

**Strategic Directions in Assessment  
Victorian Home and Community Care Program**

**Consultation Paper**

**October 2004**

Prepared by  
Anna Howe with Deb Warren,  
Consultants to the Project

Published by the Rural and Regional Health and Aged Care Services Division,  
Aged Care Branch, Home and Coordinated Unit  
Victorian Government Department of Human Services  
Melbourne, Australia

Also published on [www.health.vic.gov.au/hacc](http://www.health.vic.gov.au/hacc)  
October 2004

**Strategic Directions in Assessment:  
Victorian Home and Community Care Program**

**Consultation Paper  
October 2004**

<b>How the Consultation Paper was developed .....</b>	<b>1</b>
<b>Part 1 Setting the scene.....</b>	<b>3</b>
1.1 Current perspectives	3
1.2 Scope of the project to develop strategic directions in assessment in the HACC Program	4
1.3 Recent policy and strategic program developments	5
1.4 The need for strategic directions now	7
<b>Part 2 What the data tell us about Assessment in the HACC Program .....</b>	<b>9</b>
2.1 How many clients received an assessment service?	9
2.2 Regional patterns	9
2.3 Types of agencies reporting assessments	9
2.4 Agencies funded for Assessment and Care Management	11
2.5 How does assessment help clients?	12
2.6 Where do ACAS fit in?	13
2.7 Implications of variations in assessment practices	14
Issues for Consideration 1: Access to Assessment in your region	15
<b>Part 3 Mapping elements of Service Coordination to HACC assessment practice .....</b>	<b>16</b>
3.1 Clarifying the PCP Service Coordination Framework	16
3.2 Experience with initial contact	18
3.3 Current practice in Initial Needs Identification (INI), Service Specific and Specialist Assessment and Care Planning	19
Issues for Consideration 2: Furthering common practice in Initial Contact, INI, Service Specific Assessment, Specialist Assessment and Care Planning	23
<b>Part 4 Assessment and diversity in HACC clients .....</b>	<b>24</b>
4.1 Areas of developing practice	24
4.2 Remaining areas where development is required	24
Issues for consideration 3: Assessment and client diversity	25
<b>Part 5 What is Comprehensive Assessment? .....</b>	<b>26</b>
5.1 Definition of Comprehensive Assessment	26
5.2 Diversity in current practice	26
5.3 Identifying strategic directions for Comprehensive Assessment	27
5.4 Developing options for Comprehensive Assessment	31
Issues for Consideration 4: Comprehensive Assessment	31

## **Project Reference    Group Membership**

<b>Name</b>	<b>Organisation</b>
Jeannine Jacobson	DHS
Heather Russell	DHS
Maria De Leo	DHS
Linda Muller	DHS
Gill Pierce	Carers Victoria
Jill Thompson	COTA
Martin Wischer	RDNS
Vicky Mason	Darebin Community Health Centre, VHA representative
Alison Beckett	VAHEC
Deb Harvey	Kingston ACAS
Katherine Wositsky	MAV project worker, CEGS strategy
Jeannette Draper	Shire of Bass Coast, MAV representative
Pam Newton	Shire of Melton, MAV representative
Jeanne Poustie	City of Moreland, MAV representative
Emma Contessa	Co-As It
Penni Michael	Froniditha Care
Iwona Trickett	Australian-Polish Community Services
Ann Clendinnen	Moreland Community Health Centre (CCIN representative)

### **DHS Working Group:**

Membership includes representatives from:

- Aged Care Branch
- Primary and Community Care Branch including Primary Care Partnerships
- Mental Health
- Disability Services
- Acute Division including Continuing Care, HARP, Sub-acute.

## How the Consultation Paper was developed

This paper has been prepared for Consultations to develop strategic directions in assessment for the Victorian Home and Community Care (HACC) Program. The paper was developed with the benefit of comments and contributions from a Reference Group made up of peak body representatives. Their contribution is greatly appreciated.

The Consultation Paper follows on from detailed analysis of data from the HACC MDS, including the recently released report *Who gets HACC*, and extensive review of a wide range of policy and program material on assessment in HACC. This material includes several reports on projects carried out in the field in Victoria in recent years, and particularly in the context of the Primary Care Partnerships (PCP) Service Coordination (Better Access to Services) Framework. This background work identified a number of areas for consolidation of practice in the delivery and scope of assessment, and some issues where directions have yet to be resolved. It is these areas of practice and unresolved issues that are the subjects for consultation.

