Assessment, Care Management and Review in Home and Community Care

Final Report

September 2004

© Municipal Association of Victoria and Department of Human Services,

September 2004

MAV Project Manager: Clare Hargreaves, Senior Adviser – Social Policy
Phone (03) 9667 5555
Fax (03) 9667 5550
Email: inquiries@mav.asn.au
Level 12, 60 Collins Street, Melbourne, 3000

Prepared by Julie Prideaux, Peter Clark, Dinny Goonan and Rosemary McCormack

J Prideaux and Associates Pty Ltd

(03) 9696 8347

This Report can be found on the DHS HACC web site:
www.health.vic.gov.au/hacc/

An Appendix to the report which contains more details of survey results is also available at www.health.vic.gov.au/hacc/

For further information contact: Heather Russell at DHS on (03) 96167583; email Heather.M.Russell@dhs.vic.gov.au

FOREWORD

Assessment and care management is critical to the effective provision of services funded through the Home and Community Care program.

As the Victorian community continues to age, demand for HACC services will continue to increase. Rising demand means that assessment and care management will become more important to ensuring HACC services are both responsive and tailored to suit client need.

Local Government is the major provider of HACC services in Victoria and consequently, Councils have a long history in providing assessment for HACC and other community services programs and contributing to the funding of those services.

The Department of Human Services provided a total of $14.5 million to HACC agencies in 2003-04 for assessment and care management. Of this, Local Government received $8.1 million which included funds to implement the Culturally Equitable Gateways Strategy. This is a substantial increase in funding for this activity from 2002-03 when this survey was carried out.

This project aimed to examine the range and scope of assessment, care management and client review practices within the HACC program.

Part 1 of this report is based on research undertaken by Julie Prideaux and Associates in conjunction with the Department of Human Services and the Municipal Association of Victoria. It provides a snapshot of Local Council's approach to assessment and care management, including their approach in handling reviews, and the pressures impacting on their capacity to meet assessed need and to handle client reviews.

Part 2 presents a snapshot of assessment and care management from the perspective of a small sample of non-local government agencies. This part of the project was carried out by officers of the Victorian Department of Human Services. The final report has been prepared by the MAV, DHS and Julie Prideaux and Associates (JPA).

Overall, this document provides an important source of information for policy makers at all levels of government. It provides valuable baseline information for the development of a Victorian framework for assessment in HACC – work which is commencing in August 2004. The development of an assessment framework will assist in shaping future directions for the HACC program. Future directions include more equitable distribution of funds across geographic areas of the state as well as consistent approaches to targeting of services; equity of access; better integration of services, both horizontal and vertical; and the desire to reorient HACC services, wherever possible, to a more active, health promoting model of service delivery. Assessment is a key component of each of these objectives.

Information on the development of the HACC assessment framework for Victoria can be obtained from Heather Russell at the Department of Human Services, 03 96167583.

This project was funded by the Victorian Home and Community Care Program.

Rob Spence	Jane Herington
Chief Executive Officer	Director, Aged Care
Municipal Association of Victoria	DHS

Table of Contents

Foreword ii

List of Tables v

List of Figures vi

Executive Summary 1

Summary of Findings 1
Referrals, assessments and services 1
Type of assessments 2
Tools used for information and referral 2
Tools used for assessment 2
Time awaiting and undertaking assessment 2
Targeting and measuring need and priority 3
Reviews 4
Assessment rates per EFT 4
Assessment team composition 5
Expenditure and financing of assessment 5
Other service provider arrangements 5
Reassessments performed by Councils 5
Impact of PCP 5
Changes to assessment practices 6
Key Issues 6

Introduction 8

Background 8

Methodology 9

Results Part 1 – Local Government
Introduction 10
Council Groupings 10
Target Population 10

Survey Findings 11
Referrals 11
Assessments 12
Services Received 13
Single Entry point for HACC services 14

Nature of assessments undertaken 14
Types of assessments by council types 14

Tools used for information and referral (in last year) 16
Councils using Initial Needs Identification tool 16
Tools used for Assessment 16

Time to assessment and time spent on Assessment 16
Time taken prior to assessment 16
Time taken to undertake assessments 18

Service availability and allocation 20
Criteria for assessing need and priority 20
Clients' needs and service availability 20

Reviews 23
No. of reviews undertaken 23
Routine or 'as needed' reviews 24
'As-needed' reviews 25
Time elapsing before a review is held 25
Changes to care as a result of reviews 26
Main issues about reviews 27

Staffing for intake and assessment 27
Number of current HACC clients per Assessment EFT 28

Assessment Team Composition 29
Qualifications of Assessment Staff 29
Assessment Expenditure 30
Reassessments 31
Referrals 32
Impact of PCPs 32
Changes to assessment processes 33

Resource implications 37
Key issue facing the assessment role in HACC 35

Results Part 2 – Non Local Government
Introduction 36

Referrals and assessments 37
Type of assessments 38
Instruments used for information and referral 38
Tools used for assessment 38
Time awaiting assessment 38
Time undertaking assessment 40
Reviews 41
Assessment staff 42
Expenditure and financing of assessment 43
Arrangements with other service providers 43
Impact of Primary Care Partnerships 44
Changes to assessment practices 44
Issues in HACC assessment 44

Discussion & Conclusions 45
Clarification of definition, roles and responsibilities 46
Level of resources 47
Managing and incorporating change 47
Assessment practice and workforce issues 48

Conclusion 49

Attachment 1 - Members of project team 50

Attachment 2 - Council types and population data 51
Victorian Councils, by type 51
Population data and HACC Target Population Data, by Council 52

Attachment 3 - Interview Guide 56

List of Tables

Table 1	Number of Councils responding to the survey, by Council type	10
Table 2	HACC target group by council type (calculated)	10
Table 3	Number. of people referred to Council HACC service July 2001 to June-2002, by Council type	11
Table 4	Number of clients referred to HACC per 1,000 HACC target group, by Council type (calculated)	12
Table 5	Number of assessments by Council HACC services July2001 to June 2002, by Council type	12
Table 6	Percentage of assessed clients subsequently receiving HACC services by Council type	13
Table 7	Percentage of assessed clients (average) receiving CACPs, DVA, PAC, Private & Other services, by Council type	14
Table 8	Number of Councils reporting proportions of assessments that were 'comprehensive', 'specialist' and 'service specific', by Council type	15
Table 9	Number of Councils using, or planning to use, the INI within 12 months, by Council type	16
Table 10	How long on average Councils spend in total per assessment (minutes), by Council type	19
Table 11	Number of Councils stating clients needing service exceeds availability, by Council type	21
Table 12	Number of Councils placing limits on high needs clients	22
Table 13	Number of clients reviewed July-01 to June-02 by each Council, by Council type	23
Table 14	Number of clients reviewed per 1,000 HACC clients (May 2002), by Council type	23
Table 15	No. of Councils that review need for service routinely or 'as-needed', by Council type	24
Table 16	No. of Councils by proportion of clients reviewed by the set date, by Council type	25
Table 17	Proportion of clients reviewed in the past year with unchanged levels of care	26
Table 18	Average staff in Intake and Assessment, by Council type	28
Table 19	Percent of assessment staff with formal qualifications (percent of staff in each column)	30
Table 20	DHS funding for A&CM 2002-03	31
Table 21	Reasons for re-assessments	32
Table 22	Impact of PCP on assessment in nominated areas	33
Table 23	Characteristics of non Local-Government respondents	36

List of Figures

Figure 1	Clients discharged from hospital: Ave. time from acceptance of referral to home assessment	17
Figure 2	Clients NOT discharged from hospitals: Ave. time from acceptance of referral to home assessment	18
Figure 3	Time taken for assessment by proportion of comprehensive assessments	19
Figure 4	Time that normally elapses before a review is undertaken	26
Figure 5	HACC users per assessment staff, all Councils	29
Figure 6	Services received by clients assessed in HACC 2001-02	37
Figure 7	Waiting time for assessment – persons discharged from hospital	39
Figure 8	Waiting time for assessment – other persons	39
Figure 9	Time spent undertaking assessments	40
Figure 10	Time to review of clients, 2001-02	41
Figure 11	Reasons given for reassessment of clients	43
Figure 12	Problems confronted by HACC Assessment Officers (now and near future)	45

Executive Summary

This project surveyed 74 Local Government Councils and 26 non-Local Government HACC funded agencies across Victoria to examine the range and scope of their assessment, care management and client review practices within the HACC program. Non Local Government agencies largely comprised Community Health Services and Health Services. These agencies provide a range of HACC services with a different mix to Local Government agencies eg. non Local Government agencies provided more Nursing, Allied Health and Linkages and less Property Maintenance. Some Health Services provided a near complete suite of HACC services.

Below is a summary of the key findings. More detailed results from the Assessment and Care management survey can be found in the Appendix to the Final Report. This document can be found on the DHS HACC web site: www.health.vic.gov.au/hacc/

Findings relating to non Local Government agencies should be treated with some caution as the sample size was small. Furthermore, not all agencies answered every question. Agencies noted that the answers to some questions were estimates only as accurate sources of information were not always available.

Summary of Findings

Referrals, assessments and services

The number of people in Victoria eligible for HACC services is determined by the number of those aged over 70 years and those under 70 years with profound, severe or moderate disabilities who are in private dwellings and not receiving services from the Department of Veteran's Affairs. It is estimated by DHS that in 2002-2003 there were approximately 631,500 people in Victoria in this target group.

The average number of people referred to a council HACC service in the year July 2001 to June 2002 was 114 referrals per 1,000 of the HACC target population. The number of people assessed by council HACC services over the same period was 98 assessments per 1,000 HACC target population. There was a wide variation in the referral rates.

The average number of people referred to non-Local Government HACC agencies in 2001-02 was 924. However, the range was very large: from 30 to 5,308. An average of 552 clients was assessed by each agency in the 12 months from July 2001 to June 2002, with the range being 26 to 2,128. Two agencies reported performing more than 2,000 assessments in the year, both Health Services.

In around three quarters (77%) of Councils, more than three quarters of people assessed subsequently received HACC services including nursing services and Linkages. On average, 67% of people assessed by non-Local Government agencies received a HACC service following assessment, but the range was very broad (3% to 100% of clients assessed).

In both Local Government and non Local Government agencies, around 6% of people assessed subsequently received post-acute care services or services from DVA. Three percent of people assessed by Local Government received CACPs following assessment compared to 6% in non Local Government agencies. Three percent of people assessed by Local Government received services from 'other'

including private providers, compared to 20% of people assessed by non Local Government agencies.

Type of assessments

On average 60% of assessments undertaken by Local Government were service specific and 39% were comprehensive. Thirty-one percent of Councils undertook comprehensive assessments for more than 75% of their clients. Only one per cent of assessments were classified as specialist, and these occurred in only 10% of Councils.

Nearly one third of Councils provided routine comprehensive assessment as the first point of contact for people presenting with multiple, complex or unclear needs. A similar proportion of Councils referred all clients requiring comprehensive assessments to Aged Care Assessment Services (ACAS).

Among non Local Government agencies, there did not appear to be a relationship between the assessment throughput of an agency, the size of the agency and the type of assessment undertaken.

Ten out of the 17 non Local Government agencies responding to the question undertook some service-specific assessment; these were Community Health Services, Health Services and the MPS. Thirteen out of the 17 agencies undertook some comprehensive assessment. Six of the 17 agencies, comprising Health Services, the Hospital and the MPS, undertook some specialist assessment, and two agencies only undertook specialist assessment.

Tools used for information and referral

Thirty-two percent of Councils (and 21% of non Local Government agencies) were using the Initial Needs Identification (INI) tool (now referred to as the 'Service Coordination Tool Templates' (SCTT)) and, at the time of the survey, 93% of Councils and 100% of non Local Government agencies expected to be using it within 12 months. Almost all of those Councils, and three quarters of non Local Government agencies, not using the INI were using the Client Information and Referral Record (CIARR) in the previous 12 months.

Tools used for assessment

Few Councils used standardised instruments (ADL, IADL, MMSE or Barthel) to carry out their assessment. Only seven Councils used a standardised assessment instrument for assessing activities of daily living (for personal care needs) and even fewer Councils (2 Councils) used an instrumental activities of daily living (IADL) for assessing domestic care needs. Two Councils used the Mini Mental State Examination (MMSE), a cognitive function screening tool.

Non Local Government agencies were more likely to use standardised instruments. Thirteen of seventeen agencies responding (76%) used standardised instruments, all of them used an ADL instrument, some in combination with an IADL or other tool (two used MMSE and one used Barthel).

Time awaiting and undertaking assessment

For clients about to be discharged from hospital, most assessments were undertaken on average within 4 - 5 working days, whether by a Local Government or non Local Government agency.

For people leaving hospital and assessed by Local Government, 77% of assessments occurred within 3 working days (56% in non Local Government agencies). However, only half of assessments for people referred from sources

other than hospitals occurred within 3 working days for both Local Government and non Local Government.

The total time reported per assessment was on average three hours for Local Government and three and a half hours for non Local Government agencies. Intake screening and face-to-face interviews were estimated at around 90 minutes for Local Government (around 105 minutes for non Local Government) even for Councils that undertook comprehensive assessments. There was considerable variation across agencies in time spent on 'other' assessment activities, including travel.

Targeting and measuring need and priority

Eighty-one percent of Councils reported using explicit criteria for assigning priority to clients. Most Councils used the priority of need codes identified in the HACC Program Manual 2003 or variations of these. Fourteen (74%) non Local Government agencies also used level of need criteria.

Sixty-five percent of Councils and 89% of non Local Government agencies indicated that the number of clients assessed as needing a HACC service exceeded their service availability – the greatest demand being in Outer Metropolitan Councils and the least in Large Shires. The majority of agencies took a range of factors into account in deciding service allocation. The most important factors for both Local Government and non Local Government agencies were:

- the client's social situation (including carer availability and living alone);
- urgency of providing services;
- alternative services available and the amount of care needed.

Seventy-two percent of Councils and 63% of non Local Government agencies set limits on the level of HACC services available to clients with the highest proportion of Councils doing this in Inner Metropolitan and Large Shires. In the majority of cases, the limits were imposed because available services were not sufficient to meet assessed needs.

Councils chose from a variety of strategies to handle the imbalance between assessed need and available service level in their municipality. The major alternatives used, often in combination, were:

- ration available services so that everyone receives some services (and there is no waiting list);
- introduce a waiting list for clients with lower priority needs, reducing the early intervention impact;
- allocate available services only to those clients with the highest needs;
- refer clients with higher needs for CACPs (where possible) to limit the drain on services from those with high needs; and
- seek council funding to provide additional service levels.

Approaches used by non Local Government agencies included:

- ration available services in relation to levels of need.
- allocate set hours for all clients.
- allocate available services only to those with the highest needs

- assign a budget limit per client.
- refer some clients to private providers.

Reviews

The average number of reviews undertaken by Councils (in addition to initial assessments) represented less than half the number of existing clients. Only a few Councils reviewed all clients within a year and 11% of Councils reviewed less than one HACC user in five in the 12 month period.

Only eight (42%) non Local Government agencies were able to identify the number of clients that they reviewed during 2001-02. The average number of reviews held by those agencies that did respond was 252. However, the sample size was small and there was wide variation in the number of reviews that were undertaken.

Almost all Councils had procedures to review users on an 'as needed' basis, however only half had procedures in place to routinely review the needs of all HACC service users. Around three quarters of non Local Government agencies had procedures to routinely review the needs of all HACC service users and to review users on an as needed basis, with about half using both approaches.

Almost all Councils set a review date, however less than half these dates were achieved. There were generally higher rates of review in Small Shires and Inner Metropolitan Councils. Around three quarters of non Local Government agencies set a review date for most of their service users when they were assessed and around a third of these met the set date.

For three quarters of Councils who responded to this question, the majority of HACC service users had the same level of service following a review. For 62% of Councils up to one quarter of their clients had services increased as a result of a review. In non Local Government agencies, on average, 56% of service users saw no change in their care following a review, 24% saw some increase, 9% saw a reduction of service, and 11% saw a discontinuation of service. However, not all non Local Government agencies were able to provide information on changes in service provision following review.

