

Access Points Mapping Project Report

A National Community Care Access Points initiative

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Executive summary

The aim of this project is to provide an overview of client pathways in Victoria's community care system. The project was conducted during the period June to November 2007.

This project is part of the National Community Care Access Points initiative, whose aim is to simplify entry to the community care system. Its findings will contribute to improved navigation for frail older people, younger people with disabilities, carers, families, friends and service providers.

Client pathways and entry points were explored by analysing data on people who received a service from the Home and Community Care (HACC) Program in Victoria in 2005-06. According to the HACC minimum data set (MDS), just over 229,000 people received a HACC service in that year. No comparable data were available on people who had only enquired about a service.

Client source of referral can be summarized as follows:

self referred – direct contact with service providers	28 per cent
social network – family/friends/carers	14 per cent
general practitioners	13 per cent
hospitals	18 per cent
Aged Care Assessment Services	6 per cent
extended care or rehabilitation services	3 per cent
other pathways including inter-agency referrals	18 per cent.

Some 42 percent of people who receive a HACC service were recorded as self-referrals or as referred by family and friends.

In metropolitan Melbourne, Local Government is the largest provider of HACC services, accounting for approximately 47 per cent of clients. Community Health centres/Hospitals accounted for another 27 per cent of all HACC clients.

Rural Victoria has a different pattern. Local Governments and Community Health centres/ Hospitals each had a similar volume of clients, 43 per cent and 44 per cent respectively.

Inter-agency referrals amongst HACC providers were also examined. However, the findings are exploratory, due to limitations on available data. Further examination of inter-agency referrals at the local levels would provide a better understanding of client flows, and would assist in achieving current policy objectives – in particular, the issue of ensuring culturally equitable and appropriate access to HACC services in Victoria.

Key findings are as follows:

- There are multiple entry points for clients and carers.
- The varied pathways taken, and the varied types of information sought, demonstrate that consumers are not a homogeneous group.
- Most service providers are involved in inter-agency referrals, though some more than others.
- Service providers are making significant progress towards electronic referrals. There is a growing capacity for consumer information to be collected by one agency and transmitted to another.
- Victoria's 'Better Access to Services' policy and operational framework ensures that every service site is an entry point to the full suite of services, including assistance to navigate the system.
- The majority (90 per cent) of CALD clients live in metropolitan areas. The needs of large numbers of CALD clients in metropolitan areas are more easily catered for than the needs of small numbers scattered across rural areas.
- Approximately 40 per cent of indigenous clients are in the metropolitan region. There is a need to formulate strategies to meet the needs of this client group across Victoria.
- Several directories are available to complement the Victorian Better Access to Service framework. These directories should be rationalized to make them more useable from a consumer and service provider perspective.
- Some services in rural regions may only be sporadically available.

The implications of these findings for Access Points are:

- The initial point of contact is important to people who have had little previous experience with the service system. For people who do not know how to access the service system, an Access Point can serve as an easily identifiable point of contact that provides streamlined access to information, care and support.
- General Practitioners (GPs) already serve as the first port of call for a significant proportion of people living in the community. GPs should be encouraged to continue this role of directing people to relevant community care services. Access Points should develop strong links to GPs.
- Hospitals are another major source of referrals to community care services. Strong links with hospitals would potentially facilitate access to community care services for clients coming from the acute health setting.

- Access Points will be an incremental enhancement to Victoria's existing Better Access to Services Policy and Operational Framework. They need to provide consistency in initial contact, initial needs identification, referral, information management and local services information.
- Access Points will add value to the implementation of Victoria's HACC Assessment Framework, which aims to build good assessment processes and strong links to key health and community care organizations in order to manage client pathways more efficiently.
- Access Points will be based on the existing Victorian service system. Their proposed function needs to be fully tested and should take into account the differing capacity in each region.

The findings of this report suggest matters that could be further examined for clarifying the optimal role of Access Points in more localized areas.

1. Introduction

1.1. Context

This project is part of the National Community Care Access Points initiative in Victoria that aims to simplify entry to services in the community care system.

The Council of Australian Governments agreed in February 2006 that there should be simplified entry and assessment for the Home and Community Care Program (Council of Australian Governments 2006).

This work is closely linked with work being pursued by the Commonwealth Department of Health and Ageing to simplify entry and assessment for community care programs as set out in 'A New Strategy for Community Care – The Way Forward' (Australian Government Department of Health and Ageing 2004).

'Simplified entry to services' has been translated into the implementation of Access Points. Victoria's Department of Human Services has been actively working with the Australian Government on developing the necessary elements within the context of the Victorian community care sector.

The scope of the Access Points for the demonstration initiative is limited to the HACC Program, other State-funded Aged Care Programs and the following Commonwealth-funded community care programs: Commonwealth Carers Respite Centres (CCRC), Commonwealth Carelink Centres (CCC), Community Aged Care Packages (CACP), Extended Aged Care at Home Packages (EACH), Day Therapy Centres, and a range of information services.

The high level objective for Access Points is that they should be marketed and visible points where people can go if they are seeking services but do not know what is available or what they may be able to get access to. People may be inquiring on their own behalf or on behalf of a frail aged or disabled family member or friend.

From Victoria's perspective this fundamental objective complements the work that has been done in implementing the Primary Care Partnerships (PCP) Better Access to Services Policy and Operational Framework (Victorian Department of Human Services 2001).

The implementation of an Access Point capacity within the Victorian community care sector will therefore complement work on implementing Service Coordination already done in establishing PCPs. It will also complement the implementation of Victoria's HACC assessment framework (Victorian Department of Human Services 2007b).

The basic principle underpinning Victoria's approach to implementing Access Points is that there is *no wrong door*. This means that all community care agencies should always be helpful in taking the initiative to clarify a person's request and making an informed referral to a relevant agency.

Access Point Demonstration Sites: Two demonstration projects (one metropolitan and one rural) will be testing the Victorian model for Access Points. The model is being developed by the Victorian Department of Human Services and the Commonwealth Department of Health and Ageing. Testing will include gathering information on the volume and nature of inquiries to the Access Points during the demonstration phase, identifying the most effective business processes, the staffing required, the scope and intensity of work effort, the change management implications, and the funding implications to achieve the desired outcome. Information regarding improvement from the clients' perspective such as ease of access to the community care system will be collected.

1.2. Aims and objectives

The aim of the Access Points Mapping Project is to provide a reasonable overview of access pathways and infrastructure in Victoria's community care system by analysing existing data sources. The findings will also provide a baseline for measuring progress in the future.

The objectives of this project are:

- To identify points and pathways that people seeking community care in Victoria easily recognize and currently use.
- To identify current programs and services involved in the Victorian community care system and the current capacities of major groups of agencies.

1.3. Scope

The scope of the project encompasses community-based services for frail older people, younger people with disabilities and carers of these groups. In scope are the Home and Community Care program, other State-funded Aged Care programs and Commonwealth-funded Carers Respite Centres, Community Aged Care Packages, Extended Aged Care at Home Packages, Day Therapy Centres, Aged Care Assessment Services, Commonwealth Carelink Centres and related information services.

2. Client pathways – community care in Victoria

The first objective to identify points and pathways that people seeking community care services in Victoria easily recognize and currently use.

2.1. Methodology

The first task was to identify the first port of call for people seeking community care services in Victoria. The second task was to identify the key client pathways and referral patterns between services and programs in the community care system.

2.1.1. Analytic framework

The following questions served as the conceptual framework to generate information on client pathways and relationships between service providers.

- Question 1 What are the first contact points for community clients in Victoria?
- Question 2 For self-referring HACC clients, which agencies are their first port of call?
- Question 3 What are the patterns of interaction or relationships between HACC services and other related programs in the health and community sector?

2.1.2. Data sources for mapping client pathways

The main data sources examined for mapping client pathways include:

- Victorian Home and Community Care Program (HACC) Minimum Data Set
- Victorian Aged Care Assessment Program (ACAP) Minimum Data Set
- Commonwealth Carelink Centres (CCC) Data Set
- National Respite for Carers Program (NRCP) Minimum Data Set
- Council on the Ageing Seniors Information Victoria (COTA SIV)
- Royal District Nursing Service (RDNS)– Customer Service Centre data
- Nurse-on-Call, Victoria.

2.1.2.1. HACC Minimum Data Set

The main data source used for identifying entry points in the Victorian community care system in relation to client and carer pathways is the national HACC Minimum Data Set (MDS).

The HACC MDS has data items on *source of referral* and *reason for cessation* of a HACC service. It has no data item on subsequent referrals that a HACC agency may have made to another agency regarding a current client, nor item on people who made an initial enquiry to a HACC agency without receiving a HACC service.

The HACC MDS has been operating since 2001. Analysis shows a high degree of consistency from one period to the next. Hence, the reliability of the data can be taken to be of an acceptable standard.

2.1.2.2. Aged Care Assessment Program Minimum Data Set

The Aged Care Assessment Program Minimum Data Set is an important source of information for the project.

In particular, the recommendations made by an Aged Care Assessment Service can be used as an indicator of the movements of ACAP clients within the aged care and community care system. Relevant to this project are recommendations for Home and Community Care (HACC), Extended Aged Care at Home (EACH), Community Aged Care Package (CACP), Carer Respite and Day Therapy Centres. The ACAP dataset also has information on whether their clients were receiving any community care services at the time of assessment.

The data collection was first introduced in 1994. Version 2 of the data collection was implemented in 2003. The data items relating to ACAT recommendations have been operating for some time, hence the reliability of the data can thus be taken to be within an acceptable standard.

2.1.2.3. Commonwealth Carelink Centres Dataset

Data about clients who received only advocacy or information is not captured consistently in the HACC MDS. Information from the Commonwealth Carelink Centres would enable estimation of the volume and demand for this type of service. The data collection includes information on the total number of client contacts, method of contact, type of information sought, categories of callers who contacted the Centres and referrals to the Centres. As in most datasets, there are limitations in terms of completeness, hence the figures applied in this project should be considered as estimates only.

The Commonwealth Carelink Centre dataset is de-identified and cannot be linked to the HACC MDS. Hence, it is not possible to establish the extent to which Carelink clients also receive services from the HACC program. Nevertheless, the Carelink data has indicative figures regarding clients who sought information about community services.

2.1.2.4. National Respite for Carers Program Minimum Data Set

The National Respite for Carers Program Minimum Data Set has information regarding the volume of carers and care recipients and brokerage for the Commonwealth Carer Respite Centres. It collects socio-demographic information on both clients and carers. For the 2005-06 dataset, it has to be noted that data capture was not complete, hence the actual figures are likely to be higher than those quoted in this report.

2.1.2.5. Victorian Community /Primary Health Data

About one-third of HACC clients received services from Community Health centres. Therefore, there are commonalities in the Community Health data that might supplement the findings based on HACC MDS. Unfortunately, preliminary analysis of the Community Health data set showed that the completion rate for the data item '*Source of Referral*' was not satisfactory. Hence, this dataset was not used for this part of the project.

2.1.2.6. Council on the Ageing (COTA) Seniors Information Victoria

COTA Seniors Information Victoria operates both an information/referral service, and an advisory service to support people to navigate complex service systems. It has a shop-front office and phone service that offer free information on a wide range of issues of interest to older Victorians, including housing options ranging from independent living to residential care, home-based and community services, general information on financial and legal issues, health and wellbeing, retirement and new learning opportunities. Thus, the COTA Seniors Information Victoria data can provide extra dimensions of information regarding users of the community care system.

2.1.2.7. Royal District Nursing Service (RDNS) – Customer Service Centre

About 14 per cent of all HACC clients received services from the Royal District Nursing Service in 2005-06. In addition, the RDNS Customer Service Centre processes a substantial number of non-referred calls, which have been used in this project to provide estimates of the demand for information services.

2.1.2.8. Nurse-on-Call Victoria

Nurse-on-call was launched in June 2006. It is a 24-hour advice and information phone service staffed by registered nurses offering immediate, professional advice on an appropriate course of action such as self-care, visiting a GP, or going to an emergency department. The service aims to complement Victoria's public hospitals and emergency services. Therefore, only non-triage calls that relate to general information requests, health education and provider referrals have been included in this project.

2.1.3. Rationale for the selection of key data items

Key data items used for mapping of client pathways are:

- source of referral and
- agency category.

These two items provide information on where community clients come from and where they go to for services.

2.1.3.1. Source of referral

The data item '*Source of referral*' from the HACC MDS (Commonwealth Department of Health and Ageing 2004) categorizes the individual or organization that referred the person to the agency. The item yields information on the patterns of interaction between HACC and other related programs and sectors. It therefore illuminates the pathways that clients of HACC agencies follow to receive assistance from the program.

'*Source of referral*' can indicate the relationships that HACC agencies have with other service providers and any gaps that may exist in local or regional networks.

Preliminary analysis of 2005-06 HACC MDS shows that approximately 77 per cent of the data had a valid response for source of referral, which provides adequate confidence to use the data as representative of the population for the purpose of this project.

The item *source of referral* contains a range of responses that can be grouped into two main categories for analysis. The first category comprised sources of referral that are external to the HACC program. The second category comprised sources internal to the HACC sector.

Category A

Sources of referral that are *external* to the Home and Community Care Program

- self referred or direct contact with service agencies
- informal - represented by family / friends or significant others
- general practitioner (community-based)
- assessment services – represented as specialist aged or disability assessment team or service. Responses coded as comprehensive HACC Assessment Authority are also included in this category.
- sub-acute and post-acute care sector – this includes responses for extended care or rehabilitation facility
- acute sector – this includes hospitals (public and private)
- other - this consists of all other miscellaneous and non-specific sources that would not be classified in category B and might not assist in the analysis of inter-agency referrals.

Category B

Sources of referral amongst Home and Community Care providers

This category consists of referral from community-based agencies. The responses are grouped into four main categories.

