expertise from another agency/discipline is required to complete a full assessment.

The decision to conduct a joint assessment will be based on consent from the client, consideration of the potential benefits to the client, and determined by discussion between the relevant agency assessment staff.

For the purpose of undertaking a joint assessment, the lead agency is the HACC Assessment Service who received the referral and in general, the lead agency Assessment Officer is the Lead Assessor.

In rural areas the capacity to undertake joint assessments may be limited due to distance, travel time and limited multi disciplinary resources. However, in some instances, joint assessment may be completed over a period of time with only one assessor being present at a time – followed by collaboration; or be carried out by videoconferencing or telephone using a secondary consultation approach.

Careful consideration must be given to the most appropriate way to implement assessment for the individual client and awareness of any immediacy for the introduction of services/support while preparing for a broader multi agency/discipline assessment.

The benefits of conducting a joint assessment

- Streamlining communication between all parties in order to increase the effectiveness of the care continuum and coordination of care.
- Minimising duplication of the assessment process.
- Joint observation and assessment in order to gain a broader and more comprehensive understanding of a client's circumstances and needs.
- Improving client outcomes by utilising a collaborative, shared care, multi-disciplinary team approach to goal setting, problem solving and care planning.

Triggers for conducting a joint assessment

- A client has complex or unclear needs.
- Pre-assessment information indicates that multiple assessments or services are likely to be required.

[12] Victorian Service Coordination Practice Manual 2009, p. 20

- The HACC Assessment Service that has been approached to provide the LAHA believes their involvement is likely to be short term and/or specific (e.g. nursing) and that the longer-term involvement of another service (e.g. home care) may be required and that it is efficient and effective to collaborate at an early stage.
- A client is from a vulnerable group with complex or multiple needs (insecure housing, physical, intellectual or acquired disabilities, mental health issues, dementia, chronic health condition) and a range of expertise is required.

5.2 Joint assessment roles

The Lead Assessor role refers to that of the Assessment Officer from the HACC Assessment Service who received the referral and is delegated to complete the assessment.

The Lead Assessor is responsible for

- organising the assessment date and time with the client and their preferred contact/advocate and the joint assessor(s);
- organising informed consent from the client;
- developing a client care coordination plan (using the SCTT Care Coordination Plan);
- developing and communicating their agency client assessment report (based on existing agency specific expectation);
- ensuring the client (and their preferred contact/advocate) and other engaged service providers receive a copy of the client care coordination plan;
- completing an Outcome of Assessment report (Appendix 3) and transmitting this to the referring agency; and
- organising secondary consultations and referrals.

The Joint Assessor is responsible for

- supporting and assisting with the documentation required; and
- developing and communicating their agency client assessment report (based on existing agency specific expectation).

NOTE* The Lead Assessor role is different from the Key Worker role. Refer to Appendix 1 for a summary of the Lead Assessors role. Section 7.1 provides information about allocating a Key Worker and their role.

5.3 Secondary consultation

Secondary consultation refers to one practitioner consulting another practitioner to benefit from their specialist skills or expertise, gain another opinion and to ensure a well-informed approach.

Secondary consultation is dependent on client consent (if client information is to be shared) and can occur at any stage of the care pathway.

Triggers for accessing a secondary consultation

- The assessor wishes to check or clarify certain information in relation to a client condition, possible need, possible response etc. The assessor therefore contacts the secondary consultation person to discuss the situation and confirm an appropriate action.
- The assessor is unable to answer a client query about a particular matter. In order to provide an immediate response, the assessor contacts the secondary consultation person on the spot, thus providing an efficient response to the client.
- The assessor has considered assessment information and wishes to clarify a particular matter or gain advice from another discipline or specialist area to inform the care planning process.

5.4 Assessor conflict

Conflict arising between assessment officers from different agencies will be managed according to their own agency protocols.

Assessors must ensure the client is not disadvantaged due to worker conflict and that clear recognition is given to the client and/or their advocate always being the final decision maker in relation to preferred outcomes.