Almost all Councils indicated that an inadequate level of resources was the main issue in relation to reviews. Twenty percent also reported the limited availability of direct services to meet the needs of people following reviews and fifteen percent said a main issue was travelling time, this cohort predominantly comprising Large and Small shires.

Assessment rates per EFT

On average Councils had 530 HACC clients per 1 EFT assessment staff per year. However, the data showed a considerable range from fewer than 200 HACC clients to over 1,500 clients per assessment EFT. The wide variation is likely to relate to:

- the differing levels of resources Councils have available to them both from assessment and care management funds provided by DHS and contributions from their own Councils.
- consistency of assessment practice and tasks included in the assessment officer role
- other factors such as travel and client complexity.

In non Local Government agencies, the average number of persons involved in Assessment was 5.4, ranging from 16 to 1. On average, 4.4 EFTs were dedicated to assessment only, ranging from 17 to 0.2 EFTs.

Assessment team composition

Ninety six percent of Assessment Officers (100% in non Local Government) had some type of formal post-secondary qualifications. The most commonly held qualifications in Local Government were Nursing, Welfare or Social Studies, Social Work and Disability Studies. In non Local Government the most commonly held qualifications were Nursing, Allied Health and Social Work.

Expenditure and financing of assessment

DHS provided over $5 million in 2002-03 for assessment and care management to Councils. Information on Councils' total expenditure on assessment services (i.e. including funding from all sources) was considered to lack sufficient precision for inclusion in this report. However there was some evidence that most Councils contribute funding towards the assessment, care management and review functions.

Data provided by non-Local Government agencies around expenditure associated with assessment was also considered to lack sufficient precision for inclusion in this report.

Other service provider arrangements

Almost half of the Councils and 29% of non Local Government agencies had arrangements with other agencies that, on request, those agencies would assess clients who needed to access Council services. Approximately one third of these arrangements made by Councils were for service specific assessments and 22% each for comprehensive and comprehensive plus specialist assessments.

Thirty-eight percent of Councils had arrangements with other agencies where Council performed assessments for uptake of those agencies' services. Just under half of these arrangements were for service specific assessments. Fifty-eight percent of non-Local Government agencies also undertook a small number of assessments for other providers.

Reassessments performed by Councils

Ninety percent of Councils reported that they re-assessed at least some of these service users on presentation. Just over two thirds reassessed almost all new users who were assessed as eligible by another agency. While much of this reassessment is to gain service specific information such as occupational health and safety, domestic and personal care requirements and nutrition needs, 84% of Councils reassessed eligibility and priority of need. Eighty-three percent of non-Local Government agencies reported that on presentation to their agency, they re-assessed at least half the service users assessed by other providers, for similar reasons.

Impact of PCP

Neither Council nor non Local Government agencies reported having seen much impact from the establishment of the PCP at the time of the survey. Those that did notice some impact reported improvements in the areas of coordination between agencies and improved referral processes. Almost a quarter of non Local Government agencies found that PCPs had simplified access for clients

compared to 9% of Local Government agencies, but the response rate for this question was small so results should not be generalised.

The majority of agencies responding (82% of Councils and 89% of non Local Government agencies) expected positive impacts from the establishment of PCPs in the next year.

Changes to assessment practices

Most Councils (79%) reported they had made significant changes to assessment practice (other than the introduction of the service coordination tool templates and related changes) in the past two years. The most common areas of action included changes in:

- the role of Assessment Officer (11 Councils)
- assessment tools and processes (11 Councils)
- priority of access tool (11 Councils)
- OH & S processes (11 Councils)
- review targets and processes (10 Councils)
- intake workers (10 Councils) and
- IT systems (9 Councils).

Half the non Local Government agencies reported they had made significant changes to assessment practice (other than the INI and related changes). Major areas of change were: alignment of assessment processes, training and support for assessment change, electronic arrangements. Further changes were expected in the following year by most Councils and non Local Government agencies alike.

Eighty percent of Councils outlined resource implications from their planned changes and only a few indicated that they expected these could be managed within existing resources. No non Local Government agency suggested that these expected changes could be absorbed within existing resources.

Key Issues

The greatest problem that Councils reported in undertaking the assessment role was the level of resources. This was reported by 93% of Councils and 78% of non Local Government agencies. Seventy-eight percent of Councils and 67% of non Local Government agencies also identified the related issue of the volume of persons requiring assessment.

The majority of Councils saw the next most significant issues as staffing availability, training, quality and internal organisational issues – IT, forms and procedures. Among the majority of non Local Government agencies, a secondary set of issues included ensuring access and equity and internal organisational issues.

Discussion and Conclusion

The survey demonstrated that agencies funded for assessment and care management are carrying out assessments which ensure that individuals receive the appropriate type of service according to their assessed need. However the level of service received is often constrained by availability. Issues facing both Local Government and in the non-Local Government sector in relation to these functions include:

- clarification of types of assessments: comprehensive, service specific and specialist
- roles and responsibilities eg reviews, care management
- level of resources to undertake assessment
- managing demand, in particular priority of access

This audit highlights areas where there is a need for greater consistency of practice, improved understanding of the tasks, roles and responsibilities of HACC assessors and a review of resources available to the assessment and care management activity. The report will contribute valuable baseline data and a starting point for the development of an Assessment Framework in the HACC program.

Introduction

This project was designed to examine assessment, care management and client review practices in the HACC program.

The aim of the project was to provide an overview and analysis of the range and scope of tasks undertaken by local government and other key HACC providers funded under Assessment and Care Management activity. In addition, the project aimed to identify any barriers and concerns regarding the delivery of assessment and care management functions.

The main objectives of the project were to undertake a comprehensive survey of all local governments and a sample of other non-local government providers undertaking assessment and care management in the HACC program to find out:

- The numbers and rates of assessments undertaken in HACC funded agencies
- The types of assessment undertaken in HACC funded agencies
- The role of assessors in agencies
- Arrangements with other service providers
- Assessor qualifications
- Current tools used for measuring client dependency/need
- Agencies' use of priority of access criteria
- Agencies' view of the effectiveness of their assessment activities in targeting resources equitably.

Background

The target group for the HACC program is persons living in the community who, in the absence of basic maintenance and support services, are at risk of premature or inappropriate admission to long-term residential care. This group includes frail older people with moderate or severe disabilities and younger disabled persons with moderate or severe disabilities.

The HACC program aims to provide assistance directly to the target group and to their carers, by:

- providing a comprehensive and integrated range of basic support services for frail aged and other people with a disability and their carers;
- helping these people to be more independent at home and in the community, thereby preventing their inappropriate admission to long term residential care and enhancing their quality of life; and
- providing a greater range of services and more flexible service provision to ensure that services respond to the needs of users. [1]

[1] HACC National Guidelines, p 3

Methodology

Representatives from DHS and MAV collaborated in the development of a survey questionnaire in order to seek data relating to the aims of the project. Data collection for the project occurred in 2002.

Initial drafts of the survey were piloted with a small number of Councils. Telephone interviews were conducted with 74 (of a total of 78) Local Government Councils in Victoria. The same survey was mailed to a second group of 26 non-local government agencies, funded by HACC, which received $20,000 or more for Assessment and Care Management in 2001-2002. They were predominantly Community Health Centres, Hospitals, Koori agencies and Nursing services. Nineteen non-LG HACC agencies responded to the survey. This was an overall response rate of 73%. Participating agencies were Health Services and Community Health Services, with one each of the following: Private provider, Multi Purpose Service (MPS), hospital, extended care facility, District Nursing agency and condition specific agency.

A copy of the final survey/interview guide (see Attachment 3), with covering explanatory information, was sent to nominated staff in the Community Services or Home and Community Care sections of each Council some weeks prior to interviews. Interviewers then contacted the respondents and went through the survey with them.

The quality of data from all responding agencies was variable, with responses ranging from 'very accurate' to 'best estimates', the latter occurring where accurate information was not available. In some instances data from earlier MAV surveys on the number of HACC clients have been used.

The analysis of survey data obtained from Local Government Councils is contained in PART 1 of the following report. PART 2 constitutes the analysis of similar data obtained from Non Government agencies and the last section contains the discussion and conclusions drawn from the data.

Results: Part 1 – Local Government

Introduction

Council Groupings

For the purposes of this project, participating Councils have been classified into five groupings or types based on their location and size. The survey data was examined to identify differences between council groupings in relation to issues of HACC assessment, care management and review.

Table 1 - Number of Councils responding to the survey, by Council type

Council type	Councils included	Total Councils	Percent
Inner metro	18	18	100%
Outer metro	12	13	92%
Regional City	10	11	91%
Large Shire	14	17	82%
Small Shire	17	19	89%
Total	**71**	**78**	**91%**

Ninety-one percent of Councils responded to the survey, with a fairly even representation over the five types of Councils in Victoria.

Target Population

Victoria's 78 Councils cover a total population of more than 4.7 million. The number of people in Victoria eligible for HACC services can be determined by the number of those aged over 70 years and those under 70 years with profound, severe or moderate disabilities who are in private dwellings and not receiving services from the Department of Veteran's Affairs. It is estimated by DHS that (in 2002-03) there were approximately 631,500 people in Victoria in this target group.

Table 2 - HACC target group by council type (calculated), 2002

Council type	Proportion of Victorian HACC Target Group (%)	Proportion of Councils' Population in HACC Target Group (%)	Range of Councils' Population in HACC Target Group (%)
Inner metro	44	14	11 to 16
Outer metro	27	11	9 to 19
Regional City	14	13	9 to 16
Large Shire	10	14	9 to 16
Small Shire	6	16	9 to 21
Victoria	**100**	**14**	**9 to 21**

Source: DHS HACC Program Unit

See Attachment 2 for details of individual councils target populations

Inner metro Councils have the highest proportion of HACC target group compared to other council types. There is considerable diversity in HACC target group as a proportion of council population, as high as 21% in one small shire.

Survey Findings

Referrals

Overall, the 68 Councils responding to this question reported 60,800 referrals in the year July 2001 to June 2002 (See Table 3 below). The average number of people referred to a Council HACC service in the year July 2001 to June 2002 was 890 with a median figure of 660 (indicating half the Councils received fewer than this number and half received more than 660 referrals).

Table 3 - Number. of people referred to Council HACC service July 2001 to June-2002, by Council type

Council type	Maximum	Minimum	Average	Total from Councils responding	Percent of all referrals
Inner metro	4,040	870	1,760	30,000	49
Outer metro	2,630	410	1,210	13,300	22
Regional City	3,070	100	980	8,800	14
Large Shire	740	120	360	5,000	8
Small Shire	900	60	210	3,700	6
Victoria	**4,040**	**60**	**890**	**60,800**	**100**

Figures indicated wide variation between the different council types. Metropolitan Councils received the highest number, with Inner Metro Councils receiving on average 1,760 referrals and Outer Metropolitan Councils receiving an average of 1,210 referrals in the year. The minimum numbers of referrals in metropolitan Councils were 870 in Inner Metropolitan Councils and 410 in Outer Metropolitan Councils. Almost half of all referrals in the State are in Inner Metropolitan Councils.

The wide variation in referral numbers (from a maximum of over 4,000 to a minimum of 60) is partly influenced by varying interpretations of what constitutes a 'referral'. For many Councils 'referral' means a specific referral for one or more HACC services, but where Councils have a general intake point for a range of services, 'referrals' may include all inquiries handled through that intake point.

When allowance is made for the size of the estimated HACC target population in different Councils, there is still significant variation in the rate of referrals per 1,000 HACC target group within council types: from a maximum of 271 per 1,000 to a minimum of 28 per 1,000 (see Table 4 below).

Table 4 - Number of clients referred to HACC per 1,000 HACC target group, by Council type (calculated)

Council type	Maximum	Minimum	Average	Responses
Inner metro	271	51	122	17
Outer metro	255	48	100	11
Regional City	266	28	121	9
Large Shire	159	50	103	14
Small Shire	237	40	121	17
Victoria	**271**	**28**	**114**	**68**

The average rate across Council types was however very similar – an average across the state of 114 per 1,000 HACC target population, ranging from a maximum of 122 to a minimum of 100 within different Council types. Data indicated that 10 Councils achieved a significantly higher rate of referrals per 1,000 HACC target population than the state average and 10 Councils had a referral rate significantly lower than the state average.

Assessments

Across Victorian Councils surveyed, an average of 756 clients were assessed in the 12 months from July 2001 to June 2002. There was a wide variation, from 2,840 to 48 in the number at any single Council (see Table 5 below).

Table 5 - Number of assessments by Council HACC services July2001 to June 2002, by Council type

Council type	No. of clients assessed			No. of clients assessed per 1000 target group			Responses
	Max	Min	Average	Max	Min	Average	
Inner metro	2,840	250	1,407	191	49	94	18
Outer metro	2,000	301	1,073	216	45	88	11
Regional City	1,373	103	585	183	28	86	9
Large Shire	640	100	332	188	34	98	14
Small Shire	1,430	48	302	237	28	113	17
Victoria	**2,840**	**48**	**756**	**237**	**28**	**98**	**69**

Generally, the average number of assessments was around 90% (range 83% to 94%) of the number of referrals for each type of Council. The average for Small Shires was skewed upwards by two Councils with much higher rates of referrals and assessments than the remainder of the Shires in this group.

Table 5 above also shows the number of assessments per 1,000 HACC target group by Council type. The data indicates there was an average of 98 assessments per 1,000 across the State. The average was highest in Small Shire Councils at 113 per 1,000, and lowest in Regional Cities (86 per 1,000) and Outer Metropolitan Councils (88 per 1,000). Eight Councils assessed fewer than 50 people per 1,000 HACC target population in the year July 2001 to June 2002.

Information on the range of assessments per 1,000 HACC target group is shown in Appendix A Figure 2.2.

Services Received

The number of Councils able to provide information on services received following a HACC assessment was lower than for the previous questions. Many Councils were unable to provide this information either because it was not recorded or because their HACC services program was unable to report on this. Many of the responses received were estimates.

Eighty- three percent of clients across the state receiving an assessment subsequently received HACC services (see Table 6 below).

Table 6 - Percentage of assessed clients subsequently receiving HACC services by Council type

Council type	Maximum	Minimum	Average	Median	Responses
Inner metro	100	70	88	90	13
Outer metro	98	70	85	82	10
Regional City	93	38	76	85	8
Large Shire	100	60	84	93	11
Small Shire	100	26	81	83	14
Victoria	**100**	**26**	**83**	**89**	**56**

The proportion of those receiving HACC services varied significantly across Councils, from a maximum of 100% of assessed clients to a minimum of 26% of assessed clients.

In 43 of 56 Councils (77% of responding Councils) more than 75% of people assessed received HACC services. In 11 Councils between 50% and 74% of assessed clients received HACC services, and in two Councils fewer than 50% of assessed clients received HACC services (See Appendix A Table 3.1.1).

Table 7 below indicates that clients who were assessed and subsequently received non-HACC services. However, there are wide variations in the provision of services to assessed clients within Councils groupings, a point not reflected in average figures.

More detailed tables (see Appendix A, Tables Q3.2, 3.3, 3.4, 3.5, and 3.6), show, for example, that within the group of Large Shires the maximum percentage of assessed clients receiving DVA services was 25% in one council and 0% in another. Within the Small Shires, the range of clients receiving CACPs varied from 15% to 0% and the range of clients receiving Post Acute Care

(PAC) services ranged from 47% to 0%. This group of tables indicated other wide discrepancies between Councils within council groupings in the receipt of services listed in Table 7 below. 'Other service' included TAC WorkCover, carer supports, and respite services.

Table 7 - Percentage of assessed clients (average) receiving CACPs, DVA, PAC, Private & Other services, by Council type

Council type	CACPs	DVA	Post Acute Care	Private Services	Other Services	Responses
Inner metro	3	4	3	1	1	13
Outer metro	6	5	2	1	1	10
Regional City	3	6	6	1	8	8
Large Shire	1	7	6	1	1	11
Small Shire	3	4	10	1	1	14
Victoria	**3**	**5**	**6**	**1**	**2**	**56**

Single Entry point for HACC services

Across Victoria, 80% of Councils had a single entry point for HACC services. This level was fairly even (between 70% and 88%) across all Council types (see Appendix A Table Q4).