- government community-based agency
- non-government community-based agency
- community-based government medical and health service
- community nursing service.

Assumptions used for analysis of inter-agency referrals or pathways amongst HACC providers are:

- HACC local government agencies are represented by government community-based agencies
- HACC non-government agencies are represented by non-government community-based agencies
- community health centres are represented by community-based government medical and health services
- district nursing services are represented by community nursing services.

2.1.3.2. HACC Agency types

For the purpose of mapping client flows, HACC providers are grouped into five main categories. This configuration also takes into account the statistical requirements for analysis.

- local government
- community health centre
- district nursing service
- non-government organization
- ethno-specific non-government organization (including Aboriginal specific agency).

2.1.4. Selection of records for analysis

Examination of the HACC MDS (2005-06) showed that about 77 per cent of the records had a valid response to the data item source of referral. After excluding a small percentage of records with missing data, a total of 231,598 unique client records were selected for analysis.

The records of clients who had received services from more than one HACC provider were included (total 14.5 per cent), which helps to provide a comprehensive and realistic picture of client flows.

The resulting dataset used for analysis is comparable to the number of unique HACC clients for 2005-06, which recorded 229,128 (excluding anonymous clients). This shows that the dataset used for this project would generate estimates of client flow with a high degree of confidence.

The data used for mapping client pathways were limited to activities for the period from 1 July 2005 to 30 June 2006. This reporting period was chosen because of practical considerations such as constraints regarding the availability of data for the latest financial year.

2.2 Findings

2.2.1. Target population for HACC services

The eligible target population for HACC services is defined as 'persons living in the community who, in the absence of basic maintenance and support services provided or to be provided within the scope of the Program, are at risk of premature or inappropriate long term residential care, including: older and frail persons aged over 65 years with moderate, severe or profound disabilities; younger persons with moderate, severe or profound disabilities; and such other classes of persons as are agreed upon by the Commonwealth Minister and the State Minister; and the unpaid carers of people assessed as being within the National Program's target population' (Commonwealth of Australia 2007).

The number of clients receiving HACC services in Victoria is expected to be around 260,000 for 2007-08 (Victorian Department of Treasury and Finance 2007).

2.2.2. Where do community clients come from?

Source of referral was used to identify where community clients come from. The findings about client flows and pathways are based mainly on clients who actually received services. Information about clients who merely received information or advice is not captured in the HACC MDS.

Analysis based on *source of referral* shows that about 27.5 per cent of clients self-referred or made direct contact with HACC providers. About 14 per cent went through informal network of family, friends and significant others. General practitioners (community-based) accounted for another 13 per cent of referrals.

The acute sector (hospitals) accounted for 18 per cent of the referrals to HACC agencies, whereas the sub-acute or post-acute sector (extended care and rehabilitation services) comprised only 3 per cent of referrals. Assessment authorities (Aged Care Assessment Teams and Disability Assessment Services) were responsible for 6.5 per cent of referrals. The remaining 7 per cent of referrals were grouped under 'Others' category which comprised of a number of avenues and unspecific sources.

Using the methodology of grouping source of referral described earlier, about 11 per cent of referrals could be attributed to inter-agency referrals amongst HACC providers.

Regarding self referred clients, over half (54.5 per cent) made direct contact with their local councils. About 29 per cent of self referred clients made direct contact with Community Health centres. Non-government agencies accounted for 8.5 per cent of direct contacts from self referred clients, whilst 6 per cent self referred to District Nursing service and 2 per cent made direct contact with Ethno-specific non-government agencies.

It is possible that the true proportion of self-referrals is lower than shown. According to the Municipal Association of Victoria (MAV), with increasing pressure on intake, some councils no longer spend a lot of time on general enquiries and suggest the callers contact Carelink or COTA, particularly if the enquiry is about accommodation or residential care. These would then show on Carelink data as self referrals rather than inter-agency referrals from councils; so would people contacting councils on a recommendation from a Carelink centre.

It should be noted that a referring agency needs to make its own assessment of when it is appropriate to make a direct referral to another agency and when it is appropriate to leave it to the client or family. The MAV advised that, in the experience of some councils, many hospitals make direct referrals for HACC delivered meals when the discharge planner regards it as critical for post-acute care; when it is merely an option they tend to leave it to the client's family to decide whether to apply to the council.

A summary of the first port of call for community clients based on source of referral from HACC MDS and other datasets examined is presented in Figure 2.1.

2.2.3. Key pathways for community clients in Victoria

The data sources examined are drawn together to create the key pathways for community clients in Victoria as summarized in Figure 2.2.

Given the links between the HACC and Aged Care Assessment programs, the ACAP MDS was examined to provide additional information regarding client flows in the community care system. The results show that about 15,000 clients were recommended by ACAP for HACC services. This is similar to the estimate generated from the HACC MDS based on client's source of referral.

The Aged Care Assessment Service has the role of assessing and facilitating access of all older persons to residential and community services appropriate to their needs. Analysis of the recommendations by ACAP generated information regarding the number of recommendations for different types of services: 9,110 people were recommended for CACP, 1,723 were recommended for EACH, 906 were recommended for Day Therapy Centres and 5,022 were recommended for Carer Respite services. It has to be noted that some clients might access carer respite services through the Commonwealth Carelink Centres and Carer Respite Centres which were not included in the above figures. The ACAP MDS also collects information as to whether clients being assessed by ACAP were receiving HACC services; in which about 21,689 persons were in this category.

Commonwealth Carelink Centres provide a broad range of information, from personal care and domestic help to accommodation in nursing homes and hostels available in the region. They function as information centres for older people, people with disabilities and those who provide care and services. In 2005-06, about 20,000 contacts were recorded for Victoria.

COTA Seniors Information Victoria is another information point for older people in Victoria. It recorded about 17,000 contacts in 2005-06.

Regarding contacts for non-referred calls to the Royal District Nursing Service Customer Service Centre, there were about 6,000 contacts for 2005-06. Nurse-On-Call in Victoria provides mainly triage services, therefore only non-triage general information requests, provider referrals and health education calls were included in this project. In 2006-07, about 60,000 non-triage calls were recorded.

An estimated 11 per cent of referrals are made between different HACC agencies. However, given that some records were unable to be allocated and were grouped into the 'Other' category, it is possible that a proportion of these records are inter-agency referrals. Thus, the 11 per cent estimate for inter-HACC referrals is a conservative figure.

The relatively low level of inter-agency referrals could be interpreted in at least three ways:

- it could mean that most clients are initially finding their own way to the appropriate service
- or it may be evidence of inadequate referral links between agencies
- or a proportion of recorded self-referrals may actually be cases in which the client or family is taking the initiative after following the recommendation of another service provider.

The data examined in the present study could not provide conclusive evidence regarding the extent of inter-agency referrals.

Analyses of HACC clients' *source of referral* for each agency category are summarized in Figure 2.3 and Figure 2.4.

As expected, there are differences in the relative distribution of *source of referral* amongst the HACC provider types. For instance, the three top referral sources for Community health centres are self-referred (26 per cent), general practitioners (25 per cent) and hospitals (15 per cent). This accords with the services being more health related.

For Local Governments, the three top sources of referral are self-referred (35 per cent), family/significant other (15 per cent) and hospital (15 per cent). This fits with the fact that council HACC services are principally domestic help, property maintenance and personal care.

For district nursing services, the main referral sources are hospital (42 per cent), general practitioner (14 per cent) and self referred (12 per cent).

Non-government HACC providers recorded relatively more referrals from the non-health sector. The three main sources of referral were self referred (23 per cent), family/significant others (21 per cent) and assessment authorities (10 per cent).

The Ethno-specific non-government HACC providers had similar pattern to the mainstream non-government HACC providers, in which the top three sources of referral are family/significant others (44 per cent), self referred (32 per cent) and assessment authorities (4 per cent).

Figure 2.1 First port of call for community clients in Victoria

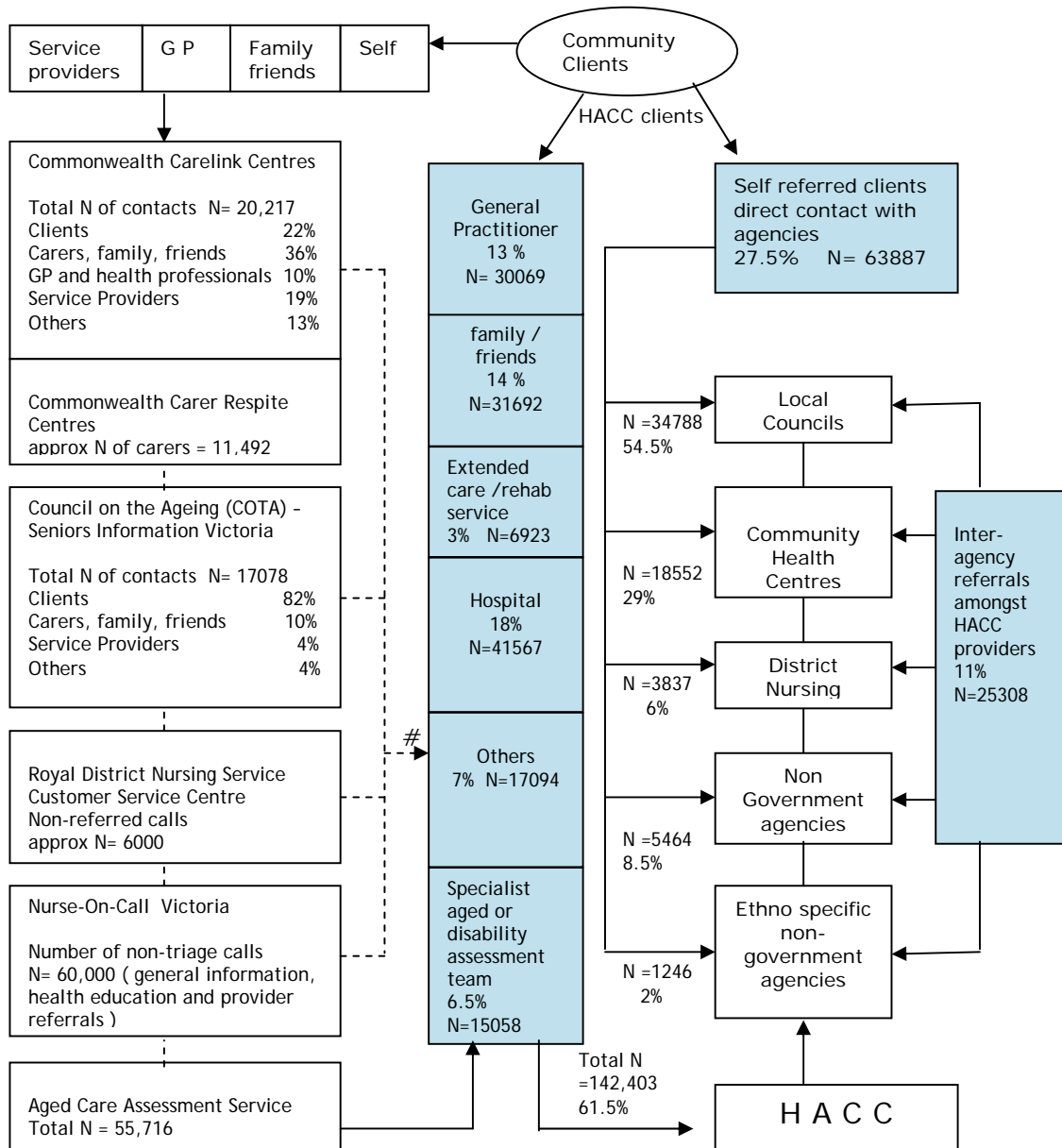
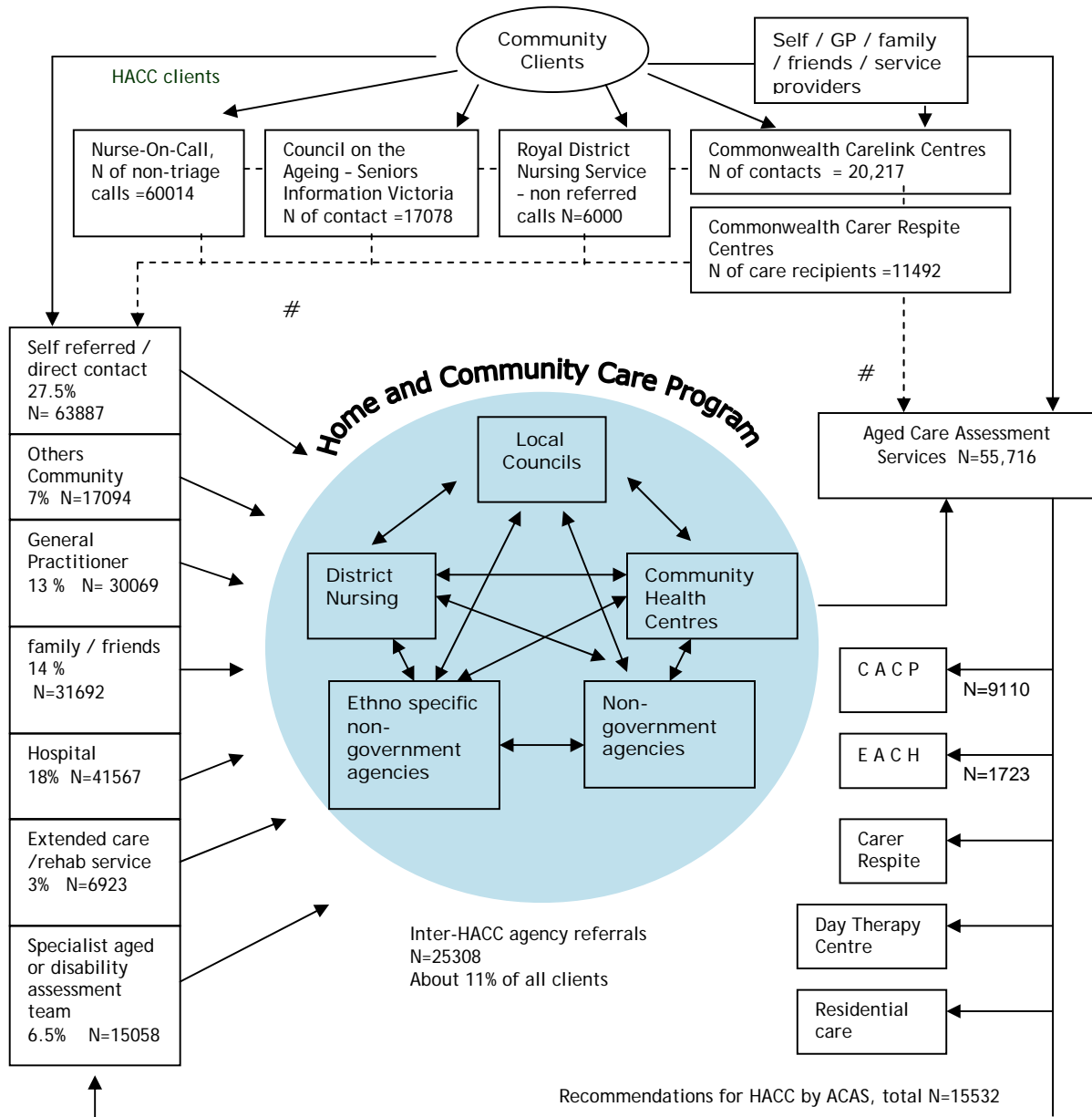


