

health

# Guidelines for streamlining pathways between ACAS and HACCC assessment services in Victoria

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# Guidelines for streamlining pathways between ACAS and HACCC assessment services

## **Improving the client journey**



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# Improving the client journey

## 1. Introduction

The Home and Community Care (HACC) Assessment Framework was endorsed by the Minister for Senior Victorians in 2007. The framework is built on the principle that assessments should be client centred, carer focussed and should promote independence.

In 2008 a mix of local councils, community health services, Aboriginal community controlled organisations, nursing services and community service organisations were designated as HACC assessment services. These services have tertiary qualified, dedicated assessment staff who undertake assessments to gain a broad understanding of client and carer needs.

The Assessment Framework focuses on a partnership approach to reduce duplication and ensure that assessments are coordinated around client need and build on client and carer strengths. The HACC Assessment Reference Group, comprising representatives from across the sector identified Aged Care Assessment Service (ACAS) as a key partner in this approach and agreed to develop improved referral pathways and coordination between the two assessment services.

In 2009, workshops were conducted in each of the eight Department of Health regions with staff from both ACAS and HACC assessment services. Information collected as a result of these workshops has been used to develop these Guidelines. The guidelines build on successful partnerships and processes currently operating between ACAS and HACC assessment services.

## 2. Purpose

The *Guidelines for streamlining pathways between ACAS and HACC assessment services* provide recommended referral pathways for frail older people to reduce unnecessary duplication of assessments. The purpose of the guidelines is to make sure that frail older people get the right assessment at the right time; to minimise the number of times clients or their carers have to tell their stories; and to reduce waiting times for assessment by using resources as efficiently as possible.

## 3. Memoranda of understanding

It is recommended that ACAS and HACC assessment services develop agreements and/or memoranda of understandings (MOUs) on a range of operational issues at the regional or sub regional level.

This document provides guidelines on:

- indicators for referral to the most appropriate assessment services: HACC or ACAS
- expectations for communication and information sharing
- supporting the transition from HACC services to Commonwealth funded aged care packages
- mechanisms for strengthening trust and building relationships between ACAS and HACC assessment services at the local level.

MOUs should incorporate the indicators and referral pathways that are provided in this document. These indicators are consistent with the indicators developed and implemented in the Direct2Care pilot project in the Eastern Region.

The target group for local MOUs will be frail older people and their carers. Younger people with a disability are not included because the requirements for referrals to ACAS for younger people with a disability are described in the *Disability Services - ACAS Protocol 2009* which is available at <http://www.health.vic.gov.au/agedcare/services/assess.htm>.

## 4. Program descriptions

### 4.1 HACC program

The HACC program is jointly funded by the Commonwealth and Victorian Governments. The HACC program provides a range of basic care and support services to frail older people and people with disabilities who experience difficulties in managing daily tasks but wish to continue living at home. The program also supports their carers and families. In Victoria, local governments contribute funds and resources to supplement HACC service delivery, as do people using services who contribute through the fees they pay.

The *Framework for assessment in the HACC program* in Victoria was released in 2007. The first step in implementation of the framework was the designation of 100 HACC assessment services across Victoria. These services provide broadly based, holistic assessments of client and carer need called Living at Home Assessments. Assessments take an active ageing approach, identifying opportunities for improved functional capacity and participation in social and community activities. Care planning takes a person-centred, goal-oriented approach. Key resources including the new practice guide *Strengthening assessment and care planning: a guide for HACC Assessment Services in Victoria* are available at <http://www.health.vic.gov.au/hacc/assessment.htm>.

The Victorian HACC Active Service Model (ASM) is a quality improvement initiative that explicitly focuses on promoting capacity building and restorative care in service delivery for people using services. The ASM is based on the premise that many people have the potential to make gains in their wellbeing and that the range of HACC services working together can facilitate this. It puts the emphasis on timely good quality assessment and interventions that prioritise capacity building and/or restorative care to maintain or promote a person's ability to live as independently as possible at home. The ASM discussion paper, implementation plan and ASM PREPARE are available at [http://www.health.vic.gov.au/hacc/projects/asm\\_project.htm](http://www.health.vic.gov.au/hacc/projects/asm_project.htm).

The HACC Diversity Framework is aimed at improving access for people who are marginalised and have difficulty accessing services, regardless of the reasons. Measures to improve access for people who have difficulty accessing services can include more responsive service design and well targeted information. The Framework focuses on the five HACC special needs groups: people from Aboriginal and Torres Strait Islander backgrounds; people from culturally and linguistically diverse (CALD) backgrounds; people with dementia; people living in rural and remote areas; and people experiencing financial disadvantage (including people who are homeless or at risk of homelessness) but also includes people living with HIV and gay, lesbian, bisexual and transgender people for example. See link [http://www.health.vic.gov.au/hacc/projects/diversity\\_framework.htm](http://www.health.vic.gov.au/hacc/projects/diversity_framework.htm).

### 4.2 Aged Care Assessment Service

The Aged Care Assessment Program (ACAP) is a national program jointly funded by the Commonwealth and Victorian Governments and administered by the Victorian Government under a cooperative arrangement with the Commonwealth Government. There are 18 Aged Care Assessment Services (ACAS) in Victoria (called ACAT in other states and territories). For ACAS contact details go to <http://www.health.vic.gov.au/agedcare/services/assess.htm>.

The core objective of the ACAP is to comprehensively assess the needs of frail older people and facilitate access to services appropriate to their care needs. They play an important role in preventing frail older people from needing to be admitted to hospital. Within the hospital setting ACAS facilitate people's access to Commonwealth funded services, primarily residential aged care and the Transition Care Program. Selected ACAS team members are authorised as Commonwealth delegates under the Commonwealth Aged Care Act 1997 to approve people for Commonwealth funded aged care services. The decision to accept a person recommended for care by an ACAS rests with the provider of the Commonwealth funded aged care service.