6. CARE PLANNING

Care Planning is a dynamic process that incorporates a range of activities including decision support, care coordination, referral, feedback, review, re-assessment, monitoring and exiting[13]. Care planning supports the consumer to identify goals and agree on strategies, actions and services to achieve those goals.

6.1 The Care Planning process[14]

- involves gathering and interpreting assessment information including consumer and other sourced information to make care decisions in collaboration with the consumer and carer;
- is based on and documents the consumer’s goals and agreed upon actions;
- involves 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;
- includes ongoing monitoring and review processes; and
- should be person centred and worded in a way which is able to be understood by the consumer and any professional involved in the consumers care.

For further detail on the objectives and principles of care planning, refer to the Victorian Service Coordination Practice Manual.

[13] Victorian Service Coordination Practice Manual 2009, p.25-
[14] Victorian Service Coordination Practice Manual 2009, p25

6.2 What should a care plan include?[15]

A care plan is the documentation of items agreed to in the care planning process. All care plans should include these items:

- date the care plan was developed
- participants in development of the care plan
- consumer-stated and agreed issues or problems
- consumer-stated and agreed goals
- agreed actions and the name of person or service responsible for each action
- timeframe for attaining goals and actions
- planned review date
- consumer acknowledgement of the care plan (signed or verbal)
- actual review date.

6.3 Care planning encompasses[16]

Service-specific care plan(s)

> A service specific plan is developed by a single service and details the type, level and the desired outcome from implementing the service by the assessing agency. A service specific care plan is documented using agency specific tools.

A Referral Action Plan

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

Information provision

> The client should receive information on services or activities that the client may choose to follow up themselves. This may include for example, health promotion/social or active living opportunities, self-management activities/strategies, self-referrals to other services.

A Care Coordination Plan

> … is developed utilising the SCTT template for consumers with complex needs who request/require ongoing support and service coordination from an agency worker.
>
> Where a client receives multiple services there may be an intra or inter agency care plan in order to coordinate service delivery and share relevant information and resources:

An intra-agency care plan

> …is developed for a consumer who requires more than one service from within a single organisation.

[15] Victorian Service Coordination Practice Manual 2009, p. 27
[16] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p. 17-18

7. CARE COORDINATION

Coordinated care planning is important in facilitating appropriate care for consumers with multiple or complex needs[17] and those who are likely to experience a better outcome if the care and services they receive are coordinated[18].

The distinctive aspects of Care Coordination are:

- the development of a Care Coordination Plan (sometimes referred to as a Service Coordination Plan [19]) as detailed under the previous section on Care Planning; and
- the nomination of a single Key Worker when a care plan/care coordination plan is established, as a single line of communication for each client[20].

7.1 The Key Worker

The role of the nominated Key Worker[21] is to be the central contact for the client and/or their carer/advocate; to promote effective communication between the consumer and service provider(s); and coordinate the delivery of care by their own organisation and other providers.

The decision to appoint a Key Worker should be based on client need, as where possible, clients and/or carers should be empowered to coordinate their own services.

Triggers for needing a Key Worker include

- multi-agency involvement,
- clients with complex needs or circumstances,
- clients who require but are waiting for a case management service.

The decision to appoint a Key Worker may be for an ongoing need or temporary need and determined by the cyclic ongoing processes of review, reassessment, monitoring and care planning.

Key Worker role

- develops their organisational client care plan
- is responsible for ensuring the Care Coordination Plan is developed, distributed and monitored; review dates are set, re-assessments are initiated where appropriate, and feedback about the outcome of the referral is provided to a referring service provider[22]
- ensures that people with multiple agency involvement have a single point of contact in the service network and promotes effective communication between the consumer and service providers[23].