Figure 2.2 Key pathways for community clients in Victoria



Notes: Total estimated number of unique HACC clients = 231,598
 N = Estimate number of unique HACC clients for 2005-06 as indicator of volume.
 Total inter-agency (HACC providers) estimated to be about 11% of total estimated volume.
 Aged Care Assessment Service (ACAS) volumes are number of recommendations.

There are no linkages between HACC MDS and other datasets such as: Commonwealth Carelink Centre dataset, COTA Seniors Information Victoria, RDNS Customer Service Centre and Nurse-on-Call Victoria. Hence, it is not possible to establish the extent regarding common clients and volume of referrals.

----- Links between services but volume unable to be established from datasets.

Figure 2.3 Key pathways for HACC clients in Victoria – Distribution by source of referral and provider type

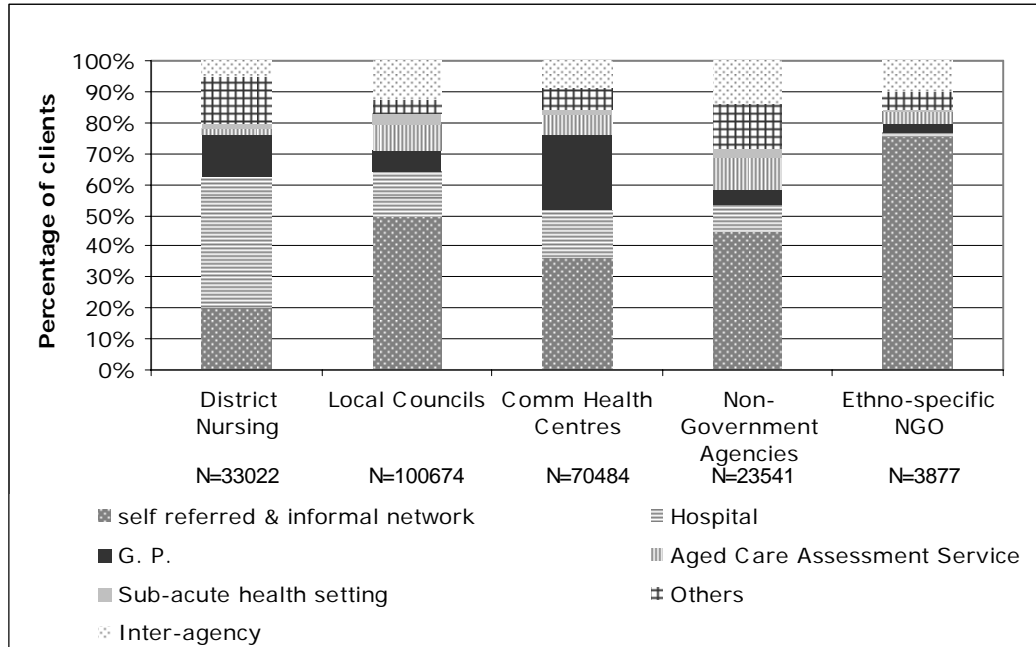
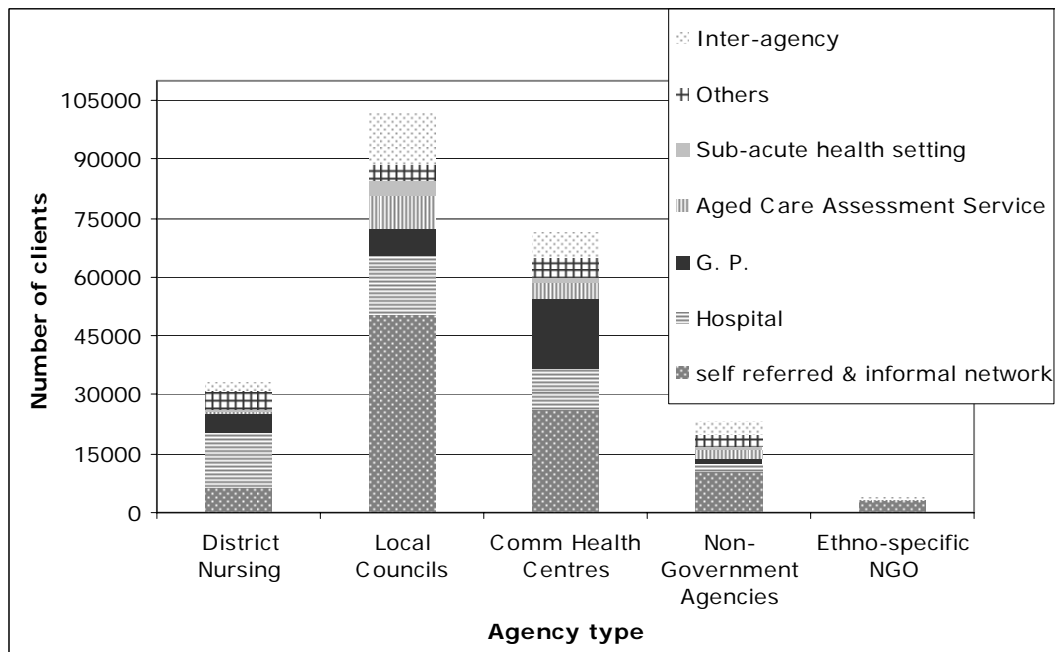


Figure 2.4 Key pathways for HACC clients in Victoria – Number of client by source of referral and provider type



2.2.4. Inter-agency referrals amongst HACC providers in Victoria

About 11 per cent of the referrals could be attributed to inter-agency referrals, based on the methodology and assumptions adopted for this project.

It is likely that some of the records under the category 'Other source of referral' were inter-agency referrals. If all of these were re-allocated, the estimated proportion of inter-agency referrals would rise from 11 per cent (lower limit) to 17 per cent (upper limit).

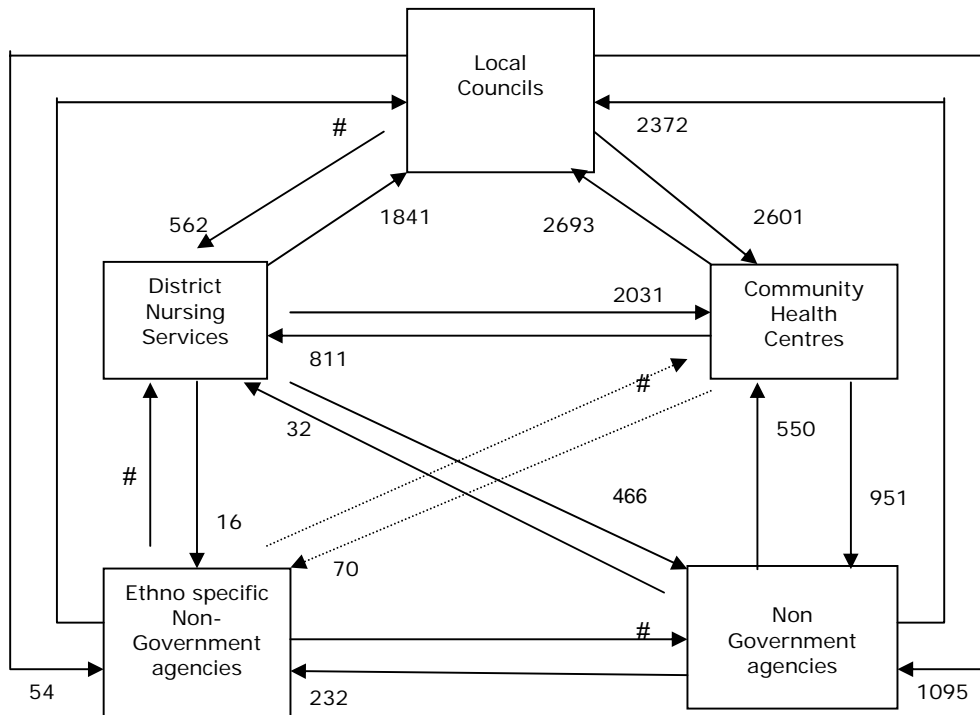
Figure 2.5 summarizes the estimated volume of client flow based on records that could be allocated to specific categories for inter-agency referrals. Allowing for unallocated referrals not shown and the volume from 'Other source of referral' category, the figures shown accounted for only 50 per cent of the actual volume.

The findings of this project had similarities with the Hume Moreland Primary Care Partnership (PCP) referral audit conducted in 2005 that examined primary care referral patterns in the Hume Moreland area.

The Hume Moreland PCP audit (Hume Moreland Primary Care Partnership 2006) found that self referrals and carer referrals accounted for about one-third of total referrals. Referrals from General practitioners accounted for about 16.5 per cent of all referrals to PCP member agencies, which is similar to the findings of this project. The audit also found that Community Health Services and Aged Care Assessment Services were referral hubs, which received substantial incoming referrals and made substantial outgoing referrals as well. For councils, the RDNS and smaller non-government HACC agencies, the volume of incoming referrals was substantially larger than outgoing referrals.

Analysis of inter-agency referrals amongst HACC agencies could provide further insight into client flows and pathways. However, due to limitations of the HACC MDS, it is difficult to develop an accurate estimate of inter-agency referrals. Further examination should be conducted at the local level.

Figure 2.5 Inter-agency referrals among HACC agencies in Victoria



= cannot be determined or not available

N = Estimate number of HACC clients for 2005-06 as indicator of volume

The above diagram serves to provide an overview of the inter-agency traffic amongst HACC providers. Intra-agency referrals amongst each HACC provider type such as referrals amongst Community Health Centres are not shown.

Based on the current methodology, the estimated number of HACC inter-agency referrals = 25,308, which is about 11% of total estimated volume (excluding records that cannot be determined).

Unspecified referral source grouped under 'Other' category (N=17904) may contribute an additional 6% to the estimated number of HACC inter-agency referrals. This potentially increases the proportion of this traffic to 17% of the total estimated number of HACC clients (N= 231,598).

Thus, the estimated inter-agency referral rate ranges from 11% (lower limit) to 17% (upper limit).

The estimated numbers shown in the diagram do not include referrals that could not be determined accurately from the data source.

Based on the upper limit estimate, the volume shown in this diagram might only account for 50% of the actual inter-agency referrals.

Source: 2005-06 Home and Community Care Minimum Data Set.

2.2.5. Client pathways by HACC provider type

Local governments

The majority of referrals to Local Governments for HACC service are from direct client contact (35 per cent) and informal pathways via client's family and significant others (15 per cent). These are followed by referrals from hospitals (15 per cent), general practitioners (7 per cent) and specialist aged or disability assessment teams (8 per cent).

Without taking into account the 'Other source of referral' category, inter-agency referrals accounted for about 13 per cent of the total referrals to Local Governments. As expected, the majority of inter-agency referrals to Local Governments were from Community Health centres, mainstream Non-Government agencies and District Nursing services.

Community health centres

For Community Health centres, main referral sources are client self referral (26 per cent), general practitioner (25 per cent), Community health centre, hospital (15 per cent) and the client's informal network – family and significant others (11 per cent). It should be noted that after self referral and information networks, general practitioner is the dominant source of referral for Community health centres.

District nursing service

As would be predicted from the nature of service provided, the majority of referrals are from the acute care sector - hospitals (42 per cent) and general practitioners (14 per cent).

Non-government agencies

Non-government agencies comprise of a variety of providers. The majority of referrals for non-government agencies are client self referrals (23 per cent) and informal pathway via clients' families and significant others (21 per cent). Specialist aged and disability assessment team (10 per cent) and hospitals (9 per cent) are also significant referral sources.

Ethno-specific non-government agencies

The pattern for Ethno-specific non-government agencies is different from Local Councils and Community health centres. About 76 per cent of referrals are from client self referrals and informal pathway via clients' families and significant others.