The ACAP target group is frail older people, that is, people over the age of 65. Aboriginal people are included in the ACAP target group from age 50. ACAS receives referrals from any source: frail older people and their families, GPs, hospitals, service providers.

ACAS assess younger people with disabilities on referral from Disability Services when no other more age appropriate services are available.

The following Information Sheets provide context and background material on the ACAP.

- How Aged Care Assessment Teams can help you:  
<http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-qcoa-01info.htm>
- The ACAP Operational Guidelines set out the core requirements and responsibilities of the ACAS. The guidelines are available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-acapopgu.htm>
- Some communities have difficulty obtaining services due to language, location, culture or religion. More information on special needs groups is also available in the ACAP operational guidelines.

### **ACAS priority categories**

ACAS determine the priority of each referral, based on the urgency of the person's need. Priority refers to the length of time within which the person needs contact of a clinical nature by ACAS.

**Priority one** refers to a person who requires a response within 48 hours.

**Priority two** refers to a person who is not at immediate risk of harm but the level of care currently available to the person does not meet their needs or is not sustainable. Visit within 2-14 days.

**Priority three** refers to a person who has sufficient support available at present, but requires an assessment in anticipation of their future care requirements. In this instance a referral to ACAS should only be made if the person is likely to be eligible for Commonwealth funded aged care services and is intending to take up such a service (if recommended) within 6-12 months. Clients can waitlist for residential care without an ACAS assessment.

### **4.3 Younger people (under 65 years of age) with a disability**

Disability Services have primary responsibility for ensuring that younger people with a disability receive the most appropriate care. Younger people (i.e. people under 65) with a disability who may require an ACAS assessment are first referred to Disability Services to explore whether there are more appropriate options for their care before making a referral to ACAS.

<http://www.health.vic.gov.au/agedcare/services/assess.htm>

### **4.4 Referrals for Personal Alert Victoria (PAV)**

Both ACAS and HACC assessment services are designated assessment organisations for Personal Alert Victoria (PAV). In most cases a PAV assessment is part of a broader home based assessment. If a person is referred to an assessment service for Personal Alert Victoria (PAV) assessment only, that is, the person is already connected with the service system and needs an assessment to determine eligibility for a PAV, local assessment services need to determine which assessment agency should carry out the PAV assessment. In general, this should be based on the agency that is most familiar with the person and or the agency with current capacity to carry out the PAV assessment.

## **5. Making effective referrals**

The aim of an effective referral is to 'assist consumers in a seamless and timely manner by streamlining access to appropriate services through self referral or assisted referral'. (Victorian Service Coordination Practice Manual, 2006). For this to happen in practice:

- Referral information needs to be accurate and contain relevant information so that the purpose of the referral is clear, and there is evidence that the person is eligible and suitable for the service.
- Agencies need to have trust in the information received in referrals. Trust comes from knowing who provided the information and how it was collected. *For example when including health conditions in a referral, it is important to state the source e.g. GP or client self report.*



These guidelines focus on improving referral pathways both directly into, and between, ACAS and HACC assessment services. The guidelines focus on three main groups:

- People who are not receiving any HACC services at the time of referral (Section 5.1)
- People who are currently receiving HACC services and who may need an ACAS assessment (Section 5.2).
- People who have been referred to or assessed by ACAS and may need a HACC assessment (Section 5.3).

## **5.1 Referral pathways for people who are not receiving HACC services**

When a frail older person, who is not receiving any formal services, presents to an ACAS or a HACC assessment service, the first step is to determine if the person is in the HACC target group. In most instances, if the person has a continuing functional restriction that makes it difficult for them to undertake the activities of daily living and their needs are likely to be able to be met by basic maintenance and support services then referral to a HACC assessment service should be made.

If the person has relatively high or complex needs or circumstances this can trigger the need for a more specialist ACAS assessment prior to, or in combination with a Living at Home Assessment. This decision will be made based on information provided at the initial inquiry and after consultation between the two services. In Grampians and Eastern region, where people may have contacted Direct2Care for assistance, then Direct2Care will make this decision in consultation with the relevant assessment service.

### **Indicators for referral to HACC assessment service**

The HACC target group includes frail older people or younger people with a disability who, due to a moderate, severe or profound disability, need assistance with basic maintenance and support services to enable them to continue living independently at home.

A person who is in the HACC target group can receive a Living at Home Assessment from any HACC assessment service regardless of whether they appear to need HACC services of the type provided by that organisation. HACC Assessment Services have an obligation to assess people's needs independently of the services their agencies deliver.

HACC Living at Home Assessments and the active service model (ASM) use a strength-based partnership approach to develop individual solutions to optimise health and wellbeing. HACC assessors are required to focus on the person's presenting needs, without having their view of these needs coloured by services provided by the assessor's own organisation. For example, a person in the HACC target group who is socially isolated or is becoming socially isolated may not require any home based services. If the assessor finds this to be the case, the focus of the assessment would then be on assisting him or her to engage with community activities.

### **Indicators for referral to ACAS (rather than HACC assessment service)**

A person should be referred to ACAS if they have a need for ongoing case management support or access to specialist support services due to the complexities in their health, social or family circumstances. The most common examples include:

- a person with dementia who needs specialist assessment and may need higher levels of support than can be provided by the HACC Program
- the person and their carer have different or higher levels of need than can be provided through the HACC program
- the person lives alone and is at risk, and may need continuing case management
- other indicators of the need for continuing case management and higher levels of service to support them at home, than are available through the HACC Program
- carer requires residential respite for the client.

These are indicators for an ACAS referral instead of a referral to a HACC assessment service.