While the other 20% did not, in almost half (6) of these cases, it was because HACC services in the municipality were split into separate geographic zones. For another 5 Councils there was a different system to handle some HACC services, for example if a person only used meals services at the time of the inquiry. One Council reported that when the INI is introduced a revised entry point roster system will be used.

Another Council, where provision of HACC services was split between Council and a Health Service, made the comment,

"We don't want to promote one access point as we are concerned that we will be overwhelmed with referrals with no hope of providing services".

Nature of assessments undertaken

Types of assessments by council types

The survey (see Attachment 3) contained definitions related to the types of assessments that may be undertaken by HACC or other assessment agencies. Some Councils considered that their assessments were comprehensive, even though they do not necessarily meet every one of the requirements outlined in the questionnaire definitions. In these cases, the assessments were not included in the "comprehensive" category.

Over the State, 60% of assessments undertaken were service specific and 39% were comprehensive. While 1% were specialist, these occurred in only a small number of Councils with specialist assessment teams. Only 4 Councils undertook more than 5% specialist assessments (see Appendix A Tables Q5.1, 5.2, 5.3).

A total of 47 Councils (70% of those responding) undertook some comprehensive assessments, while the remaining 20 did not undertake comprehensive assessments (see Table 8 below). Twenty-four Councils provided comprehensive assessments in 50% or more of their assessments – this being 34% of all Councils responding.

The results indicated three general groupings of Councils:

Councils who undertake no comprehensive assessments and refer all clients requiring them to ACAS if there are indications of complex needs	30%
Councils who undertake these assessments themselves for people presenting to them with multiple, complex or unclear needs	39%
Councils who routinely undertake comprehensive assessments, particularly when they are the first point of contact.	31%

Table 8 - Number of Councils reporting proportions of assessments that were 'comprehensive', 'specialist' and 'service specific', by Council type

Council Type	Comprehensive Assessments			Specialist Assessments			Service Specific Assessments			Total Councils	% Councils
	0%	1%-49%	50%-100%	0%	1% - 49%	50% - 100%	0%	1% - 49%	50% - 100%		
Inner metro	5	8	4	14	3	0	3	2	12	17	94%
Outer metro	3	3	6	10	2	0	3	3	6	12	92%
Regional City	1	5	2	7	1	0	1	1	6	8	73%
Large Shire	5	5	4	13	1	0	2	2	10	14	82%
Small Shire	6	2	8	16	0	0	4	3	9	16	84%
Victoria	**20**	**23**	**24**	**60**	**7**	**0**	**13**	**7**	**43**	**67**	**86%**

In outlining the circumstances under which comprehensive assessments were undertaken, Councils indicated a range of reasons, including

- comprehensive was routine practice,
- where there were indications of complex needs ie, multiple and or high needs
- for geographically isolated clients

Some of the comments made indicate that the definition of a 'comprehensive' assessment varied quite considerably across Councils. (See Appendix A: Q6 Qualitative data)

Tools used for information and referral

Councils using Initial Needs Identification tool

Twenty three (32%) Councils were using the Initial Needs Identification (INI) tool at the time of the survey, with the highest proportion being in Large Shires and Outer Metropolitan areas (see Table 9 below). Of the Councils not currently using it, 90% planned to introduce it within 12 months. Since the survey was undertaken, as of January 2004, the INI (SCTT tools) have been mandated for use by all HACC agencies.

Table 9 - Number of Councils using, or planning to use, the INI within 12 months, by Council type

Council type	No. using INI	Introduce within 12 months	% using INI now or within 12 months	Responses
Inner metro	5	12	94	18
Outer metro	5	7	92	13
Regional City	2	7	90	10
Large Shire	6	7	93	14
Small Shire	5	11	94	17
Victoria	**23**	**44**	**93**	**72**

Tools used for Assessment

Fourteen Councils indicated that they used at least one of the following assessment tools – Barthel, MMSE, an ADL or an IADL instrument. Of the various validated assessment tools, only seven Councils used an ADL instrument alone, although two others mentioned they had used this in their own instrument or were developing an ADL instrument. Two Councils used each of the Barthel, MMSE and IADL instruments (see Appendix A Table Q8).

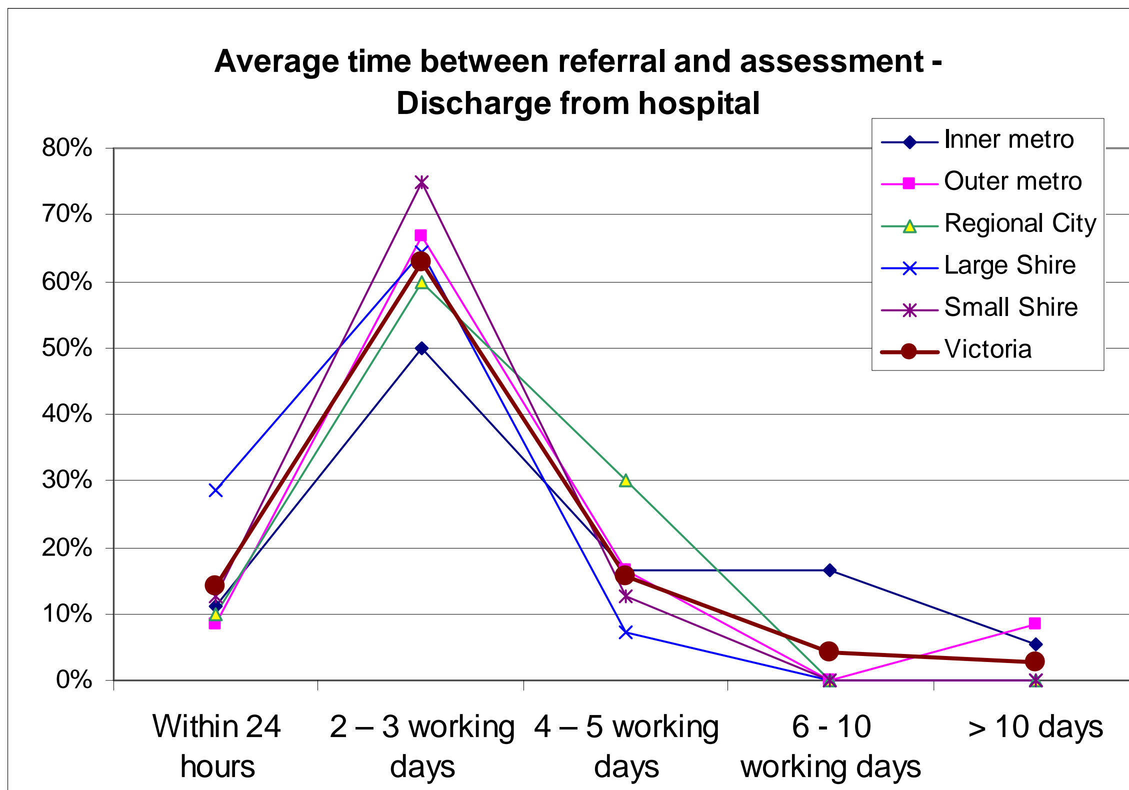
However, 23 Councils used other assessment formats, including ones they had developed. Of these, eight were priority of access tools, seven assisted in assessment of client needs and dependency, and six assessed the home environment for Occupational Health and Safety, including one from the client's perspective. Other areas systematically assessed using standard tools by at least one Council were hygiene, nursing, nutrition, cultural and packages needs. In addition, the CIARR, DVA and TAC forms were mentioned.

Time to assessment and time spent on Assessment

Time taken prior to assessment

The following data describes waiting times between referral and assessment. For clients about to be discharged from hospital most assessments were undertaken on average within 4 - 5 working days (see Figures 1 and 2 below and Appendix A Tables Q9.1 and Q9.2). A number of Councils do not record this data and could provide estimates only.

Figure 1 - Clients discharged from hospital: Average time from acceptance of referral to home assessment

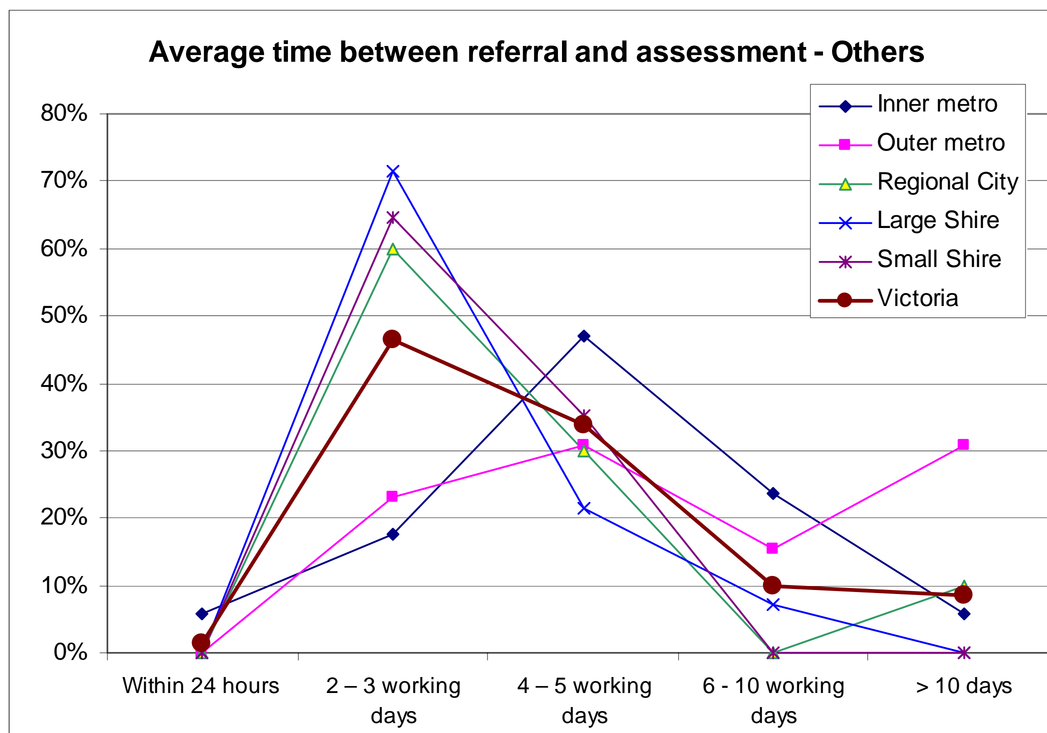


Some Councils also indicated that for referrals from a hospital under a Post Acute Care (PAC) arrangement, they rely only on the hospital's assessment at that time, and undertake any additional assessment during the time the user is receiving services.

Some comments from those who undertook assessments within 5 working days:

- Rely on hospital assessment - don't do own.
- Will do own assessment within 5 days of PAC program ending
- Varies with service type, e.g. Personal Care and Respite 2-3 days, Meals 4-5 days, Home Care 6-10 days

Figure 2 - Clients NOT discharged from hospitals: Average time from acceptance of referral to home assessment



For referrals from non-hospital sources, a number of Councils have instituted a priority system for assessments, and will undertake urgent assessments or ones for priority services in a relatively short time. Almost half of these assessments (45%) are carried out within 2-3 working days and a further 35% between 4-5 working days.

For those taking longer than 10 days for assessment following referral (10% of all assessments), four Councils generally undertook non-hospital discharge assessments within three weeks, but one inner metro Council said it took *"7 weeks if urgent, 7 months if not"*. One outer metropolitan Council routinely took 8 weeks to undertake assessments for non-hospital discharges: *"We have a large waiting list and assess when hours are available"*.

Councils also made the comments:

- For referrals, average time is not a good measure. We have a system to establish urgency, and to put in place interim services, eg PACFU, Carerlinks, to provide time to make an assessment.
- Depends upon priority of access (POA). Meals referral would receive service within 48 hrs but may not be assessed for 3 weeks.

There was similarity in time taken prior to assessment across all Council types for clients discharged from hospital. However, for clients not discharged from hospitals there was wider variation, with longer periods between referral and assessment, especially in the metropolitan areas.

Time taken to undertake assessments

The total amount of time spent undertaking each assessment is outlined in Table 10 below. This shows that the average time per assessment is close to three hours, plus or minus 15 minutes across all Council types.

Table 10 - How long on average Councils spend in total per assessment (minutes), by Council type

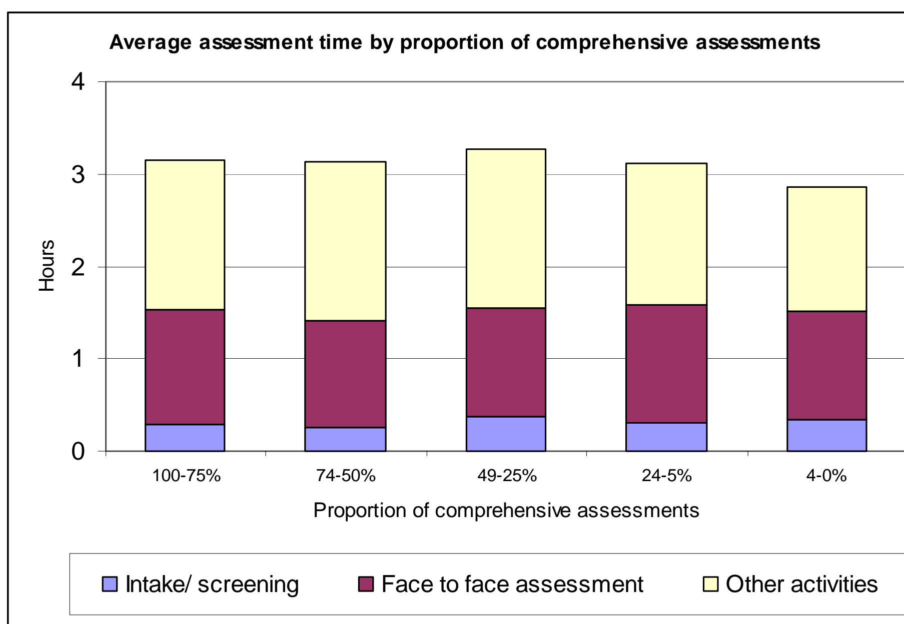
Council type	Maximum	Minimum	Average	Responses
Inner metro	285	120	190	18
Outer metro	300	100	188	12
Regional City	390	70	173	10
Large Shire	255	60	166	14
Small Shire	270	90	172	17
Victoria	**390**	**60**	**178**	**71**

When allowance is made for the number of comprehensive assessments undertaken, there is also little variation in time taken (see Figure 3 below and Appendix A Table Q10.1. This shows that only when the proportion of comprehensive assessments falls below 5% is there any discernable reduction in average assessment time, and this is largely due to a reduction in other activities undertaken as part of the assessment.

There is however, considerable variation across Councils, ranging from a reported maximum estimated time of 6.5 hours for a Regional City Council to 60 minutes in a Large Shire.

The exceptional Regional City Council included 4.5 hours on average for other activities, including data entry and travelling. Excluding this value from the data resulted in an average for the other regional Cities being 148 minutes, and a maximum for the other Regional Cities of 240 minutes.

Figure 3 - Time taken for assessment by proportion of comprehensive assessments



(Details are also provided for assessment components of intake and screening, face to face assessment and other activities in Appendix A Tables Q10.2, Q10.3 and Q10.4 and Figure 10.2).

This data shows very small variation in the average time taken across all Councils for each component of the assessment, and the median values are 15 minutes for intake/screening, 60 minutes for face to face assessment and 90 minutes for other activities.

Both types of Shires reported the highest time for other activities, possibly reflecting extra time for travelling mentioned by a number of Councils. Wide variation is observed between the minimum and maximum times spent by Councils, particularly for Other Activities and face to face assessments.

From the comments received, it is possible that some Councils have only included activities undertaken by Assessment Officers, and may not have included all data entry and activities undertaken by other staff. This may also explain some of the very wide variation between minimum and maximum values, especially for Other Activities.

Some indicative comments received:

- Often need to use interpreters - increase time of face to face assessment to 3 hrs
- Travel time in Shire is a large component, even though we attempt to minimise it.