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[17] Good practice guide 2009, p.12
[18] Victorian Service Coordination Practice Manual 2009, p.35
[19] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.18
[20] Victorian Service Coordination Practice Manual 2009, p.26
[21] Victorian Service Coordination Practice Manual 2009, p.30
[22] Victorian Service Coordination Practice Manual 2009, p.26
[23] Victorian Service Coordination Practice Manual 2009, p.26

Key Worker responsibilities include[24]:

- maintaining client and/or carer contact which may be frequently during periods of crisis or changing needs, or less frequently, dependent on need. It is recommended that contact is made with the client and/or carer at least six weekly.
- liaising with the client and/or carer and other providers (including within their own organisation) as issues are raised or care plans/care coordination plans require change. This liaison should include the General Practitioner.
- ensuring their agency progress notes are up to date; and maintaining an up to date Care Coordination Plan (including monitoring and review processes).
- ensuring copies of the Care Coordination Plan are forwarded to each engaged provider as changes are made (in accordance with the Health Records Act and relevant privacy legislation[25]).
- organising a care coordination meeting/case conference with the client and/or carers and other service providers as required, but at least annually to review the care plan.
- communicating discharge and/or re-entry with other engaged providers.

Further aspects of this role are detailed in the Victorian Service Coordination Practice Manual.

7.2 Key features of Care Planning[26] and Care Coordination

- The nomination of a single key worker when a care plan/care coordination plan is established.
- A range of staff and services participate in care planning and communicate outcomes of referrals, progress and reviews to the Key worker.
- Effective monitoring (both formal and informal) of a consumer's health and wellbeing, and the effectiveness of services being delivered, for example, through regular reviews.
- Referral and other information is coordinated, planned and efficient, and specific feedback loops are in place for other service providers and the consumer.
- Care planning is underpinned by communication between all participants and activities are integrated (from the simple booking of services through to comprehensive care coordination), where a consumer requires multiple services or has complex or multiple needs.
- Assessment and care planning considers the social, emotional and health needs (beyond presenting issues).
- Care includes health education and encourages and empowers consumers to self manage.

7.3 Care Coordination Meetings

A care coordination meeting (also referred to as a case conference) is a tool to support and integrate teamwork within the processes of assessment, care planning and care coordination. These meetings should be held when a client is identified as having unstable health, complex care needs and/or multiple service providers (intra or inter agency).

A care coordination meeting is a care planning meeting (face to face, video-conferencing or using a secondary consultation approach) of providers from all involved services.

[24] Victorian Service Coordination Practice Manual 2009, p.26
[25] Victorian Service Coordination Practice Manual 2009, p.30
[26] Victorian Service Coordination Practice Manual 2009, p. 26

The aims of the meeting are:

- to develop an integrated Care Coordination Plan;
- to ensure a client's Care Coordination Plan is underpinned by communication between all participants; and
- to ensure services are planned and delivered through a coordinated and integrated approach.

Initiating a Care Coordination meeting

A care coordination meeting will be initiated by the Key Worker where one is appointed.

Each service provider is also responsible for requesting the Key Worker initiate a care coordination meeting if issues arise.

Aspects of a Care Coordination meeting

- The Key Worker is responsible for initiating and facilitating a review (or the agency assessment worker if a Key Worker has not been appointed).
- Obtaining and recording client consent is essential prior to the sharing of client information with participants in a care coordination meeting and the subsequent development of a care coordination plan. The Key Worker (or the agency assessment worker) seeks client consent.
- The role of the client and/or their nominated contact or advocate is paramount and should include:
    - Identification by the client of people involved in their support/ advocate/ interpreter/ carer family member/ substitute decision maker.
    - Direct participation of the client and/or significant others, if appropriate.
    - Consultation with the Key Worker prior to the meeting to identify any concerns or issues they may wish to raise.
- All providers engaged in service delivery for the particular client should attend or be consulted by secondary consultation approaches where this is not possible.
- Review dates should be developed and further meetings held as necessary.

Additional information - Care Planning and Care Coordination

The Care Coordination Plan Template (SCTT) is the tool used for Care Coordination.

Consumer pathway through care planning:-Refer to VSCPM, p.37.

Practice standards and good practice indicators for care planning:-Refer to VSCPM, pp.32–33.