## 5.2 Referrals from HACC assessment services to ACAS

This section is about people who are currently receiving HACC services and as a result of a review or significant change in circumstances, the HACC assessment service and/or the client and family have concluded that an ACAS referral is required.

Prior to making a referral, HACC assessment services should do the following:

- Ring the ACAS intake worker, or the ACAS clinical coordinator/senior clinician or manager if they are not sure whether a referral to ACAS is appropriate or not.
- Talk to the person and/or carer about the purpose of an ACAS assessment and obtain their consent to a referral.
- ACAS will accept referrals for people who are considered to be at risk or unsafe at home but who may not provide consent because they do not have capacity to do so due to cognitive impairment.
- Share relevant information with ACAS using the SCTT tools (see below) and indicate urgency in order to streamline the assessment process.
- Speak to the person about commonwealth funded care packages, residential care and residential respite options.
- Provide relevant brochures and any other information that will assist the person to understand the assessment process and possible outcomes.
- Discuss the need for a family member or advocate to be present to assist the person to understand the range of options and information that will be provided, and to support them in decision making.
- Encourage Aboriginal people to have a family member and/or an Aboriginal worker from an Aboriginal Community Controlled Organisation present at the assessment to support them through the process.
- Notify the ACAS if an interpreter is required, including country of birth and language/dialect spoken

**Note:** Urgent referrals should be followed up with a phone call from the HACC Assessment Service to give supporting information.

When a referral is received from the HACC assessment service, ACAS should:

- Ring the HACC assessment service worker who made the referral if there is any query about the appropriateness of the referral or if more information is required.
- Identify the priority of the referral and the timeframe for the response.
- Send an acknowledgement of receipt of the referral back to the HACC assessment service including the priority/timeframe for response.

### SCTT and information sharing

Referrals to ACAS should use the following SCTT templates:

- Confidential Referral Cover Sheet
- Consumer Information
- Summary and Referral
- Living and Caring Arrangements
- Functional Assessment Summary
- Consumer consent to share information.

The HACC assessment service may also attach a copy of their most recent assessment/review form and care plan to the referral to ensure the narrative surrounding the person's need for assessment is clearly identified, and that agreed actions and goals are shared.

Additional SCTT profiles may be used depending on the client circumstances. The SCTT 2009 and User Guide are available at: <http://www.health.vic.gov.au/pcps/coordination/index.htm>.

Referrals should provide:

- demographic data
- a medical history (including a GP Older Person's health assessment summary if available)
- current formal and informal services and support utilised,
- social history and carer circumstances.
- client's goals and capacity building actions undertaken or planned to improve functioning and social connections.

If there has been a significant time lag between referral and assessment, the ACAS may obtain client consent to collect updated information from the HACC assessment service, if required. HACC assessment services can then provide additional verbal or written information about the person and the formal and informal supports they are currently receiving *e.g. a copy of the latest review or assessment*.

On the basis of this information, the advantages of a joint visit or joint assessment will be considered (See page 14).

#### **When a referral to ACAS is not accepted:**

If the referral is not accepted, the ACAS intake worker will provide reasons to the HACC assessment service and help to identify other options to address the person's needs. The ACAS clinical consultant or manager will provide more detailed information if the HACC assessment service is still unsatisfied with the decision.

A decision not to accept a referral for a person seeking a Commonwealth funded care package or residential aged care is a 'reviewable decision' under the Aged Care Act. Any person refused an ACAS assessment must be provided with information about grievance procedures and their rights to request a review of this decision. Where a referral for an ACAS assessment is not accepted, information on grievance procedures should also be provided to the referral source. Refer to ACAS Grievances Procedures in the Appendix.

#### **Communicating ACAS assessment outcomes**

ACAS routinely provide a standard care plan letter to the person's GP detailing the outcome of the assessment. When a HACC assessment service is the referrer, a copy of this letter should be routinely be sent to them. This will assist the person's transition from HACC services to other recommended aged care services and/or respond to other needs identified in the ACAS assessment.

Where a HACC assessment service is *not* the referrer, but is providing ongoing HACC services to the person, ACAS will obtain client consent to send a copy of their GP care plan letter to the HACC assessment service.

### **5.3 Referrals from ACAS to HACC assessment services**

This section relates to people who have been assessed by ACAS and require a referral to a HACC assessment service to enable them to continue living at home, either

- whilst they are on a waiting list for Commonwealth funded aged care services, or
- with ongoing HACC services and other community supports.

#### **Information sharing**

ACAS can contribute to the streamlining of subsequent assessment processes and assist HACC services to maintain or promote people's ability to live independently at home by sharing all relevant information gathered during the ACAS assessment (with the person's consent). Information to be shared with HACC assessment services includes:

- all relevant medical information
- physical, psychological, and social issues impacting on client's capacity to live independently
- information about recent sub-acute or community based rehabilitation episodes including goals of care
- involvement in Chronic Disease Management programs such as HARP and self management strategies
- carer needs and sustainability of the care relationship
- recent nursing or allied health interventions including goals of care
- cognitive assessments (CDAMS, MMSE results)
- list of services currently involved with the person and their family
- Commonwealth funded aged care services recommended by the ACAS, wait list processes and approximate time frames (if known).

For people not previously known to the HACC assessment service, providing information commonly required for home based care such as environmental risks to the person and/or community care workers will also help to streamline assessments.

By sharing this information, the HACC assessment service will be able to complete the holistic needs based component of the Living At Home Assessment without having to ask the person to repeat their story. This will enable the HACC assessment service to focus on developing service specific assessments and care plans. Where necessary, the ACAS assessor may be asked to provide more detail or clarification.