2.2.6. Client pathways in metropolitan and rural regions

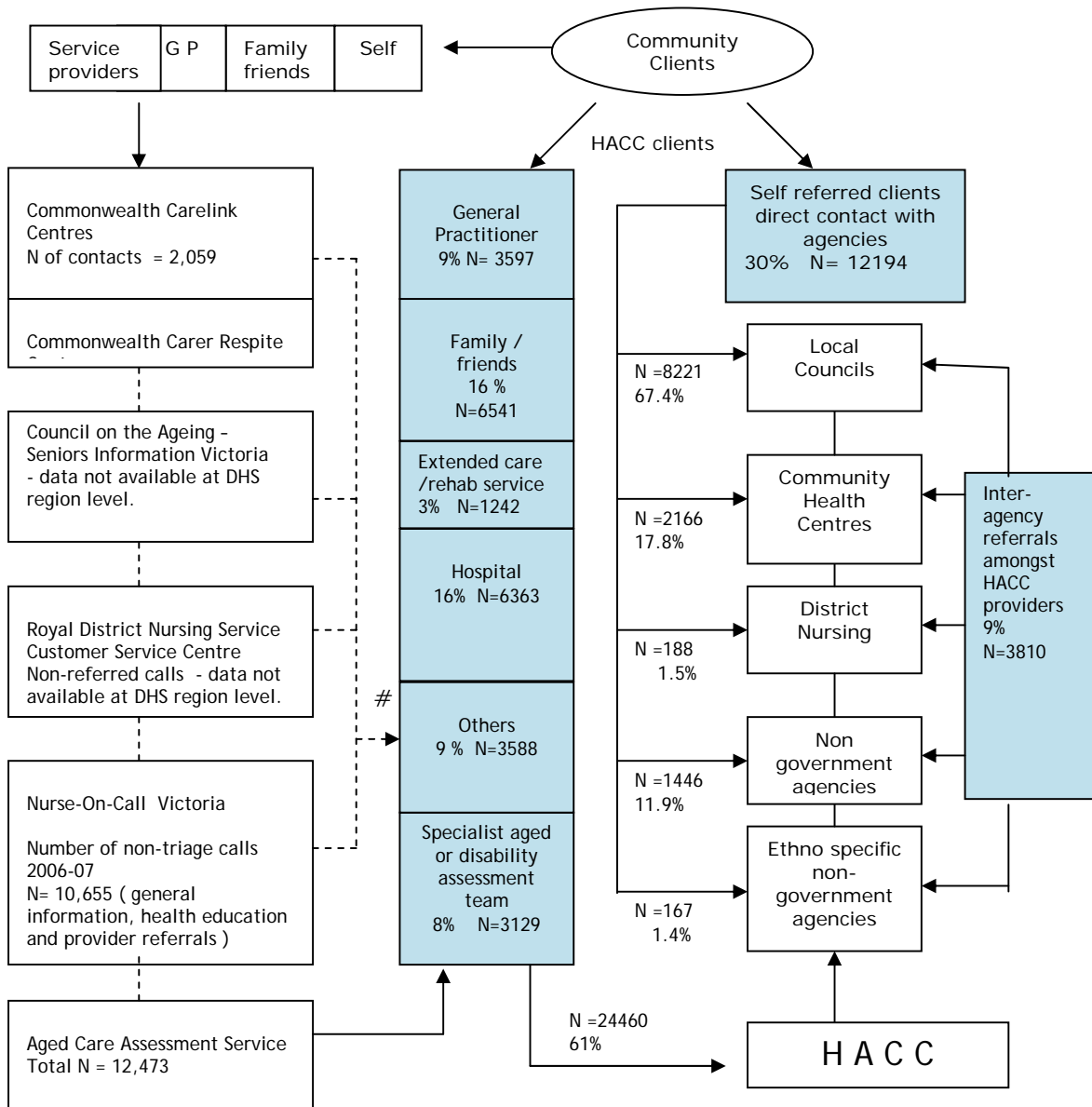
Two Access Point demonstration projects, one metropolitan and one rural, will test the proposed Victorian model for Access Points. Therefore Eastern Metropolitan Region and Grampians Region data were selected for examination.

Figures 2.6 and 2.7 summarize the client pathways for HACC clients in these two regions.

One of the characteristics of Eastern Metropolitan Region is a relatively higher percentage of self referred clients for the HACC program, being 30 per cent compared to state average of 27.5 per cent. Amongst the self referred clients, about two-thirds contacted the local government HACC agency directly. Another characteristic is the relatively lower percentage of clients being referred by general practitioners, 9 per cent compared to the statewide average of 13 per cent.

In Grampians region, the situation is slightly different: the percentage of self-referred clients was slightly lower, 23.5 per cent compared with the statewide average of 27.5 per cent. Amongst self referred clients, a relatively higher proportion made direct contact with the district nursing service, which could be a characteristic of rural regions. Also, the proportion of referrals from general practitioners is relatively higher, 16.5 per cent compared with the statewide average of 13 per cent.

Figure 2.6 First port of call for community clients in Eastern Metropolitan Region (DHS), Victoria

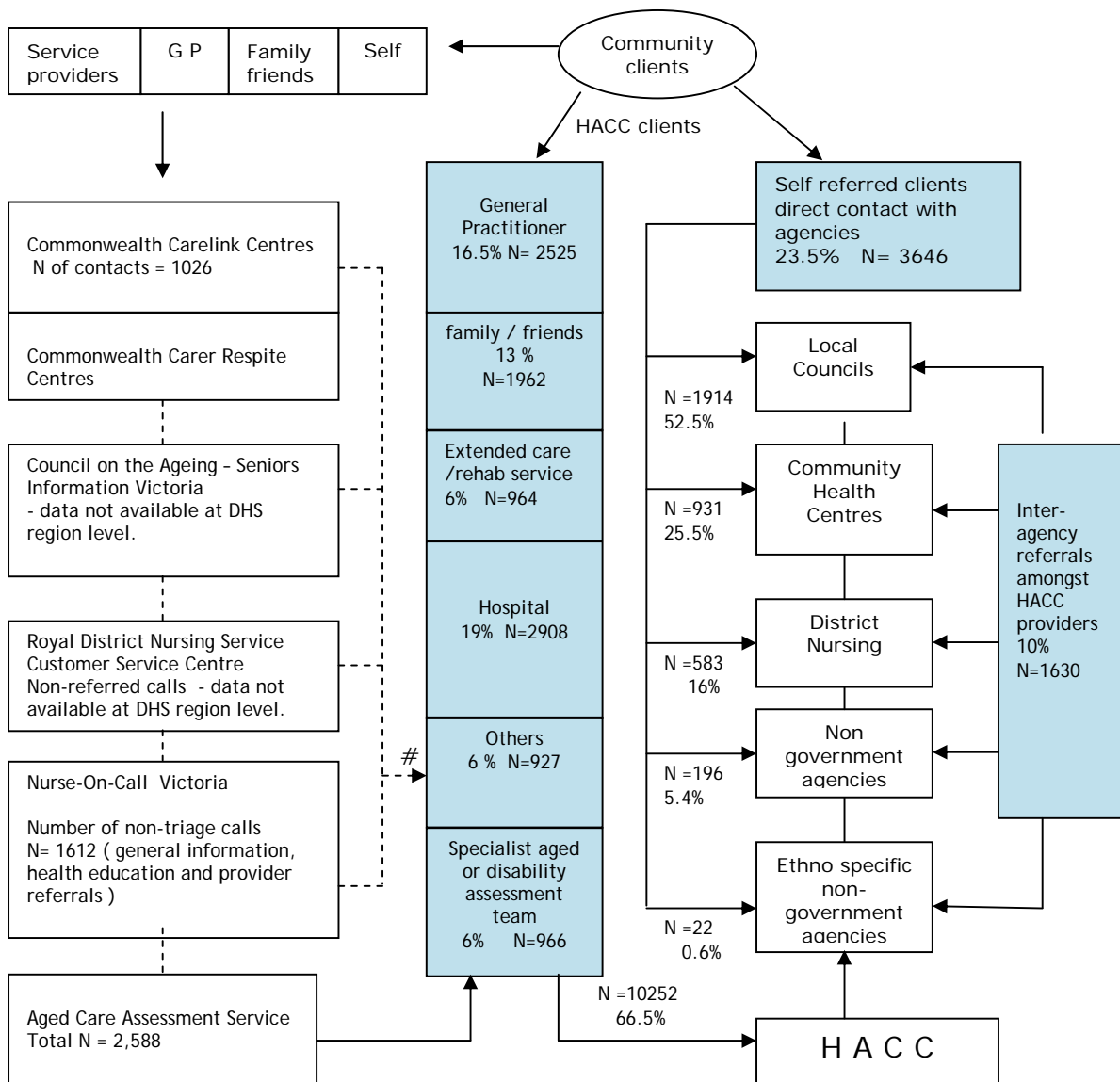


Notes: Total estimated number of unique HACC clients = 40,454
 N = Estimate number of unique clients for 2005-06 as indicator of volume

There is no linkage between HACC MDS and other datasets such as: Commonwealth Carelink Centre, COTA Seniors Information Victoria, RDNS Customer Service Centre and Nurse-on-Call Victoria. Hence, it is not possible to establish the extent regarding common clients and volume of referrals.

----- Links between services but volume unable to be established from

Figure 2.7 First port of call for community clients in Grampians Region (DHS) Victoria



Notes : Total estimated number of unique HACC clients = 15,528
 N = Estimate number of unique clients for 2005-06 as indicator of volume

There is no linkage between HACC MDS and other datasets such as: Commonwealth Carelink Centre dataset, COTA Seniors Information Victoria, RDNS Customer Service Centre and Nurse-on-Call Victoria. Hence, it is not possible to establish the extent regarding common clients and volume of referrals.

----- Links between services but volume unable to be established from

Analyses of HACC clients' source of referral for agencies in the Eastern Metropolitan Region are summarized in Figures 2.8 and 2.9. Corresponding information relating to the Grampians Region are summarized in Figures 2.10 and 2.11.

The figures show that in the Eastern Metropolitan Region (EMR), the proportion of referrals from general practitioners to Local Governments is relatively small, being 4 per cent of all clients, compared to 7 per cent for Victoria state-wide and 12 per cent in Grampians Region.

Regarding referrals to Community health centres, referrals from hospitals in EMR are also relatively lower, being 8 per cent, compared to 15 per cent state-wide and 14 per cent in the Grampians Region.

According to the data available, the above could be attributed to the relatively higher percentage of clients who were self referred to Local Governments (39 per cent) and Community health centres (30 per cent) in EMR in comparison to the Victoria statewide and Grampians Region.

The distribution of clients' source of referrals for Local Governments in EMR is quite different from the Grampians Region. general practitioners and extended care sub-acute health settings accounted for a significant proportion of client flows in the Grampians region.

In EMR, the data shows that self referrals and the informal social network (client's family and friends) accounted for about half of the referrals to the Local Governments and Community health centres.

The findings show that client pathways in the selected metropolitan and rural regions are different, which may have implications for Access Points.

Figure 2.8 Key pathways for HACC clients in Eastern Metropolitan Region (DHS) Victoria – Distribution by source of referral and provider type

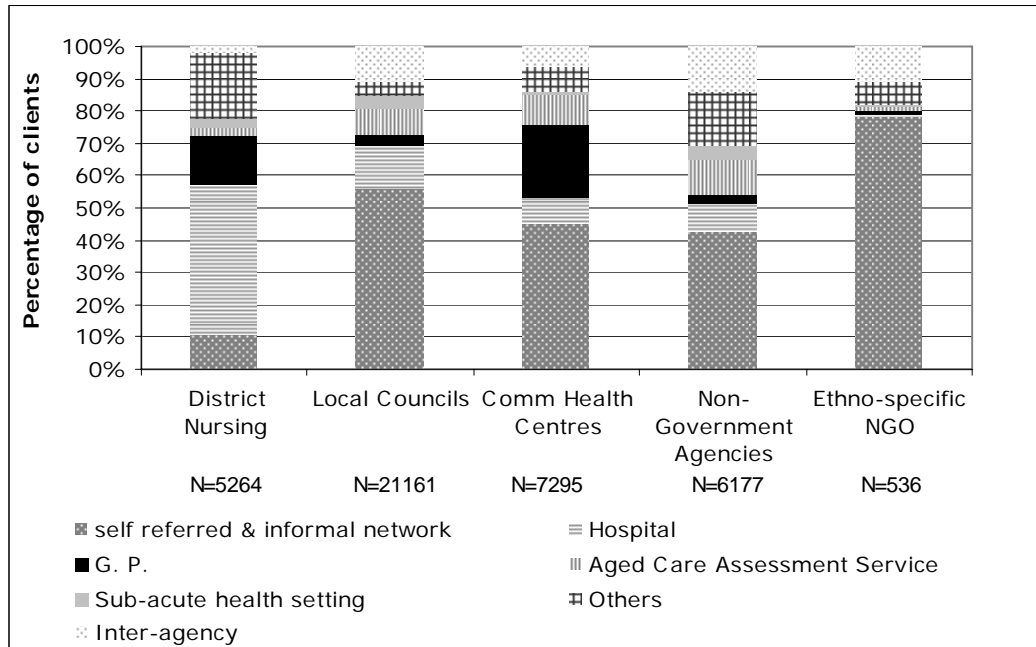


Figure 2.9 Key pathways for HACC clients in Eastern Metropolitan Region (DHS) Victoria – Number of clients by source of referral and provider type