Steps to develop a Care Coordination Plan:-Refer to VSCPM, pp.35-37.

8. MONITOR, REVIEW AND REASSESS

8.1 Monitor

Management of client's care plans involves formal and informal monitoring of client and carer's health and well being, how effectively services are meeting their needs, progress towards client goals and if OHS issues have arisen and are being managed. This is the responsibility of all HACC organisations[27].

8.2 Review

All clients should be systematically reviewed to ensure that care planning is meeting the assessed and agreed need.

Timing for reviews

- will be according to the review date recorded in the care plan,
- in accordance with organisational protocols, or
- as indicated by a change in circumstances, client triggers or service provider/client requests.

Review process will be coordinated and collaborative.

- Coordination will be by the Key Worker (where one is appointed) or the agency assessment worker in the case of service specific or intra-agency care plans. The Key Worker will undertake an appropriate role such as that detailed in section 7.
- Collaboration may involve a Care Coordination meeting depending on the complexity of the care plan and client need. The key focus is on joint reviews however, where this is not practical, each agency undertakes their own review and collaborates using a secondary case conferencing approach to ensure an holistic client centred approach.
- Where service specific reviews occur, it is the responsibility of the agency completing a review to convey the outcomes to the Key Worker (if one is appointed) to inform the overall review, using the SCTT Care Coordination Plan.

8.3 Reassessment

A Living at Home reassessment is carried out

- when client or carer circumstances change significantly requiring a complete reappraisal of the client and/or carer needs[28]
- at a pre-determined time linked to a review of the service-specific care plan.[29]

As with reviews, the reassessment process will be coordinated and collaborative.

Where there are multiple organisations involved in delivering services to one client, the Key Worker should be nominated for the purposes of initiating the reassessment.

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[27] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.19
[28] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.20
[29] Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.20

8.4 Service closure

Assessment, care planning, care coordination, monitoring, reviewing and reassessment are all components of the LAHA process and continuum. Some clients may achieve their goals and be discharged from the service(s) whilst a review of other clients may result in the development of new client goals and/or maintenance services. Clients may exit one service i.e. nursing but may continue with other services such as personal care or home maintenance.

Service closure (discharge or exiting a service) will be based on goal achievement, review and an agreed cessation of service date.

Re-entry information and contact details will be provided to clients (e.g. based on changed needs or referral) at the exit point.

9. CROSS BOUNDARY CONSIDERATIONS

Agencies have a shared responsibility to provide services to clients and should not use geographical boundaries to limit service access where it is clear that a cross boundary response will be most efficient and effective for the client.

It is agreed that:

- Each agency will work within their mandated boundary and referrals should be made recognising this.
- Should a client live near a boundary, the assessment staff will liaise to clarify which agency can best provide the service, based on what may be reasonable and efficient, and preferable for the client.

10. SUMMARISING THE AGREEMENTS:

In relation to the Wimmera HAS agencies undertaking LAHAs it is agreed that:

New clients (who are not brokerage or episodic) should receive a LAHA based on the underpinning philosophy of the Active Service Model which aims to maintain and improve client independence.

In order to develop an holistic assessment all SCTT profiles should be addressed.

Any referral from a HACC Assessment Service (HAS) will be based on consumer consent to share and 'need to know', unique to each referral. The *minimum* profiles to be forwarded from a HAS are:

Confidential referral cover sheet
Consumer information
Summary and referral information
Consumer consent to share information
Service Provider Home Safety Check List
Functional assessment summary
Accommodation and safety arrangements
Any other templates or information considered appropriate

In relation to the processes, time frame and priority for acknowledging referrals, referral processes and consumer privacy, the agencies agree to:

- send and acknowledge referrals using the SCTT templates;
- use Connecting Care (RIMS or similar) for secure transfer and sharing of client information between agencies;
- share relevant information including assessment, care planning and the Home Safety Check List when referring the client to other organisations; and within Care Coordination planning/case conferences and inter-agency care plans;
- indicate on the Referral Cover Sheet if a Living at Home Assessment has or has not been completed and the date of assessment;
- indicate on a referral whether the service initiating the referral has been and/or is undertaking a care co-ordination and/or Key Worker role;
- provide feedback and referral outcome information to the initiating service provider within 14 working days of the client being assessed on the Outcome of Assessment form.