Service availability and allocation

Criteria for assessing need and priority

Fifty-eight (81%) Councils that responded used explicit criteria for assigning priority to clients (see Appendix A Tables 11.1). Of those Councils that used explicit criteria, 34 (or 48%) used the 1, 2, 3 codes, and 19 (37%) used other criteria (see Appendix A Q11.2 & Q11.3).

Councils using other criteria had, in the main, developed their own variation on priority of access tools.

Some comments included:

- Allocation of service hours is based on the assessed level of need using a priority of access assessment tool
- More detailed priority of access and one especially designed for specific Home Care.
- Have developed own Priority of Access policy
- Based on dependency of clients, carer stress, dependency on acceptance
- Use five level Priority of Access developed by [our] Council
- Use own guide and definitions for specific services and respite care
- Use Code 1 vulnerable, 2 at risk, 3 maintaining independence.

Clients' needs and service availability

Forty-seven Councils (65%) indicated that the number of clients in their municipality exceeded the service availability (see Table 11 below). This figure was highest in Outer Metropolitan Councils and lowest in Large Shires.

Table 11 - Number of Councils stating clients needing service exceeds availability, by Council type

Council type	Yes	% Yes	Responses
Inner metro	11	61	18
Outer metro	13	100	13
Regional City	7	70	10
Large Shire	7	50	14
Small Shire	9	53	17
Victoria	**47**	**65**	**72**

Major factors taken into account in allocating services were:

	% Councils
Client's social situation	87
Urgency of providing services	81
Alternative services available to the client	68
Amount of care a client will need	62

Factors given priority by a minority of Councils were:

	% Councils
Client's financial resources	32
Length of time services are likely to be needed	26
Source of the referral	15
Risk to client if care not provided	4

(For details see Appendix A Table Q12.1)

Fifty-one, or 72% of Councils, set limits on the level of HACC services available to clients. The proportion of Councils doing this was highest in Inner Metropolitan and Large Shires where over 85% of Councils set service limits, and lowest in Small Shires (41% set limits). (See Appendix A Table Q13).

The limits in many cases reflected the priority of client needs, with higher levels of individual or total services available to higher needs clients. In some cases, restrictions were placed on the amount of services obtained by low needs clients only, in others strict limits were placed on particular services or the total hours of services available to clients with different levels of need.

In almost all cases, the limits were imposed because available services were not sufficient to meet assessed needs. There was a very wide variation in the limits placed on individual services, indicative of Councils attempting to ensure that their available services were provided on an equitable basis to the eligible users.

Table 12 - Number of Councils placing limits on high needs clients

Service	<1 hr/wk max	1-2 hrs/ wk max	2 hrs/wk max	3 hrs/wk max	4 hrs/wk max
Home care	7	5	1	1	2
Personal care	1	2		3	17

Nineteen Councils (27%) limited the total quantity of services (home care, personal care, respite care) that a client with high needs could access in a week. Eight percent of Councils limited a high need client to no more than 3 hours of combined services per weekend. For a further 18% of Councils the maximum combined service level for high needs clients was limited to between 4 and 6 hours per week. For clients with high needs, 23% of Councils limited the availability of home care to a maximum of 4 hours per week and 32% of Councils limited personal care services to a maximum of 4 hours per week. Examples from the 19 Councils for high needs clients are: 1.5 hrs per week (2 Councils), 2 hrs per week (2 Councils), 3 hrs per week (2 Councils), 4 hrs per week (3 Councils), 5 hrs per week (4 Councils), 6 hrs per week (5 Councils), 9 hrs per week (1 Council).

For personal care, eight Councils reported they limited the number of visits per week: 2 visits (1 Council), 3 visits (3 Councils), 4 visits (2 Councils), and for some Councils a much higher limit was able to be imposed: 6 or 12 hrs per week.

Meals for higher needs clients were rarely limited, but they were for lower needs clients in some cases. Home maintenance services were limited in some Councils to between 20 hours per year down to 5 hours per year, or in many cases to safety and security services alone. A small number of Councils reported limiting Planned Activity Groups sessions for high needs clients to 2 or 3 sessions per week.

For low needs clients, 10 Councils limited Home and personal care services to less than 1 hour per week, in two of these Councils, people with low level needs received no services.

This range of responses illustrates the dilemma faced by Councils where the need within the community exceeds the available resources. By seeking to address fairly the needs of their community, some Councils focus on the "early intervention-widely available support" aspect of HACC services, while others give priority to those with highest needs.

Councils chose from a variety of strategies to handle the imbalance between assessed need and available service level in their municipality. The major alternatives used, often in combination, were:

- Ration available services so that everyone receives some services (and there is no waiting list)
- Introduce a waiting list for clients with lower priority needs, reducing the early intervention impact
- Allocate available services only to those clients with the highest needs
- Refer clients with higher needs for CACPs (where possible) to limit the drain on services from those with high needs
- Seek Council funding to provide additional service levels.

(See Appendix A: Q13 Qualitative Data).

Reviews

Number of reviews undertaken

Sixty Councils responded with information about the number of reviews they undertook. The average number was 520 reviews per Council, with significantly more reviews on average being done in the metropolitan Councils (See Table 13 below).

The 60 Councils reporting data undertook a total of 31,100 reviews in the 12 month period.

Table 13 - Number of clients reviewed July-01 to June-02 by each Council, by Council type

Council type	Maximum	Minimum	Average	Total	Responses
Inner metro	1,740	200	760	12,989	17
Outer metro	2,086	98	710	6,369	9
Regional City	1,153	100	370	3,342	9
Large Shire	1,040	74	370	4,116	11
Small Shire	1,000	30	310	4,293	14
Victoria	**2,086**	**30**	**520**	**31,109**	**60**

Within each Council type, there was wide variation in the number of reviews that were undertaken.

For 47 Councils for which data was available[2] on the current number of HACC clients, the proportion of clients reviewed in a year was calculated (see Table 14 below and Appendix A Figure Q14.1). This shows that on average, a little under half HACC clients were reviewed by Councils in one year. Small Shires had the best rate of reviews, averaging over 660 per 1,000 HACC clients.

Table 14 - Number of clients reviewed per 1,000 HACC clients (May 2002), by Council type

	Maximum	Minimum	Average	Median	Responses
Inner metro	1,042	109	430	407	13
Outer metro	837	22	430	350	9
Regional City	1,172	110	380	264	7
Large Shire	762	185	490	490	8
Small Shire	1,250	170	660	735	10
Victoria	**1,250**	**22**	**480**	**419**	**47**

Clients may be reviewed more often than once per year, which was reflected in the maximums for some Inner Metropolitan, Regional Cities and Small Shires indicating more than 1 review per HACC client. In all Council types there were

[2] Data from one Council was not used as it was out of the expected range

Councils which held fewer than 200 reviews per 1,000 HACC clients in the 2001-02 year.

Routine or 'as needed' reviews

Almost all Councils had procedures to review users on an 'as needed' basis, however only half had procedures in place to routinely review the needs of all HACC service users (see Table 15 below). These figures were fairly consistent across all types of Councils.

Table 15 - No. of Councils that review need for service routinely or 'as-needed', by Council type

Council type	Routinely reviewed	% Routinely reviewed	Reviewed 'As needed'	% Reviewed as needed	Number of responses
Inner metro	9	50	18	100	18
Outer metro	7	58	12	100	12
Regional City	2	20	10	100	10
Large Shire	8	57	12	86	14
Small Shire	10	59	17	100	17
Victoria	**36**	**51**	**69**	**97**	**71**

Ninety-one percent of Councils set a review date for more than 75% of their HACC clients when the service user was assessed, and only two Councils reported they did not set any review dates (see Appendix A Table Q16). However, only 32 (49%) of Councils met these review dates for at least 50% of their clients (see Appendix A Table Q17, data from 66 Councils). Almost one in three (31%) Councils met only 25% of their review dates.

Whilst smaller Shires met the highest proportion of review dates, there was wide variation *within* all Councils types – all Council types had some Councils that met fewer than 10% of their set review dates. (See Appendix A Q16 & Q17). Combining the data from Appendix A, Tables Q16 and Q17 provides an estimate of the number of service users who were reviewed by the set date (see Table 16 below). This shows that 43% of these Councils reviewed less than 50% of their HACC users in the 2001-02 year, with higher rates in Small Shires and Inner Metropolitan Councils, and the lowest rate in Regional Cities. In all Council types, some Councils reviewed less than 24% of their service users. This totalled 20 (32%) Councils.

Table 16 - No. of Councils by proportion of clients reviewed by the set date, by Council type

Council type	Proportion of clients reviewed by set date					No. of Councils	Percent > 50%
	0-24%	25-49%	50-74%	75-90%	91-100%		
Inner metro	3	3	5	2	1	14	57%
Outer metro	4	4	2	1	-	11	27%
Regional City	6	2	1	-	-	9	11%
Large Shire	3	5	1	2	2	13	38%
Small Shire	4	2	3	4	3	16	63%
Victoria	**20**	**16**	**12**	**9**	**6**	**63**	**43%**
% of Councils	**32%**	**25%**	**19%**	**14%**	**10%**	**100%**	

'As-needed' reviews

Councils holding reviews on an 'as-needed' basis took into account the following factors (see Appendix A: Q18 Qualitative Data).

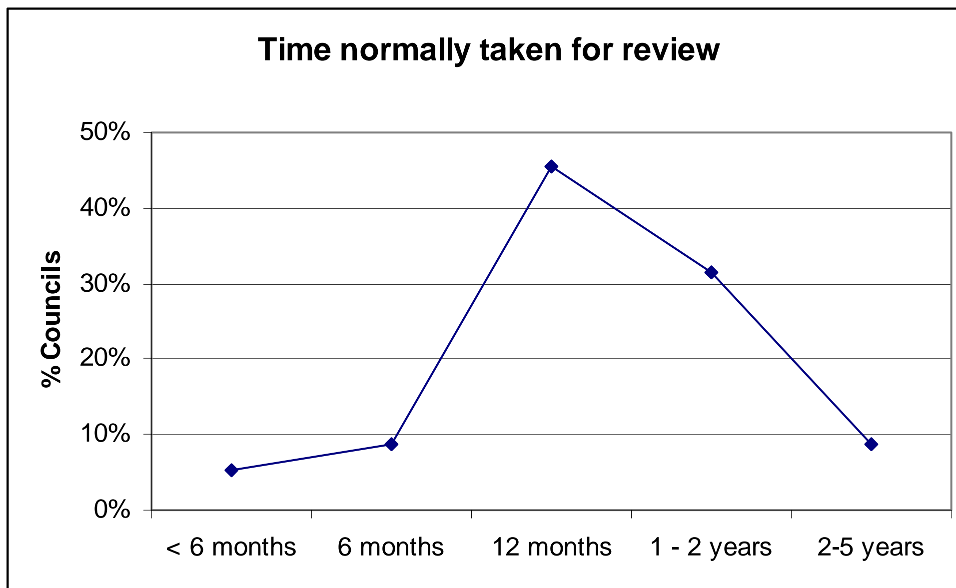
Factor	Councils (%)
Health status	85
Client or family request	79
High level of client need	71
Carer situation	60
Living alone	50
High level of care being provided	41
Involves a number of services, complex management	37
Feedback/ request from workers or services	31
Potential to adjust care level in future	22
Change in situation or needs	15
Care arranged for short period only, frequent hospitalisation	3
OH&S issues	1

Time elapsing before a review is held

A number of Councils indicated that there was no "normal" time prior to a review for all HACC service users, as their review process took into account the level of needs and/or other circumstances of clients. This ranged from a high needs client being assessed weekly, to some Councils which, due to lack of resources, had not reviewed some stable clients in the previous 5 years. Councils also indicated that they did not always record data on planned and actual review dates, and that responses to this question were an estimate.

The responses obtained are detailed in Figure 4 below. After allocating times provided by Councils indicating "Other" in response to Question 19, the response for 57 Councils across Victoria as a whole has been plotted in Figure 4. Forty-eight percent of reviews normally occur within 12 months, and 91% within 2 years.

Figure 4 - Time that normally elapses before a review is undertaken



Changes to care as a result of reviews

While there were some variations across Council types, for around two in three users, the level of service following a review remained the same. Table 17 below indicates that for the majority of Councils (43 or 79%) at least half service users had their levels of care unchanged.

Table 17 - Proportion of clients reviewed in the past year with unchanged levels of care

Proportion care unchanged	0-24%	25-49%	50-74%	75-90%	91-100%	Total Councils
Number and % of Councils	3 (5%)	9 (16%)	18(33%)	18 (33%)	7 (13%)	55 (100%)

By comparison, 34 (62%) of Councils increased the level of care for fewer than 25% of service users. Fourteen Councils increased the level of care for between 25% and 50% of service users. Only 2 Councils increased the level of care for more than 75% of service users (see Appendix A Table Q20.2).

In contrast, 50 Councils (93%) reduced the level of care of less than 25% of users, and only four Councils reduced the level of care of more than 25% of service users (see Appendix A Table Q20.3). In 25 Councils fewer than 5% of users had care levels reduced.

An even smaller proportion of Councils discontinued care of service users, with 52 (98%) discontinuing the level of care for less than 25% of users (see Table Q20.4 Appendix A). For 28 of these, less than 5% of users were discontinued.

Main issues about reviews

Councils were asked to indicate what were the main issues they faced in relation to reviews. Almost all (93%) Councils indicated that an inadequate level of resources available to them was a main issue (see Appendix A Table Q21). Nineteen Councils (27%) indicated a main issue they faced was a choice as to whether they should give priority to reviewing new service users or to use these resources to provide HACC services to existing service users. Main Issues for Councils in relation to reviews:

Issues	**% Councils**
Inadequate level of resources	93%
To provide services to new clients or to existing clients	27%
Overall level of resources they had for reviews.	18%
Travelling time	15%
Assessment staff available, training & use of direct care workers for assessment	13%
More reviews needed – service users were missing out	11%
Computer systems, assessment tools	8%
Level of Council funds contributed to maintain reviews	7%
Focus on high needs clients and was not reviewing low needs	6%
Clients concerned re service reduction following reviews	4%
Lack of resources for case coordination adding pressure on Assessment staff	3%

These responses, together with the other main issues faced by Councils, suggest an imbalance exists among almost all Councils between the needs for reviews of HACC users and the level of resources available to Councils. (See Appendix A:Q 21 Qualitative Data)

Staffing for intake and assessment

The average number of staff involved in Intake across the Councils that responded to the survey was 3.8 (ranging from 24 to none). The average number of staff involved in Assessment was 3.8 people (range 20 to 1), with an average of 1.8 people who were dedicated to assessment only (See Table 18 below and Appendix A Tables Q 22.1, Q22.2, Q23). On average, a total 2.2 EFTs per Council were allocated to assessment activities, ranging from 0.2 to 8 EFT (see Appendix A Table 23 and Table 23.1). The total staff resources allocated to assessment included an average of 0.4 staff EFTs who undertook other duties in addition to their assessment responsibilities.