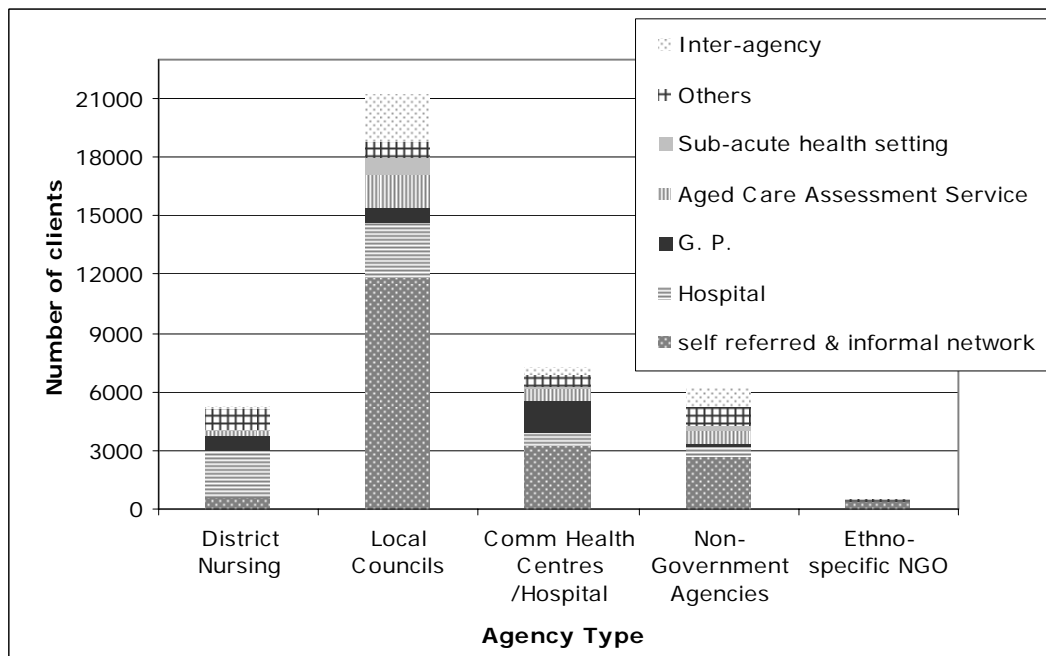


Figure 2.10 Key pathways for HACC clients in Grampians Region (DHS), Victoria – Distribution by source of referral and provider type

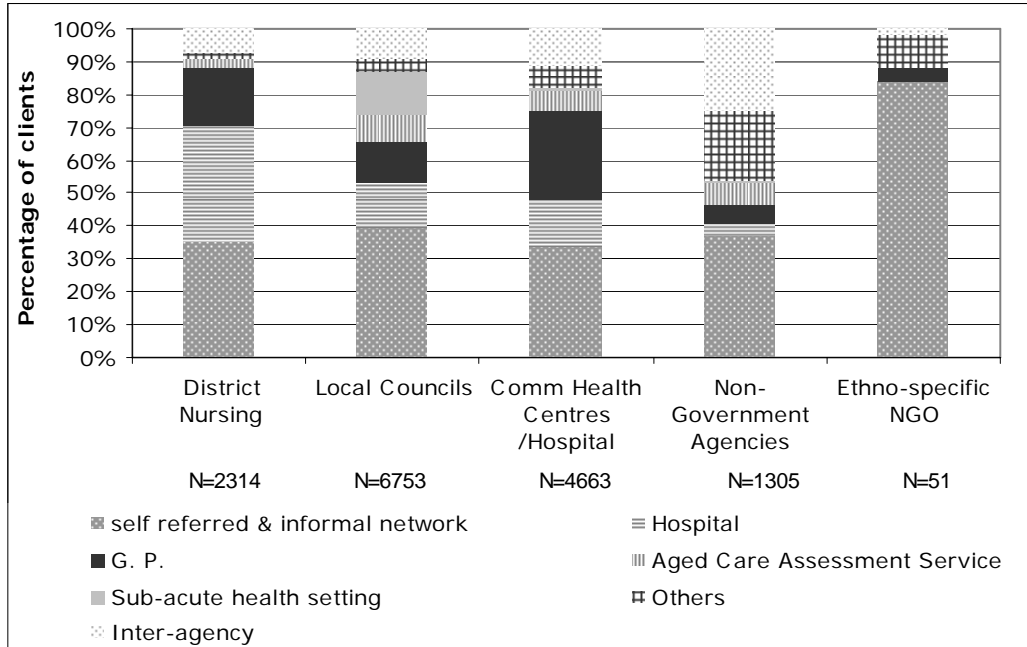
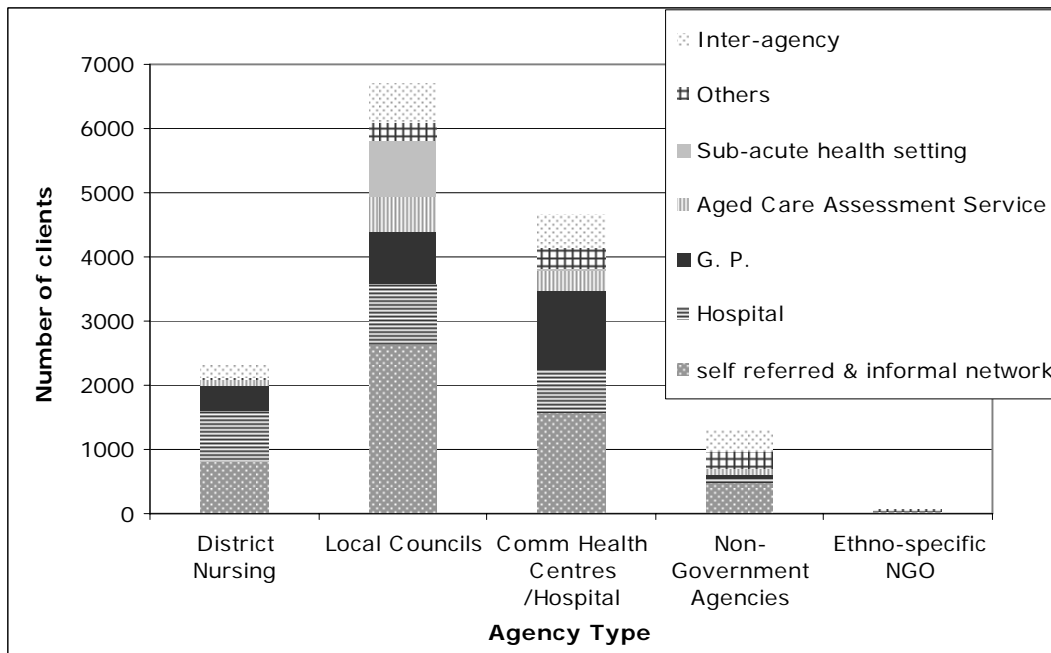


Figure 2.11 Key pathways for HACC clients in Grampians Region (DHS), Victoria – Number of clients by source of referral and provider type



3. Community care services in Victoria

The second objective of this project is:

- To identify current programs and services involved in the Victorian community care system and the current capacities of major agencies groups.

3.1. Methodology

The first task is to create a listing of current programs and services in the Victorian community care system across Commonwealth and State programs.

The second task is to merge additional information such as service volume, client mix and service mix to the above.

3.1.1. Analytic framework

A progressive analytic framework was applied to generate information for better understanding of service provision and current capacities of major agency groups in relation to Access Points in Victoria:

- 1) Overview of the volume of work in the Victorian community care system (both State and Commonwealth programs).
- 2) Analyses of service mix by rural/metropolitan region and agency type.
- 3) Analyses of client mix by rural and metropolitan region.
- 4) Analyses of service providers' capacity for e-referral.

Majority of the analyses were based on activities for the period 1 July 2005 to 30 June 2006. This was the latest full financial year of data available. For programs that commenced after this period, estimates were used instead.

3.1.2. Data sources

- Commonwealth Carelink Centres Dataset
- Connectingcare – Health and Community Service Directory & e-referral system
- Council on the Ageing – Senior Information Victoria
- Delivery of home and community care services by local government 2004 – Victorian Auditor General's Office (Auditor General Victoria 2004)
- e-Referral Capacity Building through Primary Care Partnerships 2006-07 summary report of the regional work-plans (Victorian Department of Human Services 2007a)
- HACC agency profile – Department of Human Services, Victoria
- HACC Planning Database – Department of Human Services, Victoria
- Human Services Directory – Department of Human Services, Victoria
- Infoxchange Australia
- IT Readiness Survey of the Aged Care Sector 2006 – Australian Government Department of Health and Ageing
- List of approved providers – CACP and EACH
- National Respite for Carers Program (NRCP) Minimum Data Set
- Nurse-on-Call – Department of Human Services, Victoria
- Primary Care Partnerships Victoria - Community Health Plans 2006-09
- Primary Health Client Transaction Database – Department of Human Services, Victoria
- Profile of Community Health Services across Victoria 2006 – Department of Human Services, Victoria (Victorian Department of Human Services 2006c)
- Royal District Nursing Service – Customer Service Centre
- Victorian Aged Care Assessment Program (ACAP) Minimum Data Set
- Victorian Home and Community Care Program (HACC) Minimum Data Set.

3.1.3. Rationale for the selection of indicators

The following indicators were selected for further analysis of the capacities of major provider groups:

- volume of transaction
- service mix
- client mix
- capacity for e-referrals.

3.1.3.1. Volume of transaction

Volume of transaction is represented by the number of clients who received services from the providers. This indicator can be used as a proxy for contacts, service provided, referrals and assessments within the defined period of time.

This information can provide an idea of the size of the agencies. The volume of transactions may have some relationship with the number of staff engaged to operate the service and possibly their public profile.

For the purpose of this project, the volume of transaction for HACC services is based on the number of unique clients measured at the service outlet levels. This definition and methodology is applied because a number of agencies have multiple service outlets that spread across local government areas. Therefore, the overall estimated number used in this part of the report is slightly higher than that presented in the preceding analyses in this report. It is estimated that about 12 per cent of clients are being counted more than once. However, this should not present an issue for the purpose of this task.

3.1.3.2. Service mix

Service mix can have an impact on client flows and referrals made by referrers to the services.

Community Aged Care Packages (Australian Institute of Health and Welfare 2006) and the Extended Aged Care at Home program (Australian Institute of Health and Welfare 2004b) provide support services for older people with complex needs living at home who would otherwise be eligible for admission to low-level and high-level residential care respectively. Entry to these two programs requires an assessment by an ACAT. This means that the client pathways are well defined.

Commonwealth Carer Respite Centres, Commonwealth Carelink Centres and Aged Care Assessment Services provide relatively specific services.

The Commonwealth's Day Therapy Centre Program (Australian Institute of Health and Welfare 2004a) subsidizes a range of therapies to frail older people living in the community and to residents of Commonwealth-funded aged care homes. The majority of providers in Victoria are co-located with aged residential care settings.

Within the HACC program, a broad range of services are provided. Each group of agencies offers a different range of services. Local governments usually provide delivered meals, domestic assistance, property maintenance, personal care, respite and planned activity groups.

By contrast, Community health centres offer allied health services, counselling, nursing, health promotion, women's health services, family planning, and population-specific primary care programs. Some of these services are funded by other government programs. In rural regions, there is weaker distinction between Community health centres, hospitals and district nursing providers. A wider range of HACC services are provided by this group.

Generally, the service mix for non-government agencies is similar to Local Governments, but smaller agencies have a narrower range.

For ethno-specific non-government agencies, the service mix is more limited, with the focus on planned activity group and social support.

The service mix for Aboriginal agencies is similar to non-government agencies, and narrower than local government providers.

For the purpose of this project, the analysis of service mix was focused on HACC providers. Over 400 HACC providers were grouped into six categories, namely:

- local government
- community health centre
- district nursing service
- non-government agency
- ethno-specific non-government agency and
- Aboriginal specific agency.

3.1.3.3. Client mix

It is acknowledged that clients of different age group and background may have different service needs. Therefore, three main client characteristics were selected for more detailed analysis.

Client age group

HACC clients span all age groups, though about two-thirds are in the older age range. For the purpose of this project, clients were grouped into three age groups, namely: aged up to 20, aged between 21 to 69, and aged 70 and over.

Culturally and linguistically diverse (CALD)

Language spoken at home was used as the basis for defining the CALD client in this project (Victorian Department of Human Services 2006a). The proportion of Victoria's culturally and linguistically diverse (CALD) HACC clients was analysed to examine the distribution across regions and provider groups.

Indigenous background

Clients with Indigenous background have a different pattern of service use. For instance, analysis of HACC data showed that Aboriginal clients were more likely to receive nursing and attend Planned Activity Groups, and less likely to receive home care than other clients (Victorian Department of Human Services, 2006d).

3.1.3.4 Capacity for e-referrals

Assessment of provider capacity for e-referrals was based on the capacity to send and accept secure electronic referrals.

A number of sources were examined to generate the required information.

The Connectingcare website lists agencies that are capable of accepting secure electronic referrals. ConnectingCare maintains an e-referral system that enables client information to be sent and received using encrypted email. The system uses existing Internet-based technology to create a secure platform for referral without requiring additional software or equipment.

For agencies that utilize other systems or platforms such as InfoXchange, secondary information was obtained by examining the Community Health Plans 2006-09. Each of Victoria's 31 Primary Care Partnerships is required to produce a Community Health Plan for 2006-2009, with a focus on priorities that include the implementation of e-referral systems. This served as useful source of information.

The report on regional work-plans for 2006-07 e-Referral Capacity Building through Primary Care Partnerships (Victorian Department of Human Service 2007a) also provides up-to-date information on e-referral capacity for each region.

For information on CACP and EACH providers in Victoria, the project consulted the 'IT Readiness Survey of the Aged Care Sector' conducted by DOHA in May 2006. About 65 per cent of CACP providers are also HACC providers, and the number of CACP-only providers is relatively small compared to the total number of Victorian HACC providers, therefore the result for this program is not reported separately.

The Victoria Auditor-General's 2003-04 report on the Delivery of HACC Services by Local Government was also examined (Auditor General Victoria 2004). However, the report only has summary information on use of the Service Coordination Tool Templates rather than on capacity for e-referral.

A DHS survey of primary health agency engagement in Service Coordination and use of Service Coordination Tool Template (SCTT) is currently in the planning phase. Therefore, information was not available for inclusion in this project.