### **Use of the SCTT**

ACAS referrals to HACC assessment services include the SCTT tools listed below which contain HACC MDS data required for every HACC client. Most of these SCTT tools can be auto-populated from the ACAS software (ACE) registration screen. Additional information will be auto-populated from the new electronic Victorian Comprehensive Assessment Form from late 2010.

Referrals to HACC assessment services should use the following SCTT tools:

- Confidential Referral Cover Sheet
- Consumer Information Template (INI)
- Summary and Referral Template
- Living and Caring Arrangements
- Functional Assessment Summary
- Consumer consent

Other SCTT profiles can be sent where relevant. ACAS will be able to attach a copy of the Victorian Comprehensive Assessment Form to the SCTT referral once the form is in use.

### **When a referral is received from ACAS, HACC assessment service should**

- contact the ACAS intake worker if more information is required
- identify the person's priority and timeframe for the response
- acknowledge receipt of the referral including the timeframe for response.

### **When a referral from ACAS is not accepted by the HACC assessment service**

If the referral is not accepted, the HACC intake worker will provide reasons to the ACAS and help to identify other options to address the person's needs. The HACC assessment service manager will provide more detailed information if the ACAS is still unsatisfied with the decision.

## **6. Supporting the transition to Commonwealth funded aged care services**

HACC assessment services and the ACAS both have an important role in supporting people to make a smooth transition between HACC services and Commonwealth funded aged care services.

### **6.1 HACC assessment services role**

HACC assessment services' role is to ensure that clients, carers and families are well informed about the aged care options if HACC services can no longer provide the type and level of support that is needed. HACC assessors need to be aware of the eligibility requirements and the types and amounts of care that can be provided by Commonwealth funded care packaged care so that they can refer people to ACAS at the right time. See section 5.2.

Establishing an awareness of the limits to HACC service provision and the possibility of needing to transition to other more appropriate types of care should occur early on in the person's relationship with the HACC provider in order to make the transition easier for all parties.

If Commonwealth aged care services are approved by ACAS, HACC services will continue to be provided until clients are offered the relevant aged care package or a residential aged care place. Some HACC services report difficulties providing appropriate levels of care in these circumstances. HACC assessment

services and ACAS will need to work together to determine what additional services could best support the person and their family during this interim period and where they will be sourced from.

Additional services that may be available during this period include Commonwealth Carer Respite Centres, Hospital Admission Risk Program (HARP) services or other short term rapid response services. The Transition Care Program is available for people assessed in hospitals.

## **6.2 ACAS role**

In order to support decision making about transitioning to Commonwealth funded aged care services, ACAS provide clients and their carers/families with detailed information about the various service options (care packages, residential care and residential respite). The ACAS will explain:

- The range of community care packages and the types and level of services that can be purchased.
- Case management and its benefits.
- That the level of service provision on a CACP package may be of a different type to their current services.
- Waiting times for various types of aged care services in the region.
- How to apply for a community care package and how the regional e-waiting list system works (see below)
- Processes for applying for residential care (ACAS will provide the '5 Step to Entry into Residential Aged Care' information)

ACAS cannot give financial advice. Fees are negotiated between the person and the aged care provider.

Following the assessment, ACAS should provide information to HACC assessment services about

- the types of aged care services the person has been approved for, and
- the types of services and their source that can meet the person and their carer's needs while they wait to access the recommended services.

## **6.3 Waitlisting for Commonwealth funded care packages**

Victoria's regional e-Aged Care Package Waitlist Systems have been very successful in streamlining the process of wait listing for CACPs, EACH and EACHD with benefits to ACAS, package providers and clients. There are two waitlisting systems in Victoria: Loddon Mallee region ACAS waitlist, and Infoxchange in all other ACAS.

In order to support people during this transitional period, ACAS should notify the relevant HACC service provider when

- the client has been placed on a waiting list, including their priority rating
- the client's priority category on the e-waiting list has changed due to a change in circumstances.

It is the responsibility of the client and the package provider to advise the HACC service provider when a person accepts a care package.

## **7. Opportunities for collaboration**

ACAS and HACC assessment services use elements of multi-disciplinary and inter-disciplinary practice to achieve the best possible outcomes for their clients. Some of the collaborative processes listed below are routinely practiced now by both assessment services. Other processes such as local network case conferences have lapsed in many areas. These should be reconsidered as part of the development of MOUs and streamlining processes for clients that are common to ACAS and HACC assessment services.

### **7.1 Case conferences and team work**

Case conferencing about clients with complex needs has been a feature of local aged care networks over the past ten to fifteen years. Aged care networks generally included councils, package care providers, district nursing, ACAS and community health centres. Networks met regularly for information sharing and case conferencing. A stronger focus on privacy and confidentiality, together with increased workloads has reduced the prevalence of case conferencing as a feature of network activity.

ACAS routinely hold multi-disciplinary case conferences in order to maximise the value of the care planning process to the client. These case conferences enhance assessors' understanding of clients' health conditions from a multi disciplinary perspective and ensure that a range of options are considered before the final care plan and recommendations are made.

Feedback from the regional workshops supports the reintroduction of case conferencing for complex clients by HACC assessment service and ACAS in order to build stronger partnerships, improve care coordination and build practitioner knowledge by sharing skills across disciplines, for the benefit of clients.

Those local aged care networks that continue to operate use the following strategies to protect privacy and confidentiality:

- Client consent for the case conference is obtained
- The agenda and names of clients to be discussed are circulated prior to meeting
- Providers only attend for the time of the meeting relevant to their shared clients

It is recommended that ACAS and HACC assessment service consider reinstating case conferences - using existing forums where possible - and develop strategies to protect client privacy and confidentiality.

## 7.2 Secondary consultations

Secondary consultations are conversations between practitioners, usually practitioners from other disciplines or program areas that help to:

- seek other ideas and options to address a particular client problem or issue
- confirm your own professional judgement about a particular problem or issue.