In relation to collaborative practice, the agencies agree to:

- support and promote the implementation of intra and inter agency care planning and care coordination;
- support joint assessment;
- utilise joint assessment, secondary consultation and case conferencing approaches in order to gain a fuller understanding of consumer circumstances and need, and to enhance the coordination and continuum of care and avoid duplication and/or a multiplicity of individual assessments;

- improve client outcomes by utilising a collaborative, shared care, multi-disciplinary team approach to goal setting, problem solving and care planning.

In relation to care planning and care coordination the agencies agree to

- develop and implement care planning, implementation and reviews in accordance with the guidelines and standards outlined in the VSCPM 2009 (p.25-31);
- nominate a single Key Worker when an inter-agency care plan is established, to promote effective communication between the consumer and service provider(s) and to provide care coordination (as appropriate);
- communicate outcomes of referrals, progress and reviews to the Key Worker and/or all other agencies involved in a clients care (as appropriate);
- work together to coordinate service delivery and support the consumer to achieve their goals in an integrated manner;
- use the SCTT Care Coordination Plan for complex clients requiring care coordination and intra and inter agency care plans;
- notify other agencies when a client is being discharged or exiting the service and there is more than one service involved.

Summary information should note

- if the discharging agency undertook a LAHA and the date of assessment and review;
- if the discharging agency undertook a Key Worker role. If so, summary information and interagency care planning will be forwarded to the other agency.

In relation to cross boundary considerations, the agencies agree that

- each agency will work within its mandated boundary and referrals should be made recognising this;
- should a client live near a boundary, the assessment staff will liaise to clarify who can best provide the service based on what may be reasonable, efficient, and preferable for the client.

Broadly, the agencies agree to comply with the:

Victorian Service Coordination Practice Manual 2009 (VSCPM) standards located at http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

Service Coordination Tool Templates (SCTT) user guide located at http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm

HACC privacy resources located at http://www.health.vic.gov.au/pcps/coordination/privacy.htm

REFERENCES

Victorian Service Coordination Practice Manual [VSCPM] 2009, Primary Care Partnerships Victoria, Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia.

Service Coordination Tool Templates [SCTT] 2009, user guide, Published by the Primary Health Branch, Victorian Government Department of Human Services, Melbourne, Victoria, Australia.

Framework for Assessment in the Home and Community Care Program in Victoria 2007, Published by Aged Care Branch, Rural and Regional Health and Aged care Services Division, the Victorian Government Department of Human Services, Melbourne, Victoria, Australia.

Good Practice Guide 2009: A resource of the Victorian Service Coordination Practice Manual, Primary Care Partnerships, Victoria. Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia.

APPENDIX 1 Summary of joint assessment roles and responsibilities

	Lead assessor	**Other assessor**
Assessment	The Lead Assessor refers to the Assessment Officer delegated to complete the assessment, from the HAS who received the referral. This role has primary responsibility for organising the assessment including: • prior to assessment, ascertaining if other agencies have been ***or*** are likely to be involved; • determining if a joint assessment is appropriate; • organising a mutually convenient assessment date with client, their preferred contact/advocate and joint assessors; • organising and documenting informed consent from the client for joint assessment and the sharing of information.	Provides any pre-assessment information. Attends, participates and collaborates in the assessment, providing expertise and service information as appropriate.
Documenting assessment outcomes	Documenting assessment outcomes and circulating these to other agencies for additional comment. Developing and communicating their agency client assessment report & documentation.	Reading assessment outcomes and adding/attaching comments and information as appropriate. Developing and communicating their agency client assessment report & documentation.
Care planning	Developing & documenting a Care Coordination Plan/Care Plan, based on ASM principles and client stated goals, in collaboration with other agencies. Providing expertise and strategies to contribute to goal achievement.	Supporting and collaborating in the Care Coordination Plan/Care Plan development. Providing expertise and strategies to contribute to goal achievement.
Communicating assessment outcomes	Communicating outcomes to client and other agencies. Ensures the client (and preferred contact/advocate) and other engaged service providers receive a copy of the client Care Coordination Plan/Care Plan; Complete an Outcome of Assessment report (Appendix 6) and transmit this to the referring agency.	Discusses assessment outcomes with the client.