The five parts of Consultation Paper are as follows:

- Part 1 sets the scene by identifying the policies and practices in the Victorian HACC Program Manual that specify what all agencies funded through the HACC Program should be doing, and what agencies funded to deliver assessment and care management should be doing; and highlights the reasons why it is necessary to set strategic directions for assessment in the HACC Program now.
- Part 2 presents findings from the analysis of data on Assessment and Care Management (A&CM) reported in the HACC MDS.
- Part 3 summarises the practices and issues relating to the elements of the PCP Service Coordination Framework: Initial Contact, Initial Needs Identification (INI), Service Specific Assessment and Specialist Assessment. The ways in which emerging approaches to assessment in HACC agencies are meshing with the service coordination framework are canvassed. A number of issues that have yet to be resolved are identified.
- Part 4 deals with the diversity of people using HACC funded services and the implications for assessment practices.
- Part 5 focuses on Comprehensive Assessment. In seeking to clarify the different ways in which the term "comprehensive assessment" is currently used, and to identify emerging directions, particular reference is made to the National Framework for Comprehensive Assessment in HACC and the role of ACAS.

### **Issues for consideration**

Four sets of issues for consideration in the Consultations are presented through this paper. In identifying these issues, the aim is to provide a framework of common questions for the Consultations, but three provisos have to be emphasised:

- it is recognised that people attending each of the regional consultations will give more attention to the local issues of relevance to them;
- the issues are framed in a general way, but we are seeking feedback on the experience of practitioners in the field;
- the issues identified are not a complete list; they are intended to prompt discussion of further issues of concern in the field.

### **What the Project is NOT about**

This project to develop strategic directions in assessment in the HACC Program is not about the level of resources currently allocated to assessment or about how assessment and care management is funded. These issues will be considered once the Assessment Framework is developed.

## **Part 1      Setting the scene**

### **1.1      Current perspectives**

This Project, to develop strategic directions in assessment in the HACC Program, is approaching assessment from the common perspective of the HACC Program and service coordination as set out in the Better Access to Services Framework of the Primary Care Partnerships. This is because agencies such as local councils, community health centres and district nursing services funded through the HACC Program are active participants in PCPs.

#### **The HACC Program in Victoria**

The Home and Community Care (HACC) Program provides subsidised services to frail aged people, people with disabilities, and their caregivers, in order to help them maintain their independence at home, improve their quality of life and prevent inappropriate or unnecessary admission to long term residential care.

The program is cost shared between the Australian and Victorian governments. The budget for the HACC Program in Victoria for 2004-05 is \$380.4 million. This total budget includes an additional \$44.8 million that the Victorian Government is contributing over and above its matching obligation. Funding for assessment and care management as a designated HACC activity has grown from \$5.5 million in 2000-01 to \$11.7 million in 2003-04, an increase of over 100%.

The Department of Human Services administers the program in Victoria. Services are delivered by over 500 independent agencies, including some 76 local government authorities, over 100 community health centres, the Royal District Nursing Service, a range of health services, and many non-government agencies.

The main types of services constituting the program are home care (home help), home nursing, delivered meals, planned activity groups, personal care, property maintenance, nursing, allied health services (including physiotherapy and podiatry), respite care, volunteer coordination and assessment.

#### **Primary Care Partnerships and the Service Coordination (Better Access to Services) Framework**

The Primary Care Partnership (PCP) Strategy is a major reform in the way services are delivered in the primary care and community support services sector in Victoria. The Victorian Government has committed \$45 million over four years to the Strategy.

The Primary Care Partnership Strategy aims to improve the overall health and wellbeing of Victorians by:

- Improving the experience and outcomes for people who use primary care services.
- Reducing the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.

Over 800 services have come together in 32 Primary Care Partnerships across all parts of Victoria to progress the reforms. Many agencies funded to deliver services through

the HACC Program are members of PCPs and since mid 2001, have been working with other PCP members to build on existing good practices and local collaborative arrangements to developing local models of service coordination. This activity has involved collaboration with agencies delivering services funded by other programs that are members of PCPs, and other agencies funded by the HACC Program that are outside PCPs.

### **The need for consultation**

Given the range of experience that now exists, the consultants are conducting consultations to:

- gain a first hand view of approaches to assessment and service coordination that different HACC agencies have established;
- identify the ways in which the roles of different agencies are complementary;
- clarify areas of the service coordination framework that agencies find problematic; and
- explore ways of consolidating practice within the service coordination framework to achieve the best outcomes for clients.

## **1.2 Scope of the project to develop strategic directions in assessment in the HACC Program**

The scope of this Project encompasses all assessment activity carried out by HACC agencies, regardless of whether or not they are funded for Assessment and Care Management.

The recently released report *Who Gets HACC* prompts the equally important question *How do they get it?* That is, what are the processes of assessment through which clients present to agencies, have their needs assessed and have services provided in response to identified needs? These processes have progressed from *ad hoc* approaches early in the implementation of HACC, to consolidate around more standardised approaches today.