ACAS multidisciplinary teams embed secondary consultations in their day to day practice in a number of ways; through case conferences and through informal conversations with colleagues from different disciplines within the team or from other teams within their auspice. This process ensures that a range of people have input into decisions and clinical interventions or care plans.

With the implementation of the Assessment Framework, HACC assessment services will increasingly comprise multi-disciplinary staff, creating increased opportunities for secondary consultation within the team. HACC assessment services are also encouraged to seek opportunities to access a range of expert advice from their colleagues in other services to strengthen their assessment and care planning processes.

In particular, HACC assessment services would benefit from secondary consultations with ACAS for common clients *e.g.* following a Living at Home Assessment, a HACC assessment service assessor might contact the ACAS assessor to discuss the person's cognitive status and ways in which the person could be supported to live independently, and/or behaviour management. The secondary consult may focus on where to find more support for the carer, or whether the person's higher level goal is a realistic one.

Local agreements about who to contact and how to request a secondary consultation would help to clarify expectations and support timely and appropriate responses through local protocol agreements.

## 7.3 Joint visits and joint assessments

A joint approach to assessment by ACAS and HACC assessment services provides an opportunity to learn about each other's assessment and care planning processes, techniques and outcomes and reduce duplication. A joint approach may comprise either a joint assessment or a joint visit:

- A joint *assessment* aims to undertake both a Living at Home Assessment and an ACAS assessment at the same time.
- A joint *visit* aims to carry out *either* a Living at Home Assessment *or* an ACAS assessment, and workers from both agencies attend.

When determining if a joint assessment or joint visit is appropriate HACC assessment services and ACAS must weigh up benefits to clients against any possible adverse impacts. The capacity to carry out joint assessments will also be dependent upon agency resources.

Joint assessments or joint visits should be considered for complex clients *e.g.* clients with chronic diseases, moderate or advanced dementia; where both carer and client have issues that need addressing; special

needs clients, for example Aboriginal and Torres Straight Islanders or CALD clients; and clients referred for a package that will require HACC services while they wait for a package to become available.

## **7.4 Joint training**

Joint training between ACAS and HACC assessment services enhances the skills of assessment practitioners and builds mutual respect for the professional skill base of assessors in both ACAS and HACC assessment services. Training could include:

- Objectives of a Living at Home Assessment compared to an ACAS assessment. This would include examination of assessment practices in both agencies and use of various validated assessment tools
- Sharing up-to-date education resources e.g. dementia training
- Joint in-service training from a range of local service providers. This might include:
  - Carer respite services
  - Community Health Services: range and type of services provided
  - Health Promotion programs and services
  - Clinical Assessment i.e. nursing
  - Chronic Disease management initiatives.

## **7.5 Common orientation program**

There is a significant opportunity for new assessment staff to learn about respective roles and responsibilities of each assessment service through a common orientation program. New HACC assessment staff should include in their orientation:

- attending HACC assessments /ACAS assessments
- HACC assessors attend ACAS case conferences
- visit agencies in the local catchment to meet relevant staff and learn how agencies work together.

## **8. Improving trust and building better relationships**

Development of MOUs and the implementation of these guidelines relies on trust and good working relationships. Trust and goodwill can grow from collaborative practices aimed at streamlining services for common clients (described above), as well as organisational innovation and participation in local networks and alliances as described below.

There is not doubt that strong partnerships are built by individuals (and their organisations) who have a commitment to a genuine shared purpose. (*Evaluation of the partnering development pilot projects for HACC assessment*, Department of Health 2010).

Below are some examples provided by participants at the regional workshops for building stronger relationships.

### **8.1 Organisational innovation**

At an organisational level there are a number of opportunities to strengthen relationships between ACAS and HACC assessment services. Strategies for gaining a better understanding of each other's roles and responsibilities and assessment practices include:

- Co-locating an ACAS assessor with their local HACC assessment service.
- Nominating a liaison worker in each HACC assessment service and each ACAS to streamline communication between the two services

## 8.2 Assessment alliances

Designated HACC Assessment Services are expected to play a lead role in developing assessment alliances at the PCP or regional level. Assessment alliances aim to:

- promote a coordinated and streamlined approach to assessment and care planning in a defined catchment
- develop common understanding of assessment processes and practices across different services and programs areas
- provide a forum for implementing the active service model across a region or PCP
- provide a forum for information sharing eg resources for specific client groups such as CALD communities, initiatives in the health sector, broader aged care service system issues, local leisure activities for older people.

ACAS should be included as members of these alliances in recognition of the common client group, overlapping roles and responsibilities and the better alignment and efficiencies gained through developing close working relationships.

### Keeping up to date with new services/program

All assessment services, both ACAS and HACC play a key role in assisting people to navigate and access the health and aged care service systems as well as linking people to local community activities available to the broader population. Doing this well requires systematic updating of information and keeping up with new initiatives/services/programs across a catchment.

While each assessment service has its own data base of services in their region, HACC services, particularly local councils are more likely to have a detailed knowledge of their local communities and local community services, leisure and social activities. ACAS are more likely to have information about services in the health, acute and sub-acute sector. Local government websites are a good source of local information and the Department of Health Human Services Directory is also a valuable resource [www.humanservicesdirectory.vic.gov.au](http://www.humanservicesdirectory.vic.gov.au).

Regional or PCP based Assessment Alliances provide an opportunity to share and update local information and knowledge about available services.

For example, in order to implement the active service model, HACC assessment services need to become familiar with programs and services that assist people to improve their functional capacity and developments in Commonwealth funded aged care services.

This information is well known to ACAS but not as easily accessed by HAS.