Table 18 - Average staff in Intake and Assessment, by Council type

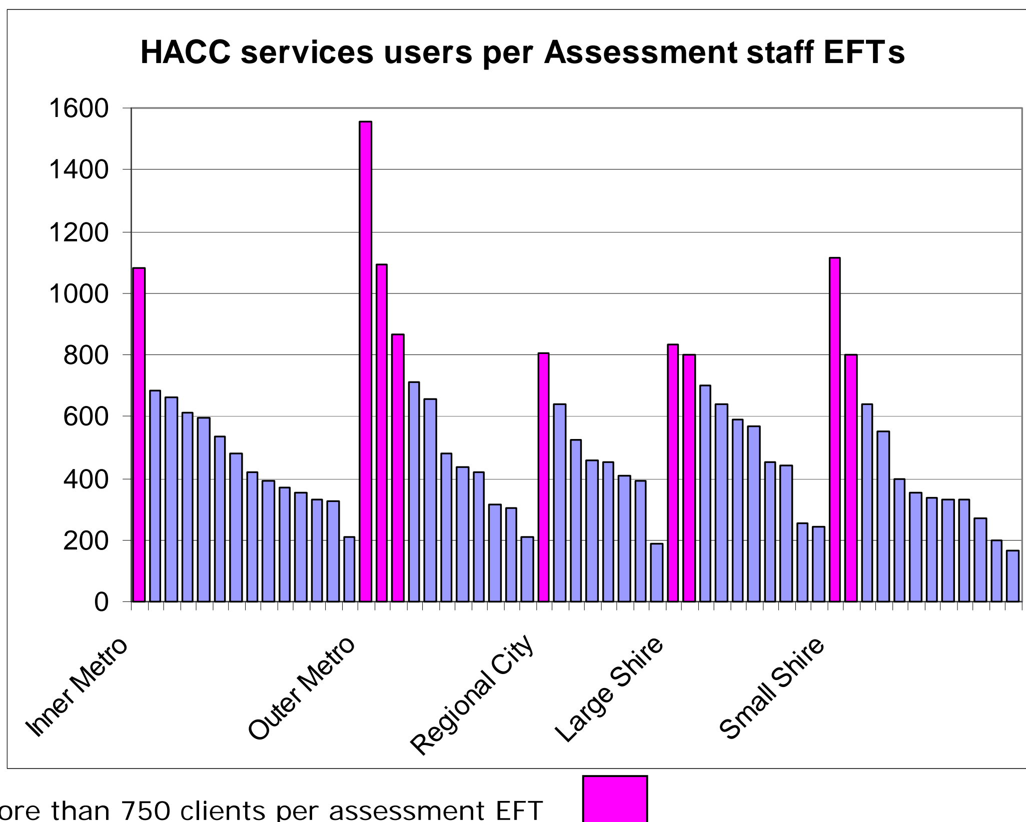
Council type	Staff involved in Intake	Staff involved in Assessment	Staff allocated to Assessment only	No of EFT allocated to assessment only
Inner metro	4.6	5.6	2.8	3.5
Outer metro	4.0	4.2	1.7	2.8
Regional City	6.5	5.3	2.0	2.7
Large Shire	2.5	2.2	1.1	1.2
Small Shire	2.4	1.9	1.1	0.9
Victoria	**3.8**	**3.8**	**1.8**	**2.2**

Number of current HACC clients per Assessment EFT

A comparison was undertaken for all Councils of the number of assessment EFTs available with the current number of HACC clients reported by the Council in the MAV Survey of Best Practice in Local Government in Home and Community Care, undertaken in September-October 2002. This survey provided the number of HACC clients at each responding Council in May 2002.

The results are shown in Appendix A Tables Q23.2 and Q 23.3 and indicate that, while on average Councils had 530 HACC clients per 1 EFT of assessment staff, there was considerable variation across Councils. This ranged from fewer than 200 HACC clients per assessment EFT to over 1,500 clients (see Figure 5 below), with 72% of Councils having between 250 and 750 clients per worker EFT. Nine Councils had more than 750 HACC clients per Assessment staff EFT.

Figure 5 - HACC users per assessment staff, all Councils



More than 750 clients per assessment EFT

While these results do not take account of variation in work time required (for example, due to travel and the number of new clients assessments), the variation is wider than appears justified.

Assessment Team Composition

Qualifications of Assessment Staff

The qualifications held by Assessment staff are detailed in Appendix A Table Q25.

Overall, 96% of Assessment Officers reported some type of formal post-secondary qualifications. The highest proportion of qualifications held were in Nursing, Welfare or Social Studies, Social Work and Disability Studies, which accounted for 72% of qualifications held by Assessment Officers. Only 10 (4%) of Assessment Officers had no formal qualifications, and many of these staff had long periods of experience in HACC services.

All types of Councils except Small Shires reported at least 94% of Assessment Officers with a formal post secondary qualification. Small Shires had 90% with a formal post secondary qualification (see Table 19 below).

Table 19 - Percent of assessment staff with formal qualifications (percent of staff in each column)

	Inner metro %	Outer metro %	Regional City %	Large Shire %	Small Shire %	Victoria %
Nursing	20	29	38	50	41	31.1
Welfare / social studies	17	19	31	13	28	20.7
Social work	28	27	2	7	7	18.3
Disability studies	11	17	4	3	7	9.6
Allied health	6	2	16	3		5.0
Social science	7	4		10	3	5.2
HACC Assessment				7	3	1.2
Aged Care Certificate IV			2	3		0.8
Teaching	2					0.8
Office Management	2					0.8
Psychology	1					0.4
OH&S	1					0.4
Physical Sciences	1					0.4
Early Childhood Development		2				0.4
% qualified	97.0	100	93.3	96.7	89.7	96.0
% No qualifications	3	0	7	3	10	4.0
Total	**100**	**100**	**100**	**100**	**100**	**100**

Table 19 shows that Regional Cities, Large Shires and Small Shires tended to have higher numbers of assessment officers with nursing qualifications whereas Metropolitan Councils had higher proportions of assessment officers with Social Work and Disability Studies.

The data also showed that most Councils with more than one assessment staff had staff with a range of qualifications and that only two Councils had no staff with formal qualifications.

Assessment Expenditure

While Councils' HACC staff were asked to estimate Council's reported expenditure on Assessment, the results are not included in this report. This is because no precise definition of assessment expenditure was included in the interview guide, and the information was not broken down into figures for salaries, oncosts, direct and indirect costs related to assessment staff.

DHS grants for assessment and care management[3] to 74 Councils amounted to $5.07 million in 2002-03 (see Table 20 below).

---

[3] Data provided by DHS HACC Unit

Table 20 DHS funding for A&CM 2002-03

Council type	Maximum	Minimum	Average	Sum	Responses
Inner metro	246,315	21,200	136,000	2,453,000	18
Outer metro	145,136	18,771	78,000	934,000	12
Regional City	124,231	11,568	63,000	692,000	11
Large Shire	75,409	13,547	32,000	485,000	15
Small Shire	87,129	4,917	28,000	503,000	18
Victoria	**246,315**	**4,917**	**68,000**	**5,067,000**	**74**

Data gathered from Councils in addition to this survey data indicates that many Councils make contributions from their own funds to assessment services – mainly to provide additional staff beyond that which DHS funding can provide. The MAV obtains key financial information from Councils, and the reader is referred there for further information.

Relations with other service providers

Findings indicate that 31 Councils (44%) have arrangements that other service providers carry out assessments for Council services, and 27 Councils (38%) have arrangements with other providers that Councils will assess for the uptake of these agencies' services (See Appendix A, Tables Q27.1 and Q27.4).

Twenty-five Councils reported that other agencies undertook an average of 70 assessments per year, ranging from 6 to 280 for any one Council (see Appendix A Table Q27.2). A total of over 1,400 assessments were undertaken for Councils. One third of these arrangements were for service specific assessments, and 25% each for comprehensive and comprehensive plus specialist assessments (See Appendix A Table Q27.3).

The 27 Councils performing assessments for other agencies reported that they undertook on average 64 assessments per year (range 6 to 300), totaling over 1,000 per year as shown in Appendix A Table 27.5. Half of these assessments done for other agencies were service specific assessments (see Appendix A Table 27.6)

Reassessments

Fifty-seven Councils (90%) reported that they re-assessed or carried out further assessments on at least some service users who had been assessed by other agencies, with 43 Councils (68%) re-assessing over 90% of new service users, and a further 9 Councils (15%) re-assessing over 50% of new users (see Appendix A Table Q28). Only 6 Councils (10%) did not re-assess any new service users.

The majority of Councils reassessed for occupational health and safety, eligibility and priority of need, domestic and personal care requirements and nutrition (see Table 21 below). Other reasons for reassessment were for specific requirements, including reassessing eligibility for particular services if relevant, data, safety and other areas.

Table 21 - Reasons for re-assessments

	Number of Councils						
	Inner metro	Outer metro	Reg'l City	Large Shire	Small Shire	Total	Total %
OH&S	17	11	9	11	13	61	98
Eligibility and priority of need	10	9	8	12	12	51	84
Domestic requirements	12	9	8	9	12	50	82
Personal care requirements	10	8	8	8	11	45	74
Nutrition	5	8	6	7	12	38	62
Review needs, specific requirements	2	2	5		3	12	20
Respite	2	2		2	1	7	12
Transport	2	1		1	3	7	12
HM	2		1	1	1	5	8
Social support	2	1			1	4	7
PAG	1	1			2	4	7
Fees	1		1			2	3
Safety		1	1			2	3
Alarms			1		1	2	3
Establish contact	1					1	2

Referrals

Many Councils do not keep accurate records of referrals they make on behalf of clients as a result of the assessment. The responses gained to this question were therefore a 'best estimate' of referral activity. Fifty-two Councils indicated they made on average around 200 referrals per year to agencies, mainly for clinical or health services (38% of referrals) or to ACAS (32% of referrals). The 'Other' category mainly consisted of a variety of referrals to a mix of services, including ACAS for CACPs, Linkages, allied health services, Department of Veterans Affairs, disability agencies, social and carer supports (see Appendix A Table Q30).

For 38 of these Councils, it was possible to compare the number of referrals with the number of HACC clients. The median value was 15% of HACC clients referred to other services in the year, with the distribution of responses detailed in Appendix A Table Q30.1.

Impact of PCPs

The survey asked Councils to respond to the question: Has the establishment of a PCP had an impact on assessment? At the time of the survey Council HACC services reported having seen little impact from the establishment of the PCP other than some impact in the areas of coordination between agencies (44% 'yes' overall, less in Large Shires) and, to a lesser extent, improved referral

processes (39% 'yes', particularly in Metropolitan areas and Small Shires). Table 22 below details the number of Councils that saw an impact in four nominated areas.

(See also Appendix A Q31)

Table 22 - Impact of PCP on assessment in nominated areas

	Simplified access % Yes	**Reduced workload % Yes**	**Improved Coordination between agencies % Yes**	**Referrals within network % Yes**	**Responses**
Inner metro	6	0	50	50	18
Outer metro	17	0	58	58	12
Regional City	10	0	40	33	10
Large Shire	0	0	29	14	14
Small Shire	13	0	44	38	16
Victoria	**9**	**0**	**44**	**39**	**70**

Other effects commented on included increased workloads and attendance at meetings, with little perceived gain to date for agencies or clients (13 comments), benefits in coordination of INI implementation and undoing the impacts of Compulsory Competitive Tendering. For a number of Councils, there was optimism that this work would produce positive effects in the future. Eighty-two percent of Councils expected positive responses from the establishment of PCPs in the next year, although this was lower in Small Shires (see Appendix A: Table Q32 and Q31 Qualitative Data).

Changes to assessment processes

Fifty-six Councils (79%) reported they had made significant changes to assessment practice (other than the INI and related changes) in the past two years, across all types of Councils (see Table Q33 Appendix A). Major areas of change Councils had undertaken in the past 2 years were:

	Councils
Change or expand role of Assessment Officer	11
Assessment tools and process changes	11
Priority of Access tool	11
OH&S processes	11
Review targets and processes	10
Intake workers and system	10
IT systems, use of laptops	9
Staff skills and training	9
Establishing area based teams	8
Reintegrate teams and service planning (post CCT)	5
Personal care assessments, role of RDNS	3
Improve cultural and language skills	3
Increased skills and capacity to assess disability	3
Accreditation, standards and service quality	3
Waiting lists	3

Other areas of improvements included strengthened emphasis on care planning, increased resourcing by Councils, and work on referrals and role with package providers, co-assessments, increased travel time allowances, client input, risk assessment and privacy issues management, one-stop shop approach, personal alarms (See Appendix A: Q33 Qualitative Data).

Further changes were expected to be introduced in the next year by 61 or 88% of Councils. Fifty-one Councils (74%) planned to introduce changes in IT and record keeping, especially in metropolitan Councils and Small Shires. Thirty-three Councils (48%) planned improvements in the organisation of the team, with higher proportions in Regional Cities and Large Shires. Twenty-eight Councils (41%) expected to make changes in the formal content of assessments, particularly in Inner Metropolitan Councils (see Appendix A Tables Q34, Q34.1 and Q34.2). Other planned changes included:

	Councils
Use of the Best Value system to identify changes	4
Increased assessment staff or capacity	3
OH&S improvements	3
Priority of Access, urgency of need	3
Increase case management resourcing	2
Use of data for service planning and improvement	2
Staff recruitment and training	2
Impact of IT use and privacy	2
Develop existing policy & procedures in assessment and care management	2

In addition, other Councils were planning research to evaluate home based and telephone reviews, introduction of regular reviews, improved assessment tools and protocols, a one-stop shop to improve service accessibility, and improved standards of practice.

Key issues

Clearly, the greatest problem Councils identified in undertaking the assessment function was the level of resourcing currently available (63 Councils, 93%), followed by the related issue of volume of persons requiring assessment (53 Councils, 78%). (See Appendix A Tables Q35.1 and Q35.2.)

The majority of Councils saw the next highest issues as staffing availability, training and quality (43 Councils, 63%); and internal organisational issues – IT, forms and procedures (37 Councils, 54%).

Ensuring access and equity was seen as a significant problem by over one third of Councils, and external coordination by one quarter. (See Appendix A: Q35 Qualitative Data)

The resource implications of planned changes to assessment were of concern to Councils. Fifty-seven Councils outlined resource implications of planned changes, and only four indicated that they expected these could be managed within existing resources. One hoped that savings from IT improvements would be able to be re-deployed to improved assessment services. Major areas where additional resourcing was identified were as follows:

	Councils
Staff (assessment, intake administration and other)	30
IT capital expenditure (computer hardware, software, & printers)	25
Training	7
Council funds	4
Transport and vehicles	4
Office space	2

(See Appendix A: Q34:Qualitative Data)

Results: Part 2

Non Local Government agencies

Introduction

HACC funds more than 100 non-Local Government agencies for Assessment and Care Management. To gain comparative information on assessment, care management and review in non Local-Government agencies, the same questionnaire was posted to 26 non-Local Government agencies that received $20,000 or more for Assessment and Care Management in 2001-2002.

Nineteen non Local Government HACC agencies responded to the survey: 9 metro and 10 rural. This was an overall response rate of 73%. The rate of response per data item was variable. Some phone support was provided for those agencies requiring assistance to complete the survey. The type of agencies that completed the questionnaire is shown below in Table 23. Given the differences between metro and rural in the types of non-government agencies which participated, and because of the small number of respondents, it was decided not to report results separately for metro and rural.

Between them, these 19 agencies received $557,584 for Assessment and Care Management (A&CM) in 2001-02. The total amount of funding for A&CM for non Local Government agencies in 2001-02 was $1,592,935, therefore, the agencies which responded to the survey received 35% of all A&CM funds to non Local Government agencies in 2001-02.

Table 23 - Characteristics of non Local-Government respondents

	Number of respondents			**Clients assessed 2001-02**	
Agency Type	**Metro**	**Rural**	**Services provided**	**Average**	**Range**
Community Health	4	1	Range of HACC services, including Linkages, no Home Care or Property Maintenance	370	97 - 670
Hospital	1		Predominantly Nursing	26	
District Nursing		1	Predominantly Nursing	933	
Extended Care	1		Predominantly Linkages, also Allied Health, Nursing, PAGs	526	
Private	1		Predominantly Home Care, some Personal Care and Respite	152	
MPS		1	Allied Health, Nursing, Home Care	50	
Health Service	2	6	Range of HACC services	1,031	51 – 2,128
Other: condition specific		1	Predominantly PAG	35	
Total	**9**	**10**		**552**	

Referrals and assessments

The average number of people referred to 19 non-Local Government HACC services in the year July 2001 to June 2002 was 924. However, the range was very large: from 30 to 5,308.

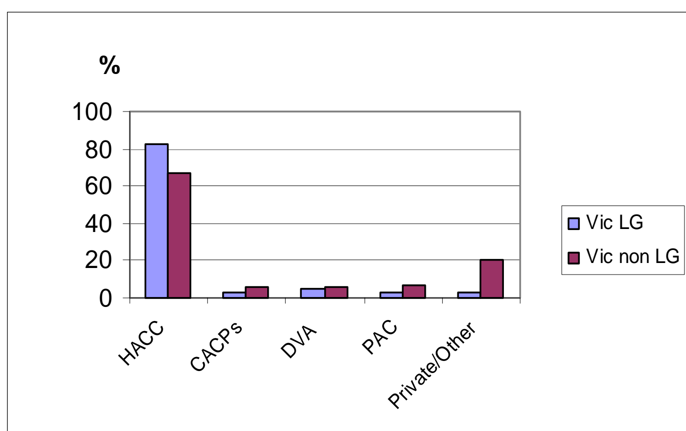
An average of 552 clients was assessed from July 2001 to June 2002, ranging from 26 to 2,128 assessments. There were two agencies which reported performing more than 2,000 assessments in the year, both of these were Health Services.