NOTE* The Lead Assessor role is different from the Key Worker role. Refer to Section 7.1 for information about allocating a Key Worker and their role.

APPENDIX 2 LAHA Check list

Check list for new client assessment for HACC	Signature	Date
Service Eligibility		
Check HACC eligibility		
Clarify financial status		
Seek consumer consent to assessment		
Time, date and persons to be present for assessment		
Undertake		
Service Provider Home Visit Safety Checklist (section one)		
Explain (and provide service documents related to)		
Overview of services		
Confidentiality/privacy		
Advocacy		
Complaints system		
Consumer rights & responsibilities		
Undertake		
Holistic assessment & collect of information using SCTT		
SCTT profiles to be addressed		
Consumer Information		
Accommodation and safety arrangements*		
Functional Assessment Summary		
Need for assistance with activities of daily living		
Health and chronic conditions		
Social and emotional wellbeing		
Care relationship, family and social network		
Supplementary		
Any additional profiles required ie Palliative Care		
Home safety checklist (section two)		
Assessment & care planning		
Discuss & clarify the clients goals & agreed on actions		
Develop care plan with client & career/advocate		
Client signs the agreed on care plan and goals		
Assessor signs the agreed on care plan and goals		
Client receives a copy of their care plan		
Provide health promotion information		
Discuss other potential services (intra & inter agency)		
Social opportunities/support		
Informal support with family & friends		
Allied health i.e. OT, dietician, balance, podiatrist, nursing		
Complex health assessment i.e. ACAS, CAPS, Linkages		
Home support & maintenance		
Other i.e. Massage, foot care		

Seek consent to share information and make referrals		
Refer on using ConnectingCare (Rims or similar)		
Consumer Information *		
Consumer Consent to Share Information*		
Summary and Referral Information		
Accommodation and safety arrangements*		
Functional Assessment Summary *		
Home Safety Checklist (completed form)		
Plus any additional SCTT profiles that may be relevant		
Shared Support Plan (if required)		
Information exchange summary		
And Ie Agency Care/Support plan (if required)		
Has your referral been		
Acknowledged		
Accepted		
Does the consumer require care coordination?		
Does the consumer consent to care coordination?		
Develop care coordination plan (intra - inter) if appropriate		
Identify key worker if appropriate		
Outcome of assessment form (feedback) completed and sent		
Review date scheduled i.e. maximum x months		
Actual review date		
Review to consider		
Referral for complex assessment i.e. ACAS, CAPS, Linkages		
Client handouts		
Service introduction & information		
Clients rights & responsibilities		
Grievance and complaints procedures		
Advocacy information		
Privacy policy		
Copy of care plan		

Name of assessor

Position

Signature ………………………………………………………………………Date………………………

APPENDIX 3 OUTCOME OF ASSESSMENT

Client Name:..   Date of Birth:....................................

Address:..

Worker Who Referred:............................. Date of Referral:................................

Agency Name:...

Reason for Referral:...

Thank you for your referral of this client.

Date of Assessment:..................................... Review Date:...................................

The assessment outcome was as follows:

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...

...

..

..

Goal of Intervention (as agreed by client and assessor):.......................................

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..

..

Name of Assessor:..

Contact Details:...

Agency:..Phone No:..

Senders Signature:................................Date:...

The referral did not proceed to assessment for the following reason(s):

Change in consumer situation – assessment no longer appropriate: ☐

Consumer Declined: ☐   Other: Please explain above