The following list gives examples of service developments and program updates that need to be shared across a catchment:

- developments in hospitals such as Long stay Older Patients initiative (LSOP) and Transition Care Program.
- developments in the Health Independence Program (HIP) including Hospital At Risk Program (HARP), community rehabilitation, CDAMS, specialist clinics - falls and mobility, continence and pain management. See the HIP Guidelines: [www.health.vic.gov.au/subacute/hip-manual08.pdf](http://www.health.vic.gov.au/subacute/hip-manual08.pdf)
- Early Intervention in Chronic Disease Management
- Well for Life and Make a Move programs (see glossary)
- services providing support for special needs groups such as people with dementia and homeless people.
- types of aged care packages available for Aboriginal and CALD clients in each local government area and the profile of clients who typically take up these packages
- waiting list management and wait times to access different types of aged care services.



### **Community Information forums**

Regional or sub-regional assessment alliances can also play a role in providing information to the *general public* via community education forums in order to promote a better understanding of community and aged care services amongst older people and their families.

This would provide a streamlined and coordinated approach across an LGA to improving older people's and their families' understanding and expectations of aged and community care services what they can deliver, how to access services and the philosophy of active ageing.

# Appendices

## ***Grievance procedure for referrals not accepted by ACAS***

There may be times when an ACAS will refuse a referral for assessment or reassessment. DoHA (Department of Health and Ageing) suggests that a decision not to accept a referral is treated as a reviewable decision so that any person refused an assessment is provided with an opportunity to request a review.

Even though a telephone or fax referral may not meet the requirements of subsection 22-3(1) and (3) of the *Aged Care Act 1997* in relation to a valid application for aged care, as the person making the referral in this way HACC assessment service no other way to make an application to meet the requirements of the Act, it is DoHA's view that there should be some review mechanism available.

ACASs should ensure that the following information is provided (in writing or by telephone) to all clients where a referral for assessment (or reassessment) is not accepted:

If you or any other person affected by this decision are not satisfied with the decision, you can write to the Secretary of the Department of Health and Ageing. You must write within 28 days of receiving this advice and give the reasons why you think the decision should be changed.

If you think the decision should be changed, please write to:-

**The Secretary  
Department of Health and Ageing  
C/- State Manager  
Ageing and Aged Care Division  
GPO Box 9848  
MELBOURNE VIC 3001**

If you are not satisfied with the Secretary's reply, or if the Secretary does not answer you within 90 days, the Administrative Appeals Tribunal can review the decision.

## Home and Community Care (HACC) Designated Assessment Services by Aged Care Assessment Service catchment in Victoria

Region	HACC Assessment Service	Aged Care Assessment Service
Barwon South West	Colac-Otway Shire Council	Geelong
Barwon South West	Otway Health and Community Services	Geelong
Barwon South West	Barwon Health	Geelong
Barwon South West	City of Greater Geelong	Geelong
Barwon South West	Bellarine Community Health Service	Geelong
Barwon South West	Borough of Queenscliffe	Geelong
Barwon South West	Surfcoast Shire	Geelong
Barwon South West	Warrnambool City Council	Warrnambool
Barwon South West	Southern Grampians Shire	Warrnambool
Barwon South West	Moyne Shire Council	Warrnambool
Barwon South West	Glenelg Shire Council	Warrnambool
Barwon South West	Timboon and District Healthcare Service	Warrnambool
Barwon South West	Corangamite Shire Council	Warrnambool
Grampians	Ararat Rural City Council	Grampians
Grampians	East Grampians Health Service	Grampians
Grampians	Ballarat City	Grampians
Grampians	Ballarat District Nursing and Healthcare	Grampians
Grampians	Golden Plains Shire Council	Grampians
Grampians	Hepburn Shire Council	Grampians
Grampians	Hindmarsh Shire Council	Grampians
Grampians	Horsham Rural City Council	Grampians
Grampians	Wimmera Health Care Group	Grampians
Grampians	West Wimmera Health Service	Grampians
Grampians	Moorabool Shire Council	Grampians
Grampians	Northern Grampians Shire Council	Grampians
Grampians	Pyrenees Shire Council	Grampians
Grampians	Edenhope and District Memorial Hospital	Grampians
Grampians	West Wimmera Shire	Grampians
Grampians	Dunmunkle Health Service	Grampians
Grampians	Yarriambiack Shire	Grampians
Loddon Mallee	Buloke Shire	Bendigo
Loddon Mallee	Campaspe Shire	Bendigo
Loddon Mallee	Central Goldfields Shire	Bendigo
Loddon Mallee	Gannawarra Shire	Bendigo
Loddon Mallee	Greater Bendigo City	Bendigo
Loddon Mallee	Loddon Shire	Bendigo
Loddon Mallee	Macedon Ranges Shire	Bendigo
Loddon Mallee	Mount Alexander Shire	Bendigo
Loddon Mallee	Swan Hill Rural City Council	Bendigo [Robinvale is Mildura ACAS]
Loddon Mallee	Mildura Rural City	Mildura
Hume	City of Greater Shepparton	Shepparton
Hume	Rumbalara Aboriginal Co-operative Limited	Shepparton
Hume	Mitchell Community Health Service	Shepparton
Hume	Moira Community Health Service	Shepparton
Hume	Shire of Strathbogie	Shepparton
Hume	Shire of Murrindindi	Shepparton
Hume	Shire of Alpine	Wangaratta
Hume	Benalla Rural City	Wangaratta
Hume	Shire of Indigo	Wangaratta
Hume	Mansfield Shire	Wangaratta