Agencies reported large ranges in the service options that followed their assessment of clients.

- The majority of agencies reported that two thirds or more people assessed subsequently received HACC services including Linkages and District Nursing. However, the range was substantial, from 3% to 100% of people assessed.
- On average six percent of people assessed subsequently received CACPs, ranging from none to 30%.
- On average six percent of people assessed subsequently received services from DVA, ranging from none to 20%.
- On average seven percent of people assessed subsequently received PAC, ranging from none to 21%.
- On average five percent of people assessed received services from private providers following assessment, ranging from none to 60% of people assessed.
- On average 15% of people assessed received or were referred to other services, which included Commonwealth Rehabilitation Centres, Vic Carers, ACAS, Occupational Therapy, TAC, Workcover, HITH, neuropsychological and behaviour modification interventions. The range was broad, from none to 93%.

Figure 6 below shows the outcome of HACC assessments for 2001-02, comparing Local Government and non Local Government. There was a higher proportion of people who went on to receive HACC services when assessed by Local Government agencies. Non Local Government agencies were more likely to refer people to Private providers or "other" services than Local Government agencies.

Figure 6 - Services received by clients assessed in HACC 2001-02



Type of assessments

Over the State, the range for each of the three assessment types (comprehensive, service specific and specialist) varied from 0% to 100%. There did not appear to be a relationship between the assessment throughput of an agency, the size of the agency and the type of assessment undertaken.

Ten out of the 17 agencies undertook some service-specific assessment; these were Community Health Services, Health Services and the MPS. Of these ten, three carried out service-specific assessment for all their clients. Six agencies undertook no service specific assessments.

Thirteen out of 17 agencies undertook comprehensive assessment. The Hospital was the only agency type that didn't undertake some comprehensive assessment. Of these thirteen, five did comprehensive assessment for all their clients. Four agencies did no comprehensive assessment.

Six of the 17 agencies (35%) undertook specialist assessment; these were Health Services, the MPS and Hospital. Of these, two undertook specialist assessment for all their clients. Nine agencies did no specialist assessment.

Appendix B Tables Q5.1, 5.2 and 5.3 show the proportion of an agency's total assessments that are comprehensive, specialist and service specific assessments for both Local Government and non-Local Government agencies.

Instruments used for information and referral

At the time the survey was undertaken, 21% of non Local Government (32% in Local Government) agencies were using the Initial Needs Identification (INI) tool (now called the SCTT); all agencies expected to be using it within 12 months.

Tools used for assessment

Thirteen Local Government agencies (36%) were using standardised tools such as an ADL tool, IADL tool, MMSE, or Barthel) compared to 13 (76%) non Local Government agencies. ADL instruments were used by 13 (72%) of agencies, and four agencies (22%) used an IADL instrument; two agencies (11%) used the MMSE, a cognitive function screening tool, and one agency (6%) used the Barthel instrument. This is consistent with the non Local Government agency type, that is, agencies which provide Nursing and Allied Health.

Other instruments were used by 8 agencies (44%), including ACAS summary templates, risk management tools and indices.

Time awaiting assessment

On average, most (88%) of non Local Government agencies assessed people in their home following discharge from hospital, within 5 working days: 31% of agencies assessed people leaving hospital within 24 hours (14% in Local Government) and 56% percent of agencies assessed within 3 working days (77% in Local Government). Thirteen percent of non Local Government agencies exceeded 5 working days, compared to 7% of Local Government agencies.

Figure 7 below shows the waiting times from acceptance of a referral while the person was in hospital to the time the assessment took place in the person's home, for Local Government and non Local Government agencies.

Figure 7 - Average waiting time reported by agencies – persons discharged from hospital

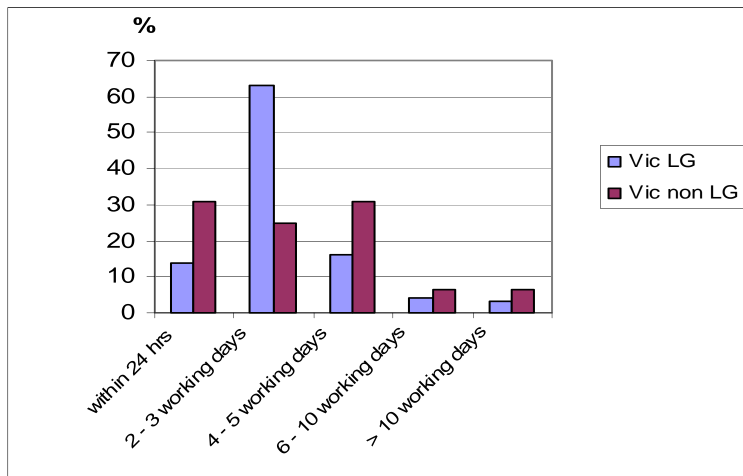
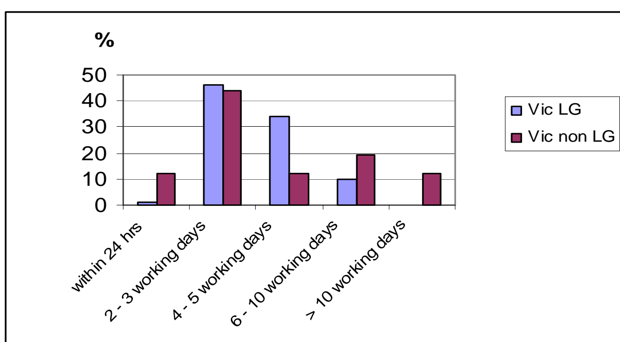


Figure 8 shows the waiting times for assessments performed for other persons who were not hospitalized: 12% of non Local Government agencies assessed other persons within 24 hours; 56% of agencies assessed within 3 working days; 68% assessed within 5 working days. More than 30% of non Local Government agencies exceeded 5 working days (up to 6 weeks).

Figure 8 - Average waiting time reported by agencies – other persons



People who had not been hospitalised at the time of their referral being accepted, had longer waiting times than people who were in hospital, regardless of whether they were being assessed by a Local Government or a non Local Government agency. Non Local Government agencies achieved 12% of assessments within 24 hours while 1% were achieved by Local Government agencies. After 3 days following acceptance of the referral, 47% of Local Government agencies had completed their assessment and 56% of non Local Government agencies.

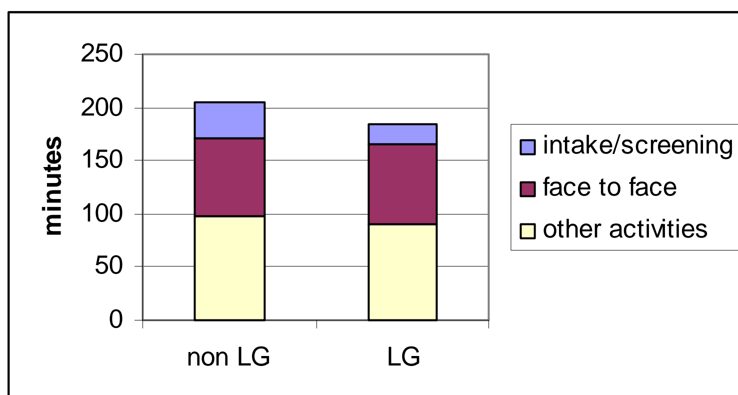
Time undertaking assessment

The total time to undertake an assessment was on average approximately 3.5 hours. There was considerable variation across agencies, particularly in the 'other activities' components of assessment. The average breakdown of components was as follows:

- 30 minutes on intake/screening
- 70 minutes on face to face assessment
- 100 minutes on other activities related to specific clients, such as client-related travel time, record-keeping, service planning and coordination; this excludes general administration and other tasks not related to specific clients. [4]

On average non Local Government agencies spent longer undertaking an assessment than Local Government agencies, mainly due to more time being spent on intake/screening, however, there were no marked differences in the proportion that each of the three components of assessment comprised of the total, as shown in Figure 9 below.

Figure 9 - Time spent undertaking assessments



Targeting and measuring need and priority

Fourteen (74%) non Local Government agencies used level of need criteria for assigning priority to clients. Ten (71%) agencies also used other criteria, which included client characteristics, living alone, level of urgency.

Seventeen (89%) agencies indicated that the number of clients assessed as needing services exceeded the availability of services. The most commonly reported factors in identifying priority of service allocation included: urgency of providing services (88% of agencies), the client's social situation (82% of agencies), alternative services available (82% of agencies) and the amount of care needed (65% of agencies).

---

[4] One agency was highly specialised and spent a great deal of time on 'other activities' related to specific clients. This agency skewed (increased) the average to 146 minutes on other activities. Therefore, it was excluded from the calculations.

Moderate factors reported included: length of time services are likely to be needed (35%) and source of referral (29%).

The client's financial resources were rated lowest by non-Local Government agencies when making decisions about service allocation (12%). Local Government agencies rated this factor more highly (32%). Non-Local Government agencies were more likely to take the source of the referral into account than Local Government agencies (29% versus 15%).

Refer to Appendix B Table Q 12.1 for the comparison between Local Government and non-Local Government agency responses about factors taken into account in deciding service allocation.

Twelve (63%) of non Local Government agencies (and 72% of Local Government agencies) set limits on the level of HACC services available to clients. In the majority of cases, limits placed on service provision were designed to manage limited resources for the assessed level of client need. Approaches to managing level of demand by non Local Government agencies included:

- Ration available services in relation to levels of need.
- Allocate set hours for all clients.
- Allocate available services only to those with the highest needs
- Assign a budget limit per client.
- Refer some clients to private providers.

Reviews

Only eight of the non Local Government agencies were able to indicate how many clients they reviewed during 2001-02. The average number of reviews held by those agencies that did respond was 252. It should be noted that the sample size was small with wide variation in the number of reviews undertaken: the range was from 32 to 1,070. Therefore the data should be treated with caution.

Most non-Local Government agencies (83%) normally reviewed clients within 12 months, 78% of agencies within 6 months, and 61% of agencies normally reviewed clients within 3 months.

Figure 10 - Time to review of clients, 2001- 2002

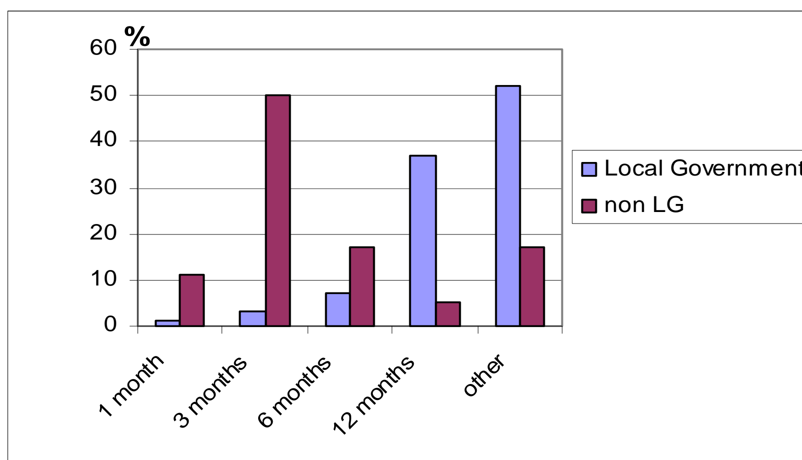


Figure 10 shows the average time that elapsed before a client was reviewed, for Local Government and non-Local Government agencies. Overall, Local Government appeared to have a lower completion rate, with 48% of clients being reviewed within 12 months, and 4% within 3 months. These findings should be interpreted with caution due to the low response rate of non-Local Government agencies.

Seventy-seven percent of non Local Government agencies have procedures to routinely review the needs of all HACC service users (51% in Local Government) and 77% to review users on an as needed basis (97% in Local Government). Forty-seven percent of agencies use both types of procedures.

Seventy-three percent of non Local Government agencies set a review date for more than 90% of service users when they are assessed (84% in Local Government) and 36% meet the set date for at least 90% of their clients (14% in Local Government). Refer to Appendix B Tables Q 16 and 17 for more information.

Seventy-nine percent of non Local Government agencies used Health status as the principal criterion for an "as needed" review of clients, 64% used 'High client need' and 57% considered 'Client and family request' or 'Carer situation'. Forty-three percent considered 'Living alone' or 'Involvement of one or more service'.

It was common for non-Local Government agencies[5] to use a combination of 'Health status' and 'High client need' to trigger a review, the next most common was 'Carer situation' and 'Involvement of a number of services'. Local Government agencies were more likely to base a review on 'Client or Family Request' more than non-Local Government agencies (79% versus 57%). (See Appendix B Q18)

While there were some variations across agencies, and not all non Local Government agencies were able to provide information on changes in service provision following review, on average, 56% of service users saw no change in their care following a review, 24% saw some increase, 9% saw a reduction of service, and 11% saw a discontinuation of service. The figures for Local Government were similar, but a smaller proportion of clients had their services ceased after review (4.4%).

Assessment staff

The average number of persons involved in Intake was 3.8, ranging from 13 to none. The average number of persons involved in Assessment was 5.4, ranging from 16 to 1. On average, 4.4 EFTs were dedicated to assessment, ranging from 1 to 11.5 EFTs[6].

All Assessment Officers in non Local Government agencies had some type of formal post-secondary qualifications, predominantly Nursing (64%), Allied Health (15%) and Social Work (9%). Others had qualifications in Welfare or Social Studies, Disability Studies, and Social Sciences. Local Government agencies had higher proportions of staff with Social Work (16.6%) and Welfare/Social Studies (18.8%) qualifications. Refer to Appendix B Table Q 25 for full list of Assessment Officers' qualifications.

---

[5] Thirty-six percent of agencies that responded selected more than four factors, contrary to instruction. This response may reflect the need for these agencies to consider a range of factors to cope with service demand.

[6] These figures exclude one agency which indicated that it had no dedicated assessment staff but nominated all 60 of its staff as involved in Assessment.

Expenditure and financing of assessment

Although agencies were asked to document expenditure on assessment, it was very difficult to ascertain what was included or excluded in the figures provided by respondents. Furthermore, about a third of agencies were unable to provide figures. For these reasons it was decided to exclude this section from the report.

Arrangements with other service providers

Twenty-nine percent of non-Local Government agencies (5/17 responding) had arrangements with other service providers whereby other providers undertook assessments to determine need for services provided by the non-Local Government agencies in the survey. Sixty percent of the assessments undertaken by other agencies were for comprehensive assessments. However, as only 3 out of the 5 agencies could indicate the number of assessments other providers undertook for them, these results should not be generalised.

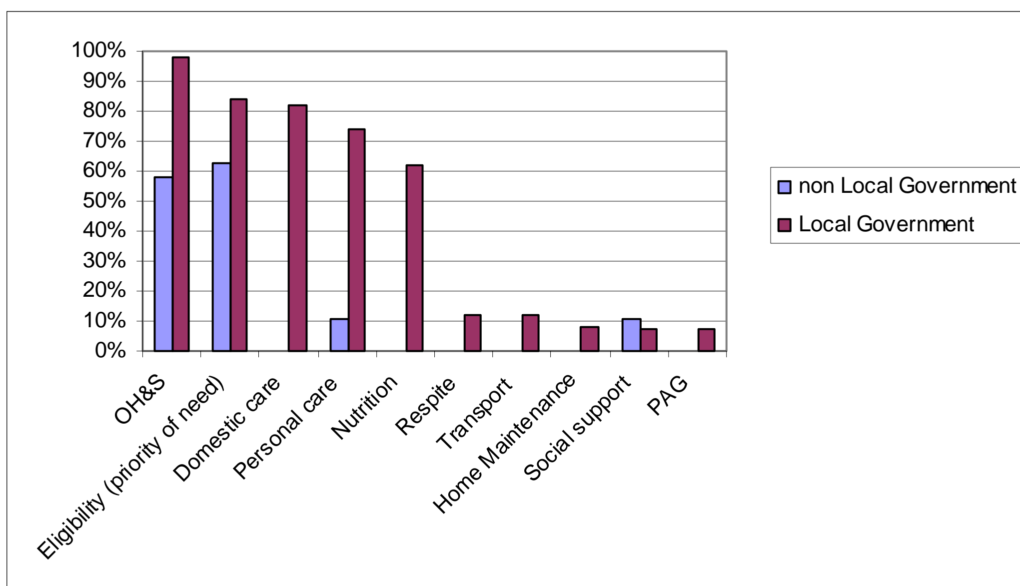
In comparison, almost half of the Local Government agencies had arrangements with other agencies that, on request, those agencies would assess clients who needed to access council services. Approximately one third of these arrangements were for service specific assessments and 22% each for comprehensive and comprehensive plus specialist assessments.