Generally the secondary sources were not sufficiently detailed to pinpoint the electronic referral capacity of individual agencies.

3.2. Findings

3.2.1. Overview of service volume

Table 3.1 provides an overview of Victoria's community care programs with the corresponding volumes, in terms of number of clients and number of places.

Regarding services specifically focused on information provision, the figures show that the Commonwealth Carelink Centres and COTA Senior Information Victoria had fairly similar levels of contacts. The total volume for Nurse-On-Call is fairly large, but the majority of calls were related to triage for health problems. Only 19 per cent of calls are included here; they concerned general information requests, health education and provider referrals.

Table 3.1 Overview of service volume for Victoria Community care programs 2005-06

Community care programs - Victoria	Grampians	Barwon South West	Loddon Mallee	Gippsland	Hume	Eastern Metro	North and West Metro	Southern Metro	Total	notes
HACC - Victoria	18,221	26,959	25,990	20,766	17,274	46,127	64,889	58,802	279,028	estimated N of clients based on service outlets ^
Aged Care Assessment Services - Victoria	2,588	5,021	4,369	2,878	3,078	12,473	11,556	13,753	55,716	N of clients assessed
Commonwealth Carer Respite Centres - Victoria										11,272 N of care recipients # 11,492 N of carers #
Community Aged Care Package (CACP)	293	802	536	457	530	2,057	2,470	1,905	9,113	N of allocated places
Extended Aged Care at Home (EACH)	45	30	54	60	45	157	194	135	718	N of allocated places
EACH dementia	0	25	0	0	0	40	60	41	166	N of allocated places
Commonwealth Carelink Centre	1,026	2,120	5,241	2,713	242	2,059	4,797	2,019	20,217	estimate N of contacts
Council on the Ageing - Senior Information Victoria										17,078 Number of contacts
Nurse on call - Victoria - non triage calls	1,612	3,681	3,055	2,524	2,721	10,655	20,979	14,786	60,014	* estimated N of non-triage calls
Royal District Nursing Service - non referred calls										estimated N of calls to 6,000 customer service centre

Notes:

^ Number of HACC clients based on service outlets, hence some clients (12%) might be counted more than once.

Due to reporting compliance, actual figures are expected to be slightly higher.

* Non-triage calls include: general information, health education and provider referral calls, which is about 19% of all calls. Figures shown for Nurse-On-Call based on 2006-07.

CACP and EACH are operational places. EACH dementia was in early development stage in 2005-06.

3.2.2. Service volume by rural and metropolitan regions

3.2.2.1. Metropolitan regions

A summary of the number of clients broken down by HACC agency type for Metropolitan regions is presented in Table 3.2. The patterns observed are:

Local Government is the major provider group in terms of number of clients; 47 per cent of the volume in the Metropolitan area was provided by Local Government HACC agencies.

Community health centres accounted for 27 per cent of the total volume, followed by the RDNS (14 per cent), Non-government organizations (8.4 per cent), Ethno specific non-government agencies (3.1 per cent) and Aboriginal specific agencies (0.2 per cent).

Detail analyses for metropolitan regions

Detailed analyses for each of the Department of Human Service region at the agency level show that the Eastern Metropolitan Region generally follows the statewide pattern. In North and West Metropolitan Region and Southern Metropolitan Region, they generally follow the statewide pattern though a few Community health centres had volumes that were similar to the smaller Local Government HACC providers.

Table 3.2 Number of clients by agency type for Victoria HACC program in metropolitan areas, 2005-06

Agency_type	Eastern Metro	North and West Metro	Southern Metro	Metro Total	Percentage for agency type
Local Government	23,427	29,472	26,916	79,815	47.0%
Comm Health Centre / Hospital	10,574	17,421	18,365	46,360	27.3%
Non Government Organisation	6,100	4,676	3,515	14,291	8.4%
NGO Ethno-specific agencies	722	3,093	1,445	5,260	3.1%
Aboriginal specific	*	305	*	305	0.2%
District Nursing Service	5,304	9,922	8,560	23,786	14.0%
	46,127	64,889	58,801	169,817	100.0%

Note

1 Number of clients based on service outlets, hence about 12% might be counted more than once.

2 The figures show above are higher than the estimates in the first part of this project for client key pathways, which exclude records without a valid response to the data item – source of referral.

* Data not available from HACC MDS. Agency grouping based on listing in HACC MDS. If the aboriginal service is a sub-program, it might not be captured separately.

3.2.2.2. Rural regions

Table 3.3 provides a summary of the number of clients broken down by HACC agency types for rural regions in Victoria. The patterns observed in rural regions are quite different from the metropolitan regions.

First, the Community health Service/Hospital group accounted for the largest number (44.1 per cent) of clients served, though only slightly higher than Local Government providers, at 42.7 per cent.

Second, the involvement of non-government organizations (4.9 per cent), ethno-specific non-government agencies (0.9 per cent) and district nursing services (6.5 per cent) is much smaller in comparison with their metropolitan counterparts.

Third, as expected, Aboriginal-specific agencies have a relatively higher volume in rural regions, accounting for 0.8 per cent of the volume compared with metropolitan regions (0.2 per cent).

It has to be noted that the boundary between district nursing service, hospital and community health centre in rural regions is less distinct. For instance, some of the rural community health services /hospitals also provide nursing services.

Table 3.3 Number of clients by agency type - Victoria HACC program in rural areas, 2005-06

Agency_type	Grampians	Barwon South West	Loddon Mallee	Gippsland	Hume	Rural Total	Percentage for agency type
Local Government	7,741	11,869	11,675	6,327	8,989	46,601	42.7%
Comm Health Centre / Hospital	8,006	11,903	12,045	11,422	4,830	48,206	44.1%
Non Government Organisation	1,276	1,413	1,022	919	716	5,346	4.9%
NGO Ethno-specific agencies	12	645	132	133	79	1,001	0.9%
Aboriginal specific	141	269	212	167	137	926	0.8%
District Nursing Service	1,045	860	904	1,798	2,523	7,130	6.5%
	18,221	26,959	25,990	20,766	17,274	109,210	100.0%

Notes

1 Number of clients based on service outlets, hence about 12% might be counted more than once.

2 The figures show above are higher than the estimates in the first part of this project for client key pathways, which exclude records without a valid response to the data item – 'source of referral'.

Detailed analysis for rural regions

The analysis for the Barwon South West Region shows that City of Greater Geelong (local government provider) accounted for the majority of client volume in the region. However, collectively Community health centres/Hospitals had similar level of volume as Local Government provider group.

The Grampians Region is similar to Barwon South West Region, in that City of Ballarat accounted for the majority of the volume in terms of client numbers. At the aggregate level, Community health centres/Hospitals accounted for similar volume as the Local Government HACC providers.

The Loddon Mallee Region follows the general rural pattern, in which both Local Governments and Community health centres/Hospitals accounted for similar volumes of clients.

In the Gippsland Region, Community health centres/Hospitals accounted for a much larger volume of clients than Local government providers.

Hume Region follows the metropolitan pattern rather than the overall rural pattern, in that Local Government had a much higher volume than Community health centres/Hospitals. It is possible that data completeness might have some impact on the observation, together with the classification of agencies delivering district nursing. Agencies in rural regions that deliver nursing only were grouped under district nursing, whilst those that also provide allied health services were grouped under Community health centres/Hospitals. However, even if all the district nursing volume was allocated to Community health centres /Hospitals, the volume is still smaller than Local Government providers.

Overall, the analyses show that there are more variations in rural regions, and that the general pattern is different from the metropolitan regions.

3.2.3. Service mix

3.2.3.1. Metropolitan regions

Table 3.4 provides a summary of service mix for the HACC agencies in metropolitan regions. Overall, the range of HACC services provided by Local Governments is fairly broad.

Community health centres/Hospitals are the main provider group for allied health services, but a few Community health centres provide a broad range of HACC services as well.

The majority of non-government organizations are small agencies, but collectively they provide a broad range of services. Aboriginal specific agencies in the Southern Metropolitan Region and North and West Metropolitan Region also provide a wide range of HACC services.

3.2.3.2. Rural regions

Table 3.5 provides a summary of service mix for the HACC agencies in rural Victoria, which has similar pattern to the metropolitan regions. Local Governments provide a broad range of services, except nursing and allied health that are the key domains of Community health/Hospital/District Nursing in the rural regions.

In some rural regions, Community health/Hospital/District Nursing providers collectively provide a full range of services including those usually delivered by Local Government.

The majority of HACC clients (86.8 per cent) are being serviced by Local Governments and Community health centres/Hospitals. The involvement of non-government organizations is relatively small in the rural regions.

Ethno-specific non-government organizations serve a relatively small CALD client group in rural Victoria, which is reflected in the results. Regarding Aboriginal-specific agencies, the range of services offered in the rural regions is quite broad.

Table 3.4 Service mix by agency type for Victoria HACC program in metropolitan Victoria

Agency type by region	HACC Delivered Meals	HACC Domestic Assistance	HACC Property Maintenance	HACC Personal Care	HACC Respite	HACC social support	HACC Planned Activity Group	HACC Flexible Service Response	HACC Nursing	HACC Allied Health
EASTERN METROPOLITAN										
Local Government	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Comm Health Centre / Hospital / District Nursing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Non Government Organisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NGO Ethno-specific agencies					✓	✓	✓	✓		
Aboriginal specific organisation **										
NORTH AND WEST METROPOLITAN										
Local Government	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Comm Health Centre / Hospital / District Nursing				✓	✓	✓	✓	✓	✓	✓
Non Government Organisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NGO Ethno-specific agencies					✓	✓	✓	✓		
Aboriginal specific organisation		✓	✓	✓	✓	✓	✓	✓	✓	✓
SOUTHERN METROPOLITAN										
Local Government	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Comm Health Centre / Hospital / District Nursing			✓	✓	✓	✓	✓	✓	✓	✓
Non Government Organisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NGO Ethno-specific agencies						✓	✓	✓		
Aboriginal specific organisation	✓	✓	✓	✓	✓	✓	✓	✓		✓

✓ = service available
Based on 2005-06 HACC MDS

** specific information not available

Table 3.5 Service mix by agency type for Victoria HACC program in rural Victoria

Agency type by region	HACC Delivered Meals	HACC Domestic Assistance	HACC Property Maintenance	HACC Personal Care	HACC Respite	HACC social support	HACC Planned Activity Group	HACC Flexible Service Response	HACC Nursing	HACC Allied Health
Barwon South Western										
Local Government	✓	✓	✓	✓	✓	✓	✓	✓		
Comm Health Centre / Hospital / District Nursing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Non Government Organisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NGO Ethno-specific agencies	✓					✓	✓	✓		
Aboriginal specific organisation	✓	✓	✓	✓	✓	✓	✓	✓		✓
Gippsland										
Local Government	✓	✓	✓	✓	✓	✓	✓	✓		
Comm Health Centre / Hospital / District Nursing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Non Government Organisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NGO Ethno-specific agencies						✓	✓			
Aboriginal specific organisation	✓	✓	✓		✓	✓	✓	✓		
Grampians										
Local Government	✓	✓	✓	✓	✓	✓	✓	✓		✓
Comm Health Centre / Hospital / District Nursing	✓			✓	✓	✓	✓	✓	✓	✓
Non Government Organisation				✓	✓	✓	✓	✓		✓
NGO Ethno-specific agencies						✓	✓			
Aboriginal specific organisation		✓	✓		✓		✓	✓		✓
Hume										
Local Government	✓	✓	✓	✓	✓	✓	✓	✓		
Comm Health Centre / Hospital / District Nursing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Non Government Organisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NGO Ethno-specific agencies						✓	✓			
Aboriginal specific organisation		✓	✓	✓			✓	✓		
Loddon Mallee										
Local Government	✓	✓	✓	✓	✓	✓	✓	✓		
Comm Health Centre / Hospital / District Nursing	✓	✓		✓	✓	✓	✓	✓	✓	✓
Non Government Organisation	✓			✓	✓	✓	✓	✓		✓
NGO Ethno-specific agencies							✓			
Aboriginal specific organisation		✓	✓	✓	✓	✓	✓	✓	✓	

✓ = service available
Based on 2005-06 HACC MDS

3.2.4. Client mix

Three client characteristics have been selected for analysis, namely age group, clients with culturally and linguistically diverse (CALD) background, and clients with Indigenous status.

Table 3.6 provides an overview for each region. The majority (90 per cent) of CALD clients live in metropolitan regions. This finding supports the analysis of service mix, in which the involvement of ethno-specific agencies is less prominent in rural regions. The implication is that it might be easier to respond to the needs of large numbers of CALD clients in metropolitan areas than to the needs of very small numbers in rural areas (Victorian Department of Human Services 2006a).

Regarding HACC clients with indigenous status, about 60 per cent live in rural regions. The North and West Metropolitan Region also had a relatively large number of HACC clients with Indigenous status, which indicates the need to formulate strategies to meet the needs of this client group across Victoria.

Two-thirds of HACC clients were aged 70 and over. The Eastern Metropolitan Region, Southern Metropolitan Region and Hume Region had relatively higher proportion of clients aged 70 and over than statewide average.