Hume	Tallangatta Health Service	Wangaratta
Hume	Rural City of Wangaratta	Wangaratta
Hume	Wodonga Rural City	Wangaratta
Gippsland	Bass Coast Shire Council	Gippsland
Gippsland	Baw Baw Shire Council	Gippsland
Gippsland	Cann Valley Bush Nursing Centre	Gippsland
Gippsland	Gippsland Lakes Community Health	Gippsland
Gippsland	Mallacoota District Health	Gippsland
Gippsland	Omeo District Health Service	Gippsland
Gippsland	Orbost Regional Health	Gippsland
Gippsland	The Buchan Bush Nursing Association	Gippsland
Gippsland	Latrobe City Council	Gippsland
Gippsland	South Gippsland Shire Council	Gippsland
Gippsland	Central Gippsland Health Service	Gippsland
Gippsland	Yarram and District Health Service	Gippsland
Metro	Royal District Nursing Service	All metro
North West	Aborigines Advancement League	All North West Region ACAS's
North West	Hume City Council	North West
North West	Baptist Community Care	North West
North West	Moonee Valley City Council	North West
North West	Melbourne City Council	North West
North West	Moreland City Council	North West
North West	Brimbank City Council	Western
North West	Hobson's Bay City Council	Western
North West	Maribyrnong City Council	Western
North West	Melton Shire Council	Western
North West	Wyndham City Council	Western
North West	MECWA Community Care	Western
North West	City of Darebin	Bundoora [Northcote is St Vincent's ACAS]
North West	Whittlesea City Council	Bundoora
North West	Nillumbik Shire Council	Bundoora
North West	Banyule City Council	Heidelberg [North Banyule is Bundoora ACAS]
North West	Yarra City Council	St Vincent's
Eastern	City of Boroondara	Central East [Camberwell, Hawthorn & Kew are St Vincent's ACAS]
Eastern	City of Manningham	Central East
Eastern	City of Monash	Central East
Eastern	City of Whitehorse	Central East
Eastern	City of Knox	Outer East
Eastern	City of Maroondah	Outer East
Eastern	Shire of Yarra Ranges	Outer East
Southern	Casey City Council	Mt Eliza
Southern	Frankston City Council	Mt Eliza
Southern	Mornington Peninsula Shire	Mt Eliza
Southern	MECWA Community Care	Mt Eliza
Southern	Bayside City Council	Kingston
Southern	The City of Greater Dandenong	Kingston
Southern	City of Kingston	Kingston
Southern	City of Port Phillip	Caulfield
Southern	City of Stonnington	Caulfield
Southern	Glen Eira City Council	Caulfield
Southern	Jewish Care (Victoria)	Southern Region ACAS's

## **Suggested MOU Structure**

### **Regional ACAS and HACC assessment service: Memorandum of Understanding**

- Local area protocol scope and purpose
- Information about regional ACAS teams
- Information about regional HACC assessment services
- Referral pathways
- Making effective referrals
- Information sharing
- Transitioning from HACC Services to Commonwealth funded aged care services
- Opportunities for collaboration
- Improving trust and building better relationships
- MOU endorsement and review process.

# Frequently asked questions

- 1. Why do we need MOUs between HACC assessment service and ACAS?** In 2008 100 HACC agencies were designated to provide Living at Home Assessment. An MOU would document agreed actions at the local level for sharing assessment information to reduce duplication of assessments between these two assessment services. These Guidelines provide a framework for local MOUs.
- 2. How were the guidelines developed?** Eight regional workshops were held in late 2009 with staff from HACC assessment service and ACAS. Information collected at the workshops was used to develop the guidelines.
- 3. What is the difference between HACC assessment service and other HACC providers?** Victoria has 500 HACC funded organisations that deliver HACC services including nursing services, Planned Activity Groups (PAG) and personal care. Of these 500 there are 100 agencies that are designated HACC assessment services.
- 4. What are the objectives of the ACAP?** To assess the care needs of frail older people and ensure that older persons who belong to the following groups have equitable access to Aged Care Assessment Services:
  - 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 or socially disadvantaged
  - veterans, their spouses, widows and widowers
  - people with dementia
  - people who are homeless or at risk of becoming homeless
  - forgotten Australians (include people who have experienced childhood in institutional care or an out-of-home care environment, and include former child migrants. People in this group are also known as 'care leavers').
- 5. Can ACAS assess a person under 65 years?** ACAS core target group is frail older people with high and/or complex care needs. If a younger person requires a Commonwealth aged care service he or she should be considered for Disability Services in the first instance. Please refer to the statewide ACAS-Disability Services protocol <http://www.health.vic.gov.au/agedcare/services/assess.htm>
- 6. Can ACAS assess a younger Aboriginal person?** The lower life expectancy for Aboriginal and Torres Strait Islander people means that Aboriginal people can also be expected to require assessment services at an earlier age than is the case for the wider community. ACAS will accept referrals for Aboriginal and Torres Strait Islander people from age 50 years (or younger if demonstrating chronic health conditions and not in the target group for Disability Services).
- 7. With the legislative changes to the Aged Care Act effective 1 July 2009 it is difficult to know when an assessment for someone is required.** If you are unsure about making a referral discuss with the ACAS intake worker. For information about the legislative changes go to <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-legislation-change.htm>
- 8. If someone needs an ACAS assessment but they already have a current Aged Care Client Record will ACAS still accept a referral?** Reassessments of clients can be undertaken when the client's care needs change, if referrers are unsure they should discuss with the intake worker.
- 9. What is the difference between an ACAS and ACAT?** In Victoria we use the term ACAS but other states and territories use Aged Care Assessment Teams (ACAT). There is no difference in the services provided.