Two-thirds of Councils and non Local Government agencies re-assessed close to all clients on presentation to their agency.

Only around 10% of people presenting to Council and non-Local Government agencies were not re-assessed.

Reasons given by non Local Government agencies for reassessment of presenting clients included eligibility of need, occupational health and safety, and other criteria such as the need to develop a care plan, social support, neurological deterioration and cognitive changes. Figure 11 shows some of the reasons given for reassessment of clients assessed by other agencies and referred to responding agencies. Refer to Appendix B Tables Q 28 and 29 for the full breakdown of reasons given, for Local Government and non-Local Government agencies.

Figure 11 - Reasons given for reassessment of clients



Fifty-eight percent of non-Local Government agencies (11/19) undertook assessments for other providers. Fifty percent of these assessments were service specific, 30% were specialist, 10% were comprehensive, and 10% a combination. For the six agencies which reported the number of assessments undertaken for other agencies, the average was 79 assessments; however, the range was quite broad, from 3 to 391 assessments.

Non Local Government agencies were more likely to undertake assessments for other agencies than Local Government agencies (58% versus 38%); the range for Local Government for numbers of assessments taken by individual agencies was as broad as it was for non Local Government agencies (above). Refer to Appendix B Tables Q 27 for more information on numbers and types of assessments undertaken on behalf of other agencies.

Ten non Local Government agencies reported a total of 1,258 people they referred to other agencies for assessment. Mainly people were referred to Councils, Clinical Health services and ACAS.

Impact of Primary Care Partnerships

Overall non-Local Government HACC agencies had seen an impact from the establishment of PCPs at the time of the survey. Of those 15 non-Local Government agencies that responded, 40% reported improved coordination between agencies, 38% reported improved referral processes and 23% reported simplifying access to clients.

Changes to assessment practices

Nine non-Local Government agencies (50%) reported they had made significant changes to assessment practice (other than the INI and related changes). Major areas of change were:

- alignment of assessment processes,
- training and support for assessment change,
- electronic arrangements.

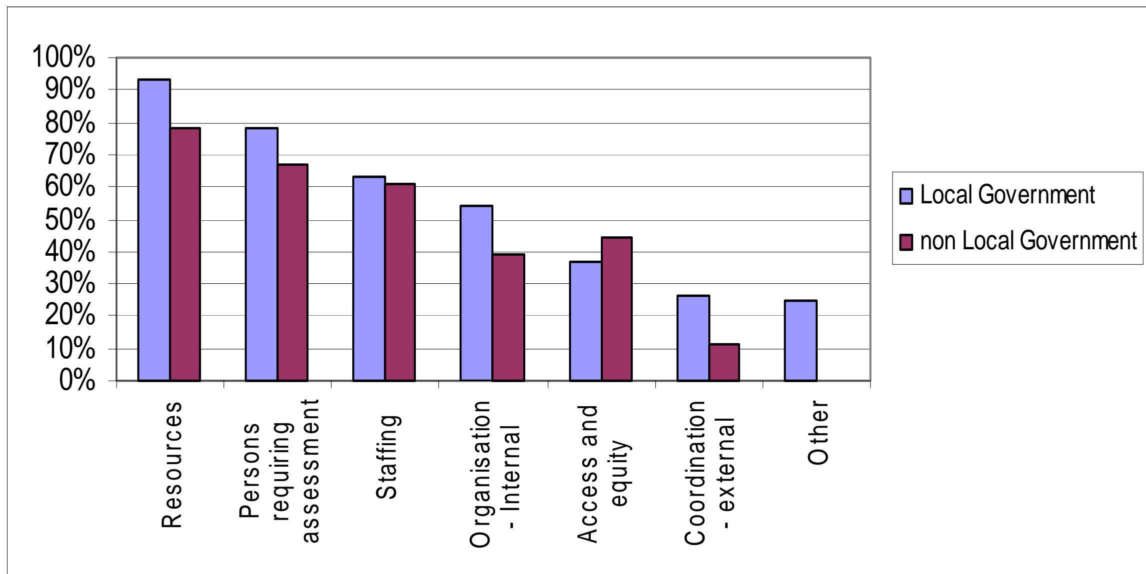
Further changes were planned in the next year by 80% of non-Local Government agencies. Anticipated changes were ranked in the following order for both non-Local Government and Local Government agencies responding: IT/record-keeping; issues around team organisation; content of formal assessment. Refer to Appendix B Tables Q 34.1 and 34.2 for more detailed information.

Thirty-two percent of non-Local Government agencies outlined resource implications of planned changes and indicated that they would need to upgrade electronic systems, recruit more staff or compromise their current work effort. None suggested that it could be absorbed within existing resources and tasks.

Key Issues in HACC assessment

The greatest challenge non-Local Government agencies saw in undertaking their current and future assessment role was the level of resourcing currently available (78%), followed by the related issue of volume of persons requiring assessment (67%) and staffing availability, training and quality (61%). A secondary set of problems for the majority of agencies included: ensuring access and equity (44%) and internal organisational issues, such as IT, forms and procedures (39%). Local Government agencies were slightly more likely to express concerns with resources and demand, internal organisation and external coordination than non Local Government agencies. See Figure 12 for comparison of Local Government and non Local Government agencies.

Figure 12 - Problems confronted by HACC Assessment Officers (now and near future)



Discussion & Conclusions

According to the HACC Program Manual, agencies funded for assessment and care management to ensure that:

- Individuals receive support to remain in the community and maximise their levels of functioning and independence
- Individuals receive appropriate types and levels of services for their particular needs
- Service are targeted to those most in need of support
- A coordinated and integrating service response is organised
- Service gaps are identified and included in local and regional service planning
- There are processes in place which recognize the right of an individual to refuse an offer of service (HACC Program Manual, 2003:79)

This survey examined current practice in assessment, care management and reviews for the HACC program across 71 Local Governments and a selection of non-local government agencies.

The survey demonstrated that most agencies receiving assessment and care management funds are carrying out the above functions however the level of services that can be provided is often constrained by availability. The survey also showed that there are some significant issues facing both Local Government and non-Local Government agencies in relation carrying out these functions. The most significant ones are:

- clarification and consistency in assessment and care management as an activity
- defining types of assessments: comprehensive, service specific and specialist
- roles and responsibilities eg. reviews, care management
- level of resources to undertake assessment
- managing and incorporating changes in the broader environment into assessment practice eg service coordination
- managing demand in particular priority of access
- practice issues eg workforce issues, IT requirements

Clarification of definition, roles and responsibilities of HACC assessors

The HACC Program Manual states that assessment should assess for community support services, both HACC and non-HACC, and that Assessment and Care Management activity should be consistent with the 'National Framework for Comprehensive Assessment in HACC' (HACC Program Manual, 2003:79).

Survey data showed that many Local Governments and some non Local Governments reported carrying out no comprehensive assessments at all, while others considered all their assessments to be comprehensive. This suggests that within those agencies receiving assessment and care management funds across

Victoria, clients with similar needs are likely to have quite different experiences of assessment.

Other data such as the wide range of assessments per 1000 HACC target group (98 per 1000 HACC target group, range 48-2840 across individual Councils); the wide range of assessments carried out per EFT (from 200-1500 assessments per EFT); and the wide range of outcomes of an assessment ie. services subsequently received following an assessment, shows the need for greater clarity in role definition and expectations of the assessment process.

The results demonstrate the need for greater clarity in the definitions of all assessment types, under what circumstances a comprehensive assessment may be required and what constitutes a comprehensive assessment.

The survey also revealed shortcomings in some agency IT systems which did not systematically collect information on certain aspects of assessment activity eg. referrals made (in particular, referrals to non-HACC services) and reviews undertaken.

The survey also demonstrated the difficulty Councils and non-Local Government agencies have in carrying out regular routine reviews as most reviews were carried out on as 'as needed' basis. This is an area for further investigation to establish a clear purpose for reviews, best practice for carrying out reviews and to identify ways in which the reviews can be carried out on a routine basis for a greater proportion of clients.

This data also suggests there is a need for a review of the assessment and care management funding across Councils and other non-Local Government agencies to ensure equity of distribution of these resources, and some target setting to guide agencies in the number of assessments that might be expected from the funding provided. How Councils translate this into assessment EFT depends on the tasks and activities that are assigned to assessment officers. Further clarification of assessment officers' role and the definition of care management is required before systematic benchmarking of this activity on the basis of EFT can occur.

Level of resources

The survey demonstrated that one of the most important issues confronting Councils and non-Local Government agencies is the level of resources available for HACC assessment and review.

In particular, the level of resources limited the numbers of reviews that could be carried out and agencies capacity to undertake the changes they would like to implement eg. IT and record keeping, team organization and planned improvement to the formal content of assessment.

A review of the resources allocated for assessment, care management and review and the manner in which these resources are distributed is an important next step for DHS and MAV.

Managing and incorporating change

The survey demonstrated that many changes in the 'front end' of the delivery of HACC services is occurring in order to meet the demands of new policy initiatives such as the Primary Care Partnerships, and increased community demand for HACC services.

These changes included:

- changes to the intake processes and role of assessment staff;
- introduction of service coordination including the Initial Needs Identification tools
- introduction of priority of access tools;
- agreements between providers regarding shared assessment tasks, information and referrals;
- increased coordination between agencies; and
- changes to referral processes required through Service coordination.

Further work in local areas on shared assessment tasks may in future reduce, but not eliminate, the amount of time needed by Councils to assess new users referred to them.

Changes in assessment practice are expected to continue in the near future, both from the expected positive impact of the PCPs and from other changes the great majority of Councils plan to introduce.

Workforce issues

The survey results showed that HACC assessment is carried out partly by staff dedicated to assessment only and partly by staff who are involved in assessment, but undertake other activities as well. As noted above, the wide range of assessments carried out per EFT across agencies indicate that there is likely to be significant divergence in the activities that are captured under the banner of assessment.

With regard to workforce, the survey clearly indicates an assessment workforce in HACC that is qualified with almost 93% of assessment officers having post secondary qualifications and 70% having nursing, welfare/social studies or social work qualifications. This is a good platform for HACC to improve the consistency and standard of assessments. From a practice perspective improvements such as greater use of standard assessment tools can be achieved through building on the existing skills and professional training of this workforce.

More recent discussions on this issue suggest that many HACC assessment officers are not employed under the term and conditions of these professional groups. The extent to which assessment officers maintain their registration under these professional groupings needs further investigation.

Assessment practice

Care planning including referrals to non-HACC services following assessment is an area where there appears to be inconsistent practice. Implementation of service coordination including a standardised approach to initial needs identification should assist in improving practice in this area. This element of assessment requires further clarification.

Duplication of assessment, ie. reassessment of clients following assessment by another agency such as Aged Care Assessment Service, is a practice that commonly occurs for reasons such as OH&S, eligibility and priority, and service specific requirements such as domestic requirements, nutrition needs, respite needs etc. These reassessments are critical steps in the delivery of a HACC service. The feasibility of a more integrated approach to assessment which would minimize or eliminate possible duplication of effort should be investigated.

The survey data suggests that HACC performance in assessment could routinely be monitored against the following criteria

- Assessment rates per 1,000 HACC target population in each Local Government area (taking into account any other assessment services in each LGA);
- Time between referral and assessment, both for clients discharged from hospital and for other HACC users, where there can be major delays in some areas;
- Review rates and frequency of review activities for HACC service users.

In order to do this, HACC agencies need IT systems and client management software that can track assessment and review activities as well as waiting times for assessment. This survey was useful in identifying areas in which agencies cannot report against these activities. In addition, assessment data has the potential to identify demand and levels of unmet need. At present this information is not routinely collected.

Conclusion

Increasing demand for HACC services means that assessment, care management and service coordination will continue to be an important activity in the HACC program.

This audit of assessment and care management activity has provided valuable data highlighting areas where there is a need to achieve greater consistency of practice, improved understanding of the tasks, roles and responsibilities of HACC assessors and a review of resources available to the assessment and care management activity.

This survey will contribute valuable baseline data and a starting point for the development of an Assessment Framework in HACC for Victoria. This three year project is being carried out by Victorian Department of Human Services with key stakeholders and will commence in August 2004. Information on the development of the Framework can be obtained from Heather Russell at the Home and Coordinated Care Unit, Aged Care Branch.

Attachment 1 - Members of project team

Clare Hargreaves, Municipal Association of Victoria

Jeremy Maddox, DHS

Justin McDermott, DHS

Vikki Perre, DHS

Monica Pfeffer, DHS

Julie Prideaux, J Prideaux and Associates

Attachment 2 Council types and population data

Victorian Councils, by type

Inner Metropolitan	**Outer Metropolitan**	**Regional City**	**Large Shire**	**Small Shire**
Banyule	Brimbank	Ballarat	Baw Baw	Ararat
Bayside	Cardinia	Greater Bendigo	Campaspe	Alpine
Boroondara	Casey	Greater Geelong	Colac Otway	Bass Coast
Darebin	Frankston	Greater Shepparton	Corangamite	Buloke
Glen Eira	Greater Dandenong	Horsham	Delatite	Central Goldfields
Hobsons Bay	Hume	La Trobe	East Gippsland	Gannawarra
Kingston	Knox	Mildura	Glenelg	Golden Plains
Manningham	Melton	Swan Hill	Macedon Ranges	Hepburn
Maribyrnong	Mornington Peninsula	Wangarattta	Mitchell	Hindmarsh
Maroondah	Nillumbik	Warrnambool	Moira	Indigo
Melbourne	Whittlesea	Wodonga	Moorabool	Loddon
Monash	Wyndham		Moyne	Mount Alexander
Moonee Valley	Yarra Ranges		Murrindindi	Northern Grampians
Moreland			Southern Grampians	Pyrenees
Port Phillip			South Gippsland	Queenscliffe
Stonnington			Surf Coast	Strathbogie
Whitehorse			Wellington	Towong
Yarra				West Wimmera
				Yarriambiack
18	**13**	**11**	**17**	**19**

Total number of Councils 78

Selected data from Victorian Councils

Sources:

Estimated population Department of Infrastructure projections, Victoria in Future, November, 1996

Council HACC clients MAV – Survey of Best Practice in Local Government Home and Community Care, 2003

HACC Target Group DHS HACC Unit, September 2002, using DoI population estimates for 2002.

The HACC target group is the estimated number of people living in the community who are:
i) over 70 years, plus
ii) aged 0-69 years who are profoundly, severely or moderately disabled

This latter figure is calculated by applying age specific rates of disability in the Australian community to the age profile of each Local Government area.

The HACC Target Group does not include people in institutional or other residential care.