Table 3.6 Clients' characteristics by regions – Victoria HACC program, 2005-06

DHS_region	Total N clients	Percent of clients with Indigenous background	N of Indigenous clients	Percent of CALD clients	N of CALD clients	percent aged up to 20	percent aged 21 to 69	percent aged 70 and over	N clients aged up to 20	N clients aged 21 to 69	N clients aged 70 and over
LoddonMallee	25990	1.7%	440	2.1%	533	2.7%	32.7%	64.6%	702	8,393	16,606
Gippsland	20766	1.7%	354	1.7%	360	5.9%	36.5%	57.6%	1,215	7,527	11,859
BarwonSW	26959	1.2%	311	5.0%	1336	4.1%	29.2%	66.7%	1,092	7,784	17,741
Grampians	18221	1.3%	228	0.6%	117	3.6%	32.2%	64.2%	657	5,816	11,589
Hume	17274	1.4%	248	3.3%	576	2.9%	27.8%	69.3%	495	4,762	11,869
North and West Metro	64889	1.0%	631	25.9%	16788	3.2%	32.2%	64.6%	2,067	20,530	41,220
Southern Metro	58802	0.5%	270	10.3%	6084	2.9%	28.8%	68.3%	1,692	16,842	39,977
Eastern Metro	46127	0.2%	113	11.2%	5157	3.6%	24.9%	71.5%	1,657	11,426	32,773
statewide	279,028	0.9%	2,595	11.1%	30,951	3.5%	30.1%	66.5%	9,577	83,080	183,634

Note – number of clients based on service outlets, about 12% of clients might be counted more than once.

Figure 3.1 Proportion of Victorian HACC clients with Culturally and Linguistically Diverse background by regions, 2005-06

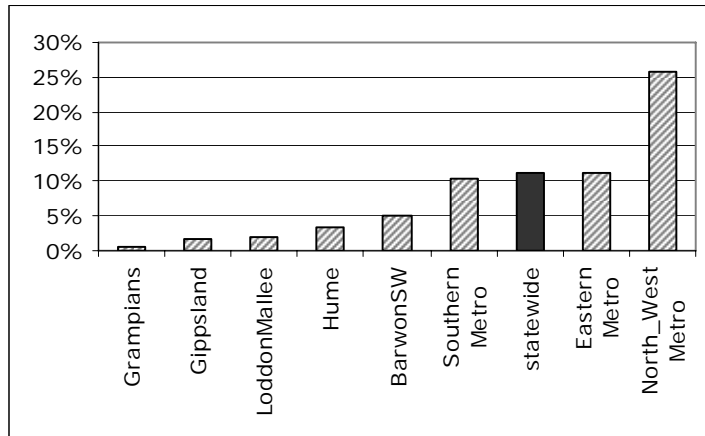


Figure 3.2 Proportion of Victorian HACC clients with Indigenous status by regions, 2005-06

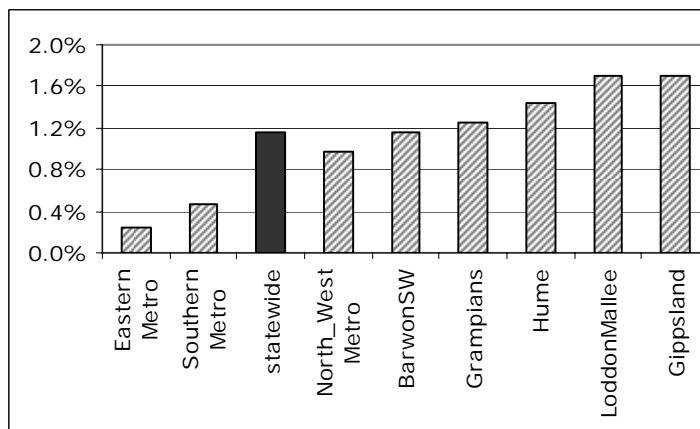
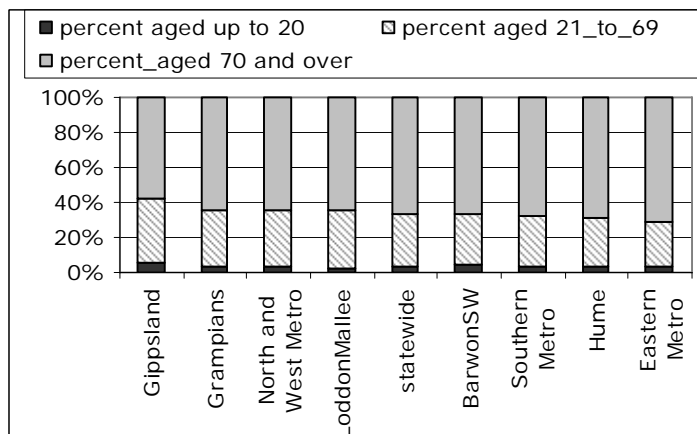


Figure 3.3 Age structure of Victorian HACC clients by regions, 2005-06



3.2.5. Capacity for e-referrals

Assessing the capacity of agencies for e-referrals was based on their capacity to send and accept secure electronic referrals. Some of the available data were at the agency level, but some were at Primary Care Partnership and regional level, hence there are limitations in the available data.

Since some agencies provide services across the State or across a whole Department of Human Services region rather than within a specific PCP catchment area, the ideal e-referral system should enable agencies to make referrals anywhere in the State or at least across the Department of Human Services region. It has to be noted that the e-referral system also has the capacity to support case management in some regions.

According to the Primary Health Report for 2005-06 (Victorian Department of Human Services 2007c) as at 1 February 2005 some 533 organizations or services were using the Service Coordination Tool Templates and service coordination practices, protocols, processes and systems. Of these, 172 (32 per cent) agencies stated they were using e-referrals. By 30 June 2006, this number had increased to 291 (55 per cent of agencies).

Regarding e-referral infrastructure, about 230 (43 per cent) of the organizations stated that they had fully or partially installed infrastructure as at 1 February 2005.

Primary Care Partnerships (PCPs) are voluntary alliances of local governments, HACC service providers, community health centres/hospitals, aged care assessment teams and other services. The members usually agree on common ways of dealing with enquiries, collecting the same client information and making referrals based on the Better Access to Services policy and operational framework (Victorian Department of Human Services 2001).

Several service directories are available to complement the above framework. The main ones are the InfoXchange Service Seeker Directory, the Connectingcare Health & Community Services Directory, the Victorian Government Human Services Directory and the Commonwealth Carelink Services Directory.

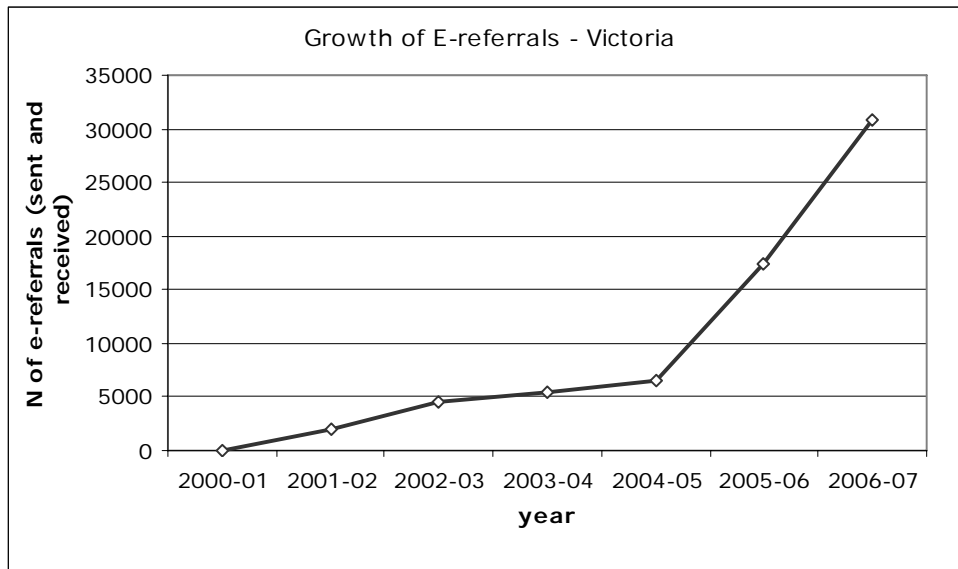
The capacity for PCP member agencies to refer electronically is steadily growing. Following the 2006-07 funding round, the number of electronic referrals sent and received during the year increased by more than fifty percent to over 30,000 (Figure 3.4). This large increase is primarily attributable to the change management work undertaken through Primary Care Partnerships, which includes agency-based service coordination, training for electronic referrals, and the production of user guides and other materials undertaken by the partnerships with their member agencies.

Other factors contributing to this large increase in the number of electronic referrals sent and received include the uptake of the Service Coordination Tool Templates, and the use of electronic referrals by a broader range of Department of Human Services program areas. There is growing appreciation across the sector on the role that the Service Coordination Tool templates, electronic referral, and the timely sharing, with

consent, of high quality and relevant health information can play in supporting the management of chronic and complex conditions, as well as their role in early intervention, care planning, and improved population wellness.

The Primary Health Branch (Department of Human Services) is currently working with a range of stakeholders – including Department of Human Services program areas, the General Practice Divisions Victoria, the Australian Institute of Primary Care and the National E-Health Transition Authority – to revise the Service Coordination Tool Templates. The revised tool templates, together with the rapid maturing of e-referral systems used by PCP member agencies and the promising uptake of the technology by general practitioners, will support future growth in electronic referral.

Figure 3.4 Growth of E-referrals in Victoria



4. Synthesis of findings

This chapter draws together the key findings of the project regarding entry points and pathways currently recognized and used by people seeking community care in Victoria and the current capacities of major provider groups in relation to the function of Access Points in the Victorian community care system.

4.1. Analytical framework

The synthesis is based on the following analytical framework:

- volume of transactions
- service mix
- main type of information sought by users
- type of contact - phone versus walk-in
- profile of agency amongst main user groups
- capacity for referrals to other providers
- capacity for electronic referrals
- capacity to meet the needs of clients with CALD background
- capacity to meet the needs of clients with Indigenous background.

Three major provider groups and two information provision services were selected for analysis. The provider groups were Local Governments, Community health centres/Hospitals and Non-Government organizations. The information services were Commonwealth Carelink Centres and Council on the Ageing Seniors Information Victoria.

Data from the RDNS Customer Service Centre was not available at the level required for comparison with Commonwealth Carelink Centres and COTA Seniors Information Victoria. Information from Nurse-On-Call has not been included because the client group for Nurse-On-Call is quite different from the main user group in this project. The majority of calls to Nurse-on-Call are medical triage. About 59 per cent of the male patients are 0-14 years and 39 per cent of female patients are 18-44 years (Victorian Department of Human Services 2006b). Being a recently established program, detailed information is not available at the level required for the present analysis. Commonwealth Care Respite Centres also could not provide data on public requests for information at the level of detail required.

4.2. Findings

Table 4.1 presents a synthesis of the key pathways for HACC clients described in the first part of this project, together with findings of the second part of this project regarding volume of transaction, service mix, client mix and capacity for electronic referrals of major provider groups.

Table 4.1 Synthesis of findings based on community care client pathways and service agency capacities in Victoria

	Volume (N of clients or contacts) 2005-06		service mix	Counseling /Support, Information & Advocacy	Assessment Services	Respite Care	Home based services	Accommodation	Health	Transport	Others	Type of contact	Profile amongst users - self referred, users' family and friends	Profile amongst GP based on existing clients' source of referrals	Referrals to other providers	capacity for e-referral		CALD clients		Indigenous clients		
	Rural	Metro														Rural	Metro	Rural	Metro	Rural	Metro	
				Main Type of Information sought from Carelink and Council on the Ageing																		
Local Governments / Councils	46601	79815	broad range of HACC services									face to face and phone	50%	7%	Inter-HACC agency referrals estimated to range between 11% to 17%	mixed, range from early to advanced stage	significant coverage and progress	^ 37.5%	^43.1%	* 16.7%	* 17.5%	
Community Health Centres / Hospitals	48206	48360	broad range of HACC services									face to face and phone	37%	25%	as above	as above	as above	^ 30.3%	^24.6%	* 30.2%	* 22.78%	
Non government agencies - exclude Ethno-specific	5316	14291	narrower range of services in smaller agencies									face to face and phone	46%	5%	as above	less coverage		^ 5.3%		*5.3%		
Commonwealth Carelink Centres	8976	11241	information provision	22%	15%	8%	9%	4%	6%	3%	33%	70% phone 14% walk-in	56%	3%	provide guided referrals to other providers	with e-referral capacity		similar to HACC statewide average		similar to HACC statewide average		
Council on the Ageing (COTA)	statewide =17078		information provision	42%	2%		6%	33%	10%	7%		54% phone 44% walk-in	92%	not applicable	18% calls resulted in 'referrals' - clients self referred to other providers	not applicable		less than 1 % required Telephone Interpreting Service		less than 0.1% of issues were related to Indigenous		

Notes

^ CALD clients as percentage of all CALD clients in the region.

* Indigenous clients as percentage of all Indigenous clients in the region.

4.3. Discussion

4.3.1. Volume of transaction

Volume of transactions can be used to estimate the likely workload of a network of Access Points. Analyses of available data by DHS region, Primary Care Partnership, the current volume of transactions of the Commonwealth Carelink Centres and Council on the Ageing enable an estimate of potential volumes.

Compared to the capacities of existing agencies, Access Points could present substantially different management and technology challenges. Creation of a more easily accessible 'shop-front' could put additional demands on an organization.

4.3.2. Service mix

The service mix provided by Local Governments and Community health centres/Hospitals is generally quite broad. Non-government agencies generally offer a narrower range of services.

4.3.3. Type of information sought by the public

The type of information sought by the public is an *indicator of the training needs* for Access Points. Counselling, support, information and advocacy is the most common cluster of information being sought by users of Commonwealth Carelink Centres and COTA Seniors Information Victoria, followed by enquiries regarding health and home based services.

There are differences in the type of information sought by these two client groups. *Accommodation* and *transport* were the main types of other information sought by people contacting COTA Seniors Information Victoria, whilst information relating to assessment and respite were sought by clients of Commonwealth Carelink Centres.