# Dictionary of abbreviations

ACAS	Aged Care Assessment Service
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ASM	Active Service Model
BATS	Better Access to Services
CALD	Culturally and linguistically diverse
CDM	Chronic Disease management
COAG	Council of Australian Governments
DoHA	Department of Health and Ageing
D2C	Direct2Care
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
EiCDM	Early intervention in Chronic Disease Management
HACC	Home and Community Care
HARP	Hospital Admissions Risk Program
IC	Initial Contact
INI	Initial Needs Identification
LAHA	Living at Home Assessment
LGA	Local Government Area
MAV	Municipal Association of Victoria
MOU	Memorandum of Understanding
MIC	Migrant Information Centre
NRCP	National Respite for Carers Program
PAG	Planned Activity Group
PAV	Personal Alarm Victoria
PCP	Primary Care Partnership
RDNS	Royal District Nursing Service
SCTT	Service Coordination Tool Template

# Glossary of terms

**Aged Care Act legislative changes** Came into effect on 1 July 2009. Some ACAS assessments no longer expire, unless time limited. These include assessment for EACH/D, High level care and respite. [www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-legislation-change.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-legislation-change.htm)

**Active Service Model (ASM)** This is a quality improvement initiative currently being implemented in the HACC program in Victoria, which explicitly focuses on promoting capacity building and restorative care for people in service delivery.

**Aged Care Australia** A Department of Health and Ageing website providing information for consumers about the services available to help look after an older person. [www.agedcareaustralia.gov.au](http://www.agedcareaustralia.gov.au)

**Aged Care Client Record** The Aged Care Client Record (ACCR) is the formal client record, application and approval form used by the ACAT as prescribed by the *Aged Care Act (1997)*. It is not a client assessment form or tool, although it does record data collected at assessment and provides essential narrative data to inform the service provider of a person's care needs.

**CACP** Community Aged Care Packages (CACPs) are individually planned and coordinated packages of care tailored to help older Australians remain living in their own homes. To receive a CACP, you must be assessed as requiring at least low level residential aged care. The Australian government provides CACP approved providers with a daily subsidy per package to supply and coordinate care services for frail older people. The individual services within a CACP may be provided by a variety of organisations in your local area, but will be coordinated and planned by the approved aged care service provider.

**Care coordination** Care Coordination describes activities undertaken for a subgroup of clients with complex needs and circumstances. Clients needing care coordination include clients receiving services from multiple organisations and are not receiving case management as part of a package of care.

**Case conference** Case conferencing is the process in which members of a multidisciplinary or interdisciplinary teams come together to present and discuss cases. Case conferencing is an opportunity to have broader input into the decision making process surrounding an assessment and care planning.

**Case management - CACPS, EACH, EACHD** Commonwealth government subsidised case management packages of care are available in the community for clients with complex needs. Eligibility is determined via an assessment by the Aged Care Assessment Service. For further information [www.health.gov.au/acats](http://www.health.gov.au/acats)

**Victorian Comprehensive Assessment Form** Developed for Victorian ACAS to collect and record common, core information required to provide a comprehensive assessment. The form contains all the required information to electronically auto-populate the ACCR. The form is designed to be used for a face-to-face assessment.

**HACC Diversity Framework** is a quality improvement initiative aimed at: improving access for people who are marginalised and have difficulty accessing services, regardless of the reasons. The Framework focuses on the five HACC special needs groups and also includes but is not limited to people living with HIV and gay, lesbian, bisexual and transgender people for example. For further information [http://www.health.vic.gov.au/hacc/projects/diversity\\_framework.htm](http://www.health.vic.gov.au/hacc/projects/diversity_framework.htm)

**Direct2Care** Direct2Care is a new service funded by the Commonwealth and Victorian Governments. In its initial phase of development, it currently operates in the Eastern Metropolitan Region (EMR) of Melbourne and the Grampians Region. Direct2Care provides information, advice about local community services, health services, and services for carers for people in the HACC target group. Direct2Care staff will provide referrals for further assessment or for a specific service as required.

**EACH** Extended Aged Care at Home (EACH) packages are individually planned and coordinated packages of care, tailored to help older Australians remain living in their own homes. EACH packages are very flexible and are designed to help with individual care needs. Generally a person who requires high level residential aged care could be eligible for an EACH package.



**EACHD** Extended Aged Care at Home Dementia (EACHD) packages are individually planned and coordinated packages of care tailored to help older Australians who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia.

**High Level residential care** (previously known as nursing homes) These facilities provide care for people with a high level of frailty, who need continuous nursing care.

**Intake** ACAS uses an intake system to triage referrals. Some ACAS operate their own intake system but others have a centralised intake system which may accept referrals for other programs as well.

**Joint assessment** A *joint assessment* aims to undertake two different assessments at the same visit eg a Living at Home Assessment and an ACAS assessment.

**Joint visit** A joint *visit* aims to carry out one assessment only (either a Living at Home Assessment or an ACAS assessment) but workers from the other agency attend.

**Key worker** The nominated person who works with the client/carer and other organisations to facilitate inter-agency care-planning and care coordination. Key workers are only nominated for clients with complex needs and/or multi-agency involvement.

**Living At Home Assessment** A Living at Home Assessment is a HACC funded activity delivered by designated HACC Assessment Services. A Living at Home Assessment is a person centred assessment of the person and their family or carer's needs, which leads to a care plan and individualised service responses. The purpose of a Living at Home Assessment is to gain a broad understanding of the range of community based services a person and their family or carer's need in order to build people's capacity to remain living as independently as possible.

**Low Level residential care** (previously known as hostels) These facilities provide accommodation and personal care, such as help with dressing and showering.

**Make a Move Home** Home based or group exercise and nutrition programs for Home and Community Care clients at risk of falls.

**Packaged care** HACC-funded Linkages managed by the Victorian Department of Health or solely Commonwealth-funded services – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACHD). Eligibility for Commonwealth packages is determined by the ACAS.

**Well for Life** Aims to improve the health and wellbeing of frail older people living at home and in aged care settings by improving nutrition, increasing levels of physical activity and improving emotional wellbeing.