Population data and HACC Target Population Data, by Council

Council	Estimated total pop'n 2001 (DoI)	Council HACC clients May 2002 [7]	HACC clients as % of total pop'n	HACC target group (2002 proj'd pop'n) [8]	HACC target gp as % of pop'n	HACC clients as % of HACC target pop'n[9]
Inner metro						
Banyule	117,354	1,205	1.0	15,698	13.4	8
Bayside City	85,138	1,591	1.9	13,162	15.5	12
Boroondara	150,195	2,357	1.6	22,097	14.7	11
Darebin	125,794	2,633	2.1	19,142	15.2	14
Glen Eira	117,188	2,513	2.1	19,080	16.3	13
Hobsons Bay	80,044	n/a		11,069	13.8	
Kingston	131,927	2,737	2.1	19,567	14.8	14
Manningham	115,110	2,651	2.3	14,891	12.9	18

[7] Data from MAV survey of Best Practice in Local Government Home and Community Care, undertaken September-October 2002. Note: this data is not drawn from HACC MDS data

[8] Data provided by DHS HACC Unit, *Target popns by LGA_pclark.xls*, September 2002

[9] See footnote 7. This data is not drawn from HACC MDS data

Council	Estimated total pop'n 2001 (DoI)	Council HACC clients May 2002 [7]	HACC clients as % of total pop'n	HACC target group (2002 proj'd pop'n) [8]	HACC target gp as % of pop'n	HACC clients as % of HACC target pop'n[9]
Maribyrnong	63,419	1,186	1.9	9,339	14.7	13
Maroondah	94,243	1,833	1.9	12,062	12.8	15
Melbourne	43,117	624	1.4	4,575	10.6	14
Monash	161,222	n/a		23,267	14.4	
Moonee Valley	106,875	1,564	1.5	16,253	15.2	10
Moreland	134,364	n/a		21,957	16.3	
Port Phillip	68,921	n/a		10,225	14.8	
Stonnington	84,568	2,160	2.6	11,969	14.2	18
Whitehorse	140,724	2,665	1.9	22,948	16.3	12
Yarra	63,250	852	1.3	7,580	12.0	11
Outer metro						
Brimbank	162,747	947	0.6	18,511	11.4	5
Cardinia	45,422	604	1.3	5,107	11.2	12
Casey	182,998	1,051	0.6	17,520	9.6	6
Frankston	121,766	1,729	1.4	14,582	12.0	12
Greater Dandenong	130,097	3,424	2.6	17,402	13.4	20
Hume	132,939	1,308	1.0	12,256	9.2	11
Knox	141,128	4,378	3.1	15,172	10.8	29
Melton	48,223	419	0.9	4,365	9.1	10
Mornington Peninsula	123,290	2,493	2.0	23,119	18.8	11
Nillumbik	59,275	n/a		5,503	9.3	
Whittlesea	117,656	1,399	1.2	11,967	10.2	12
Wyndham	90,121	n/a		7,635	8.5	
Yarra Ranges	139,763	1,433	1.0	15,542	11.1	9
Regional City						
Ballarat	78,804	1,828	2.3	10,783	13.7	17
Greater Bendigo	91,007	2,261	2.5	11,543	12.7	20
Greater Geelong	195,047	3,424	1.8	28,078	14.4	12
Greater Shepparton	57,426	n/a		7,063	12.3	
Horsham	18,162	n/a		2,892	15.9	

Council	Estimated total pop'n 2001 (DoI)	Council HACC clients May 2002 [7]	HACC clients as % of total pop'n	HACC target group (2002 proj'd pop'n) [8]	HACC target gp as % of pop'n	HACC clients as % of HACC target pop'n[9]
Latrobe Shire	72,894	1,922	2.6	9,747	13.4	20
Mildura	49,121	1,225	2.5	6,843	13.9	18
Swan Hill	21,202	n/a		2,543	12.0	
Wangarattta	25,228	791	3.1	3,711	14.7	21
Warrnambool	28,933	783	2.7	3,913	13.5	20
Wodonga	35,957	373	1.0	3,051	8.5	12
Large Shire						
Baw Baw	37,562	1,252	3.3	5,082	13.5	25
Campaspe	36,666	n/a		5,519	15.1	
Colac Otway	21,760	n/a		3,293	15.1	
Corangamite	17,583	399	2.3	2,667	15.2	15
Delatite	21,593	703	3.3	3,213	14.9	22
East Gippsland	42,609	n/a		6,993	16.4	
Glenelg Shire	21,106	454	2.2	2,917	13.8	16
Macedon Ranges	37,866	932	2.5	3,992	10.5	23
Mitchell	29,944	n/a		2,921	9.8	
Moira	27,405	n/a		4,302	15.7	
Moorabool	29,953	408	1.4	2,805	9.4	15
Moyne	16,642	292	1.8	2,182	13.1	13
Murrindindi	13,933	349	2.5	1,943	13.9	18
Southern Grampians	17,229	801	4.6	2,746	15.9	29
South Gippsland Shire	27,687	1,186	4.3	4,042	14.6	29
Surf Coast	19,561	383	2.0	2,839	14.5	13
Wellington	43,715	n/a		5,841	13.4	
Small Shire						
Ararat	11,763	n/a		1,706	14.5	
Alpine	13,046	331	2.5	2,293	17.6	14
Bass Coast	23,031	670	2.9	4,894	21.2	14
Buloke	8,486	n/a		1,366	16.1	
Central Goldfields	13,753	n/a		2,162	15.7	

Council	Estimated total pop'n 2001 (DoI)	Council HACC clients May 2002 [7]	HACC clients as % of total pop'n	HACC target group (2002 proj'd pop'n) [8]	HACC target gp as % of pop'n	HACC clients as % of HACC target pop'n[9]
Gannawarra	12,631	n/a		1,890	15.0	
Golden Plains	16,410	128	0.8	1,527	9.3	8
Hepburn	15,425	196	1.3	2,206	14.3	9
Hindmarsh	6,939	264	3.8	1,221	17.6	22
Indigo	15,564	n/a		1,958	12.6	
Loddon	10,045	330	3.3	1,582	15.7	21
Mount Alexander	18,105	800	4.4	2,764	15.3	29
Northern Grampians	13,985	420	3.0	1,893	13.5	22
Pyrenees	7,181	176	2.5	1,101	15.3	16
Queenscliffe	3,307	167	5.0	650	19.7	26
Strathbogie	9,792	600	6.1	1,633	16.7	37
Towong	6,629	n/a		1,112	16.8	
West Wimmera	5,267	223	4.2	853	16.2	26
Yarriambiack	8,803	n/a		1,619	18.4	

Attachment 3 Interview Guide

Please note:

More detailed results from the Assessment and Care Management Survey can be found in the Appendix to the Final Report. The Appendix can be found on the DHS HACC web site: www.health.vic.gov.au/hacc/

Department of Human Services

Assessment, Care Management & Review

Interview guide

Please note that all information will be treated anonymously: in reports no information which you supply will be used in ways which allow any individual agency to be identified.

Only the MAV will know your agency's identity.

Council:

Name:

Position:

Phone:

Date:

AssessSurvDHS_Final.Doc 13-Feb-03

© J Prideaux and Associates - August 2002

A Your assessment

1 How many people were *referred* to your service (including self-referral) July 2001 to June 2002?

2 How many clients did you *assess* July 2001/June 2002?

3 What proportion of the clients you assessed subsequently received each of the following service options? *(Estimate the proportions)*

HACC (inc Linkages, RDNS)	%
CACP	%
DVA	%
Post Acute Care	%
Private	%
Other (describe)	%
	100 %

4 Is there one entry point for your HACC services?

❑ Yes ❑ No

Please comment

5 Of the assessments which your service undertakes, what proportion are (see Attachment 1 for definitions)

Comprehensive	%
Specialist	%
Service – specific	%

6 Under what circumstances would you undertake a comprehensive assessment?

7 Are you now using the INI?

❑ Yes ❑ No

If not,

Do you plan to introduce the INI in the next 12 months?	❑Yes	❑ No
Have you used the CIARR in the past 12 months?	❑Yes	❑ No
Do you use any other standard screening, intake or referral instrument? *(please specify)*	❑Yes	❑ No

8 Please tick if your agency uses any of the following tools for assessment

❑ Barthel

❑ MMSE

❑ An ADL instrument

❑ An IADL instrument

❑ Other(s), please specify

9 What is the average time between accepting a referral at intake and assessing the client in the home?

a. Clients discharged from hospital

❑ Within 24 hours

❑ 2 – 3 working days

❑ 4 – 5 working days

❑ More .... days

b. Others

❑ Within 24 hours

❑ 2 - 3 working days

❑ 4 - 5 working days

❑ 6 - 10 working days

❑ More .... weeks

10 About how long on average do you spend per assessment?

Intake / screening	.... Hrs	................Min
Face to face assessment	.... Hrs	................Min
Other activities related to specific clients	.... Hrs	................Min

('Other activities' includes client-related travel time, record-keeping, service planning and coordination; excludes general administration and other tasks not for specific clients)

B Your criteria for targeting, measuring need & priority

11 Do you use explicit criteria for assigning priorities (Priority of Access) to clients?

Levels of need? *(see Attachment 2)*	❑ Yes	❑ No
Codes 1, 2, 3 as specified	❑ Yes	❑ No
Other?	❑ Yes	❑ No

(Please describe)

12 Does the number of clients assessed as needing your service exceed service availability?

❑ Yes ❑ No

▼

If yes, indicate factors taken into account in deciding allocation of service (if applicable, please tick up to 4 factors considered):

- ❑ Source of the referral (eg hospital, GP)
- ❑ Amount of care a client will need
- ❑ Urgency of providing services
- ❑ Length of time services are likely to be needed
- ❑ Alternative services available to the client
- ❑ Client's financial resources
- ❑ Client's social situation (including carer availability, living alone)
- ❑ Other (please specify)

Please comment ....

◄ ....

....

....

13 Do you set explicit limits on the amount of service you will provide to clients – maximum or minimum *(e.g. in cost or hours per week?)*

❑ Yes ❑ No

Please outline ....

C Your review procedures

14 How many clients did you review in the July 2001/June 2002 period?

15 Do you review or reassess your clients' continuing need for service?

(Formal review only, i.e. visit by assessment officer, exclude ongoing monitoring)

All clients reassessed routinely	❑	Yes
Clients reassessed as needed	❑	Yes

16 For what proportion of clients do you set a review date at assessment?

%

17 What proportion of set dates are met?

%

18 If you review on an "as needed" basis, can you outline the criteria taken into account?

(if applicable, please tick up to 4 factors considered):

❑ Health status

❑ Living alone

❑ Carer situation

❑ High level of client need

❑ High level of care being provided

❑ Potential to adjust care level in future

❑ Client or family request

❑ Involvement of a number of services – complexity of management

❑ Other (please specify)

❑ Other (please specify)

❑ Other (please specify)

Please comment

19 What is the time that normally elapses before a review is undertaken?

- ❑ 1 month
- ❑ 3 months
- ❑ 6 months
- ❑ 12 months

❑ Other *(specify)*

20 What proportions of those reviewed in the past 12 months had care:

Discontinued?	%
Reduced?	%
Left the same?	%
Increased?	%

21 What are the main issues for your service in relation to reviews?

D Your assessment team

22 How many staff are directly involved in

Intake? (No of persons)

Assessment? (No of persons)

23 How many staff are dedicated to assessment only?

(No of persons)

24 How many Equivalent Full Time *(1 EFT = 38 hrs per week)* are allocated to assessment?

(No of EFTs)

25 What formal qualifications do your assessment staff have?
(Count each staff person only once; if more than one applies, assign to highest on list)

Allied health	(No of persons)
Nursing	(No of persons)
Social work	(No of persons)
Welfare / social studies	(No of persons)
Disability studies	(No of persons)
Social science	(No of persons)
Others *(specify)*	(No of persons)

26 What was your agency's approximate expenditure on assessment in the year July 2001 – June 2002? *(including funds from all sources, nearest $'000)*

$

E Your relations with other service providers

27 Do you have an understanding with any other agencies that:

(a) they will make assessments for your services at your request

or conversely, that

(b) you will perform assessments for uptake of their services?

(Refer to Attachment 1 for definitions of types of assessments)

(a) They assess for you	**(b) You assess for them**
❑ No ❑ Yes: .... (No. per year) **Type of assessment** ❑ Comprehensive (incl ACAS) ❑ Specialist ❑ Service-specific ❑ Other	❑ No ❑ Yes: .... (No. per year) **Type of assessment** ❑ Comprehensive (incl ACAS) ❑ Specialist ❑ Service-specific ❑ Other

28 What proportion of clients assessed by other agencies do you re-assess on presentation?

%

29 If you re-assess, what do you assess for? ***(Tick more than one box if relevant)***

❑ Eligibility of need
❑ OH&S
❑ Domestic requirements
❑ Personal care requirements
❑ Nutrition
❑ Other *(please specify)*
❑ Other *(please specify)*

30 Approximately how many clients did you refer to other agencies for assessment in the past 12 months? *(July 2001 to June 2002)*

ACAS	(clients)
Clinical / health	(clients)
Psychiatric	(clients)
Alcohol / drug	(clients)
Other *(specify)*	(clients)
Total	(clients)

31 Has the establishment of a PCP in your area had an impact on assessment?

Impact		Comment on impact
Simplified access for clients	❑ Yes	
Reduction of your workload	❑ Yes	
Coordination between HACC-funded agencies	❑ Yes	
Referrals within the network	❑ Yes	
Other effect (please specify)	❑ Yes	
Other effect (please specify)	❑ Yes	

32 Do you expect any more impacts in the next 12 months? *(If yes, please specify)*

❑ Yes ❑ No

F Recent changes and problems

33 Other than INI and related changes, have you made any significant changes to assessment practice in the past 2 years? *(since July 2000)*

❑ Yes ❑ No

If yes, please describe

34 Do you have changes to assessment planned in the next 12 months?

❑ Yes ❑ No

If yes, please describe

❑ Content of formal assessment
❑ IT / record-keeping
❑ Organisation of team
❑ Other *(please specify)*

Please outline any resource implications?

35 What is the greatest problem confronting your HACC assessment role, now or in the near future?

❑ Volume of persons requiring assessment
❑ Resources
❑ Staffing (availability / training / quality)
❑ Ensuring access and equity
❑ Organisation – internal (IT / forms / procedures)
❑ Coordination – external
❑ Other *(please specify)*

<< THANK YOU FOR YOUR PARTICIPATION >>

Interview Guide Attachment 1

Definitions related to assessment

Questions 5 and 27

Service Specific Assessment

Is undertaken by the service provider where clients have relatively straight forward, obvious and distinct need.

Builds on the initial needs identification and may include developing an individual service plan, and identifies:

client's particular service requirements

any modification of the service needed

Specialist Assessment

Is undertaken by a provider who has specialist skills, knowledge and expertise where the presenting issue clearly requires a specialist service response such as that provided by mental health, women's health or drug and alcohol services.

Builds on the initial needs identification and any other relevant assessment and service delivery information.

Comprehensive Assessment

A face to face interaction with a client who has multiple, complex or unclear needs and who requires long term or intensive service provision.

Is undertaken by a range of service providers when a client:

has multiple, complex or unclear needs

requires long term and or intensive service provision

Builds on the initial needs identification and any other relevant assessment and service delivery information.

Is independent of service delivery to ensure the client's needs are considered irrespective of the assessing organisation.

It is undertaken by skilled health professionals with a broad range of expertise, and requires an advanced level of history taking from a wide range of sources. It may involve intense level of inquiry, including history-taking, examination, observation and measurement/ testing and assessment of medical, physical, cultural, psychological and social aspects of a client's situation.

Involves analysis and interpretation of the assessment information and a clinical judgement and diagnosis.

Links directly to care planning.

For further information, see: *Better Access to Services, A policy and operational framework*,
Primary Care Partnerships, June 2001

Interview Guide Attachment 2

Indicators for each level of need

Question 11

Level 1/Low

Experiences difficulty with minor tasks of daily living, either regular or irregular (e.g. household hygiene).

Infrequent but regular general health difficulties (e.g. podiatry)

Socially or geographically isolated

Carer stress (including anticipated)

Level 2/Medium Any combination of:

Unstable health

Little family or other support

Unable to monitor own medication

Experiences difficulty with tasks of daily living e.g. unable to shop/ prepare meals, environmental hygiene

Moderate frailty/ some confusion

Socially or geographically isolated

Limited mobility

Carer stress

Level 3/High Any combination of:

Unstable health – long term

Lives alone or with a carer who is frail, ill, stressed, or who has a disability

Unable to make own decisions

Unable to monitor or administer own medication

Experiences difficulty with a range of tasks of daily living

Socially or geographically isolated

At risk, vulnerable

Complex needs

Carer stress

For further information, see Victorian Home and Community Care (HACC) Program Manual, February 2003