4.3.4. Method of contact

Commonwealth Carelink Centres collect data on the method of contact. About 70 per cent of contacts were by telephone, and 14 per cent were over-the-counter (walk-in) enquiries. The split between telephone and walk-in contact for COTA Seniors Information Victoria is 54 per cent and 44 per cent respectively. This pattern should assist in planning the set-up of Access Points. Similar information was not available from Local Governments, RDNS and Community health centres.

4.3.5. Public profile of agencies

The profile of an agency is another useful concept for this analysis. However, measuring the profile of an agency is a relatively complex task. One aspect is the knowledge and competence of the organization's staff and the tools and techniques that they apply to delivering quality services. Measuring this was beyond the scope of this project. Instead, the approach relied on the *client's source of referral* as a more tangible proxy measure.

There are limitations with this approach. The source of referral may be affected by the type of service sought by the clients. For instance, referrals from a general practitioner would be expected to be more frequent in Community health centres rather than in Local Government providers.

Two measures were introduced for the analyses, namely agency profile among clients and carers, and agency profile among GPs.

Agency profile amongst clients and carers was represented as the percentage of clients who were self-referred or entered the system through informal channels (family, friends and carers). All these are described here as self-referrals.

It was found that Local Government agencies have a higher profile amongst clients and carers (50 per cent of clients self-referred) compared to Community health Services (37 per cent self-referred). Commonwealth Carelink Centres (56 per cent self-referred) had a similar profile to Local Government.

Agency profile amongst general practitioners was represented by the percentage of clients who were referred to the service by GPs. On this measure, it was found that Community health Services/Hospitals tend to have a higher profile (25 per cent of referrals came from GPs) than Local Governments (7 per cent) and Commonwealth Carelink Centres (3 per cent).

Overall, Community health centres/Hospitals appear to have a good balance for the two main user groups – clients/carers and general practitioners – in terms of agency profile.

4.3.6. Capacity for sending referrals to other providers

Local Governments and Community health centres/Hospitals have established referral networks to other providers. In the first part of this report, inter-agency referrals amongst HACC providers were estimated to be between 11 per cent and 17 per cent of clients. According to data from COTA, about 18 per cent of calls resulted in some form of referral, in which clients self-referred to other service providers. According to the operational guidelines of Commonwealth Carelink Centres, 'guided referrals' are used to assist people to find the right service provider.

4.3.7. Capacity for electronic referrals

Capacity for electronic referrals is an indicator of a service provider's readiness in terms of Information Technology, eliminating the burden of re-capturing basic data, and delivering up-to-date and accurate information. E-referrals can also streamline communication between agencies and support better service coordination.

The findings have shown that metropolitan agencies have made significant progress in terms of capacity for electronic referrals, whereas in rural regions the situation is mixed, ranging from early implementation to achieving similar levels to the metropolitan regions. Commonwealth Carelink Centres also indicated the capacity to make e-referrals.

4.3.8. Capacity to meet needs of clients with CALD background

Capacity to meet the needs of clients with CALD background was measured as the proportion of CALD clients in an agency compared to the proportion of all CALD clients in the region. This serves to indicate the agency's day-to-day interaction with clients from different cultural backgrounds.

This is a crude measure, which does not provide information on the extent to which staff of HACC agencies have language and cultural backgrounds similar to clients in their local area, or training in dealing with a diverse population.

The data show that both Local Governments and Community health centres /Hospitals have substantial coverage in both rural and metropolitan regions (though the absolute number in rural regions is small). Generally, the involvement of other non-government agencies is small as there are Ethno-specific non-government agencies serving this function.

4.3.9. Capacity to meet needs of Indigenous clients

Similarly, an agency's capacity to meet the needs of Indigenous clients was measured as the proportion of indigenous clients attending the agency compared to all indigenous clients in the region. This serves to indicate the extent in which the agency had day-to-day interaction with clients from indigenous background.

The analysis shows that Community health centres/Hospitals had a higher percentage and a greater number of clients with indigenous background compared to Local Government agencies.

4.4. Risks, issues and gaps due to methodology

4.4.1. Issues

As is usually the case, coverage or capture was not complete for the datasets used in this project. The major reason was agency non-compliance with reporting. While only a small percentage of HACC clients are completely missing from the MDS, only 77 per cent of records have a valid response to the key data item – *source of referral*. Missing data on this item may have some impact on the findings.

Data quality is another issue that might affect the interpretation of the analyses. For instance, data on clients with Indigenous status has known inaccuracies that may affect the interpretation of the results.

4.4.2. Gaps

Given the defined scope of the project and data limitations, the findings about client flows and pathways are necessarily based mainly on clients who actually received services and are captured in the data systems.

Linkage between data sets was not possible within the scope of the project. There is some information about clients common to the HACC and ACAS programs, but generally it is not possible to establish the extent of common clients amongst the other programs of the community care services in Victoria.

Based on the type of information sought by clients who accessed the different information provision services (Commonwealth Carelink Centre, COTA Senior Information Victoria, RDNS Customer Service Centre and Nurse-on-Call), it is likely that the people making contact with these services fall into distinct groups. However, without being able to link the data, it was not possible to confirm this.

Comparable information for Local Governments on workforce, staffing characteristics, numbers, mix, distribution, and competency levels is not readily available, which limits the analyses regarding this component.

A Department of Human Services survey of primary health agency engagement in Service Coordination practices and use of Service Coordination Tool Template (SCTT) was not completed at this stage, therefore information is not available for inclusion in this project.

4.4.3. Methodology

The approach adopted for the first part of this project to map client pathways was based on data reduction, in which the categories for *source of referral* and *agency type* were reduced to the minimum so as to facilitate discovery of any simple yet meaningful pattern of relationships among the key items. The grouping of *source of referral* and *agency type*, although arbitrary, followed common-sense principles in which low-frequency items are combined into similar categories. From the findings, it appears that this approach has been able to strike a balance to limit the number of items and still provide a meaningful description of client pathways for the HACC program.

In order to analyze current capacities of major groups of agencies in the second part of this project, a different method of counting clients was adopted. Agency outlets were used to build the list of community care services in each Department of Human Services region. Organizations such as Royal District Nursing Service that provide services across regions were represented in each region. This methodology meant that some clients might be counted more than once if they received services from more than one service outlet or provider. As a result, the estimated number of clients was about 12 per cent above the total number of unique HACC clients. For the purpose of this project, this did not present a significant risk of over-estimation, taking into account there is some degree of non-compliance with reporting.

4.4.4. Assumptions applied

The assumptions that grouped HACC agencies into six categories generated patterns that aligned with anecdotal evidence.

The analyses of inter-agency referrals are exploratory because of data limitations. Nevertheless it provided estimate HACC inter-agency client flows, which could enable further examination of interactions amongst service providers.

5. Summary and conclusion

5.1. Key features of existing Victorian community care system

- There are multiple entry points for clients and carers.
- The varied pathways by which clients and carers access services and the type of information sought give support to the view that the consumers are not a homogenous group.
- The majority of service providers are involved in inter-agency referrals, though some more than others.
- Significant progress is being made in relation to the capacity to collect consumer information at one point and transmit it to another agency through electronic referral.
- Victoria's Better Access to Services Policy and Operational Framework treats every service site as an entry point to the full suite of services, including assistance and information to navigate the system.
- The majority (90 per cent) of CALD clients live in metropolitan areas. The needs of large numbers of CALD clients in metropolitan areas are easier to cater for than the needs of small numbers scattered across rural areas.
- Approximately 40 per cent of Indigenous clients are identified in the metropolitan region. There is a need to formulate strategies to meet the needs of this client group across the State.
- Several service directories are available to complement Victoria's Better Access to Services policy and operational framework. They should be rationalized to make them more useable from both the consumer's and service provider's perspective.
- Some services in rural regions may only be sporadically available.

5.2. Client pathways in Victoria

People's most common initial contact with the community care system is by telephone or in person. For some clients, it may simply be the point where basic information is provided and no further service is necessary. In many cases, this initial contact results in either receiving a service or making an appointment to do so.

For people who are seeking direct services as well as information, the agency can either make an assisted referral or suggest that the person initiate contact with the other agency; in the latter case the contact is recorded as a self referral. Some clients may be transferred to the next process of screening for risk and service requirements; this is described as Initial Needs Identification in Victoria's Service Coordination Framework (Primary Care Partnerships, Victoria 2007).

Analysis of the HACC minimum data set reveals the following as key client pathways:

self referred – direct contact with service providers	28 per cent
social network – family/friends/carers	14 per cent
general practitioners	13 per cent
hospitals	18 per cent
Aged Care Assessment Services	6 per cent
extended care or rehabilitation services	3 per cent
other pathways including inter-agency referrals	18 per cent.

This pattern of source of referral is similar to corresponding New South Wales data (Australian Government Department of Health and Ageing 2004), thus supporting the methodology in this project.

Local Government is currently the most common entry point for people seeking community care services in Victoria.

- Overall, 42 per cent of all clients received services from their Local Governments as their first contact with HACC provider.
- Of the 27.5 per cent of self-referred clients, about half made direct contact with their Local Government.

Community health centres/Hospitals are the next most popular entry point:

- Overall, 30 per cent of all HACC clients received services from a Community health centre / Hospital as their first contact with HACC provider.
- Of the 27.5 per cent of self-referred clients, about one-third contacted the Community health centre directly.

With regard to volume of clients receiving services, Local Government is the largest HACC provider group, serving approximately 47 per cent of clients in the metropolitan region. Community health centres/Hospitals accounted for about 27 per cent of all HACC clients in the metropolitan region.

In rural Victoria, both Local Governments and Community health centres / Hospitals serviced similar volume of clients, 43 per cent and 44 per cent respectively.

Another key client pathway is through dedicated information providers. The main agencies involved are Commonwealth Carelink Centres, COTA Seniors Information Victoria, RDNS Customer Service Centres, and Nurse-On-Call.

Because data linkage could not be made between the information service datasets and the HACC MDS, it was not possible to establish the true extent of common clients amongst these services. However, data from these information services did indicate the magnitude of demand for information about community care in Victoria. It is possible that users of these different information services are quite distinct client groups.

Data collected by Commonwealth Carelink Centres, Commonwealth Carer Respite Centres, COTA Seniors Information Victoria, Nurse-On-Call and RDNS Customer Service Centre could be used to estimate the size of the population seeking information about community care.

Given the defined scope of the project, the findings about client flows and pathways are necessarily based mainly on clients who actually received services. There are limitations in the data available, but it is sufficient to generate a reasonable overview of key client pathways.

Inter-agency referrals amongst HACC providers were examined, but the findings were exploratory. Further examination of inter-agency referral patterns would assist our understanding of client flows, and benefit current policy directions – in particular, the issue of ensuring culturally equitable and appropriate access to HACC services in Victoria.

Regarding client mix, the majority (90 per cent) of Victorian HACC CALD clients live in the metropolitan regions, which supports the finding that the involvement of ethno-specific non-government agencies are less prominent in rural regions. The implication is that it might be easier to respond to the needs of large numbers of CALD clients in metropolitan areas than to the needs of very small numbers in rural areas. Concerning clients with Indigenous status, a significant proportion was identified in the North and West Metropolitan Region besides the rural regions, which implies that strategies to meet the needs of this client group have to be applied across Victoria.

5.3. Implications for access points

- The initial point of contact is important to people who have had little experience with the service system. For people who do not know how to access the service system, the Access Point can serve as an easily identifiable, highly visible and well recognized point of contact that provides simplified and streamlined access to information, care and support.
- General Practitioners serve as the first port of call for a significant proportion of community clients, therefore this group would potentially benefit from Access Points as contact for information about all community care services to improve access for services for their clients.
- For non community-based providers, hospitals are a major referrer group to community care services. Strong links with hospitals would potentially facilitate access to community care services for clients coming from the acute health setting.
- Access Points will be an incremental enhancement to the Victorian Better Access to Services Policy and Operational Framework already in place, particularly in relation to consistency in initial contact, initial needs identification, referral, Information Management and Local Services Information.
- Access Points will also add value to the implementation of the Victorian HACC Assessment Framework, which aims to support and build good assessment processes and strong links with key health and community care organizations to efficiently manage client pathways.
- Access Points will be based on the existing Victorian service system. The proposed function of Access Points need to be fully tested and take into account the differing capacity in each region.

5.4. Conclusion

Given the defined scope of the project, and the limitations in the data and information available, the findings about client flows and pathways are necessarily based mainly on *clients who actually received services*.

In regard to inter-agency referrals amongst HACC providers, the findings are exploratory. Further examination of inter-agency referral patterns at the local levels would assist our understanding of client flows and would benefit current policy directions – in particular, the issue of ensuring culturally equitable and appropriate access to HACC services in Victoria.

Concerning agency capacities, only broad observations are warranted by the available data. Comparable information on workforce, staffing characteristics, numbers, mix, distribution, and competency levels is not readily available for all major providers. It is likely that there are disparities across Victoria, and that rural regions find it more difficult to attract and retain qualified staff.

Overall, the methodology and analytical framework applied have been successful in providing a reasonable overview of current community care access pathways and infrastructure in Victoria. The findings can serve as the starting point for further examination in more localized areas.

Abbreviations

ACAP	Aged Care Assessment Program
ACAS	Aged Care Assessment Services
ACAT	Aged Care Assessment Team
CACP	Community Aged Care Package
CALD	Culturally and Linguistically Diverse
CCC	Commonwealth Carelink Centre
CCRC	Commonwealth Carers Respite Centre
COAG	Council of Australian Governments
COTA	Council on the Ageing
DHS	Department of Human Services, Victoria
DTC	Day Therapy Centre
EACH	Extended Aged Care at Home package
GP	General Practitioner
MAV	Municipal Association Victoria
HACC	Home and Community Care Program
MDS	Minimum Data Set
NGO	Non-Government Organization
NRCP	National Respite for Carers Program
PCP	Primary Care Partnership
RDNS	Royal District Nursing Service

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