### **The Victorian HACC Program Manual (2003)**

The Victorian HACC Program Manual (2003) specifies that *all* HACC agencies are expected to:

- act as an **entry point** for consumers to both the HACC and the broader service system;
- receive **referrals** from all sources including self-referral;
- receive from, or make timely referrals to, other services on an approved information record. This will be on the Service Coordination Tools.
- develop policies such as priorities for service access, assessment and inter-agency referral processes;
- provide consumers with information on service options to inform their decision-making;
- develop policies, practices and protocols with other agencies regarding service coordination and care management practices and inform consumers and other services in the system of these;
- have a clearly defined process for dealing with referrals of differing priority;
- clearly explain the agency's role to consumers and how information gathered during the service coordination process will be used;

- **regularly monitor and review** consumers' conditions and circumstances;
- have clearly defined complaint and grievance handling procedures;
- **assess the consumer's need for the specific service** provided by the agency (this is different to the Assessment and Care Management activity—see below);
- manage risk and ensure occupational health and safety checks occur; and
- implement policies to ensure consumer privacy and confidentiality in service coordination.

*In addition to the functions set out above, agencies funded to deliver Assessment and Care Management are required to:*

- provide a broad needs-based assessment in order to identify an individual's need for community support services, both HACC and non-HACC, plus assess their strengths and abilities and in order to maximise the individual's independence;
- develop and implement a care plan, monitor the effectiveness of the care plan in meeting consumer needs, and regularly review and re-assess consumer needs. Agencies should also assess for fees in accordance with the HACC Fees Policy.

Nursing and Allied Health practitioners undertake clinical assessments, such as clinical assessment to develop a treatment or therapy plan, or determination by an Occupational Therapist of the physical placement of a handrail, as part of nursing or allied health activities funded by the HACC Program.

### **1.3 Recent policy and strategic program developments**

The main policy and strategic program developments in recent years have been:

- 1997** *Targeting in the Home and Community Care Program*
- 1998** *National Framework for Comprehensive Assessment in the HACC Program*
- 2000** Introduction of **Veterans' Home Care** and associated assessment process
- 2001** **Primary Care Partnerships** established and **Service Coordination (Better Access to Services) Framework** introduced a common framework and operational processes for HACC and other primary care services
- 2002** **Service Coordination**, supported by Service Coordination Tool Templates - **SCTT**
- 2003** Compliance with **HACC Service Standards** assessed in all HACC agencies in Victoria
- 2003** Release of the Australian Government's Consultation Paper on Community Care
- 2004** Victorian Departmental Advisory Committee on HACC (HACC DAC) contributions to the Australian Government's **Community Care Review**
- 2004** **Auditor General Victoria** report on its performance audit of the delivery of home and community care services by Local Government tabled in Parliament
- 2004** **The Way Forward: A New Strategy for Community Care**, Australian Government, Department of Health & Ageing

Policy documents that have recently been developed or revised are:

- HACC National Program Guidelines, revised in 2002
- **Victorian HACC Program Manual**, third edition published in 2003, provides policy and practice guidance on all aspects of the program, including Assessment and Care Management (A&CM), and includes cross references to Service Coordination.

Several practice initiatives have promoted innovation and development in approaches to assessment:

- **HACC service development grants** have funded several projects on assessment and care management, including ICT projects and access and equity projects for culturally and linguistically diverse groups.
- **PCP** service coordination initiatives have involved numerous workshops on practical application of the terminology and principles of the Service Coordination (BATS) Framework, and have also supported projects to advance implementation, including projects focused on initial access and needs identification, and inclusion of carers in assessment.
- **The Culturally Equitable Gateways Strategy** has initiated projects to facilitate access to HACC services for clients from culturally and linguistically diverse communities, with a particular emphasis on linking Local Government and ethno-specific agencies for culturally appropriate assessment and service delivery.
- **The Koori Going Forward Together Strategy** highlights the role of assessment coordinator positions.
- **The HACC Food Services Review** stressed the need for nutritional risk screening of clients, the need for a broad needs based assessment for clients requiring food services and identified scope for innovation in delivery of food services.

These policy and practice developments have produced a wide range of information on assessment in the HACC Program. As well as reports generated by the policy and practice initiatives noted above, analysis of the HACC MDS and other research projects have provided statistical data. The two main sources of data reviewed for the Project and drawn on in this Consultation Paper are:

- Municipal Association of Victoria and DHS 2004. **Assessment, care management and review in HACC**. This report is a survey of local governments and a sample of non-local government agencies conducted in late 2002, which provides important baseline data for this project.
- **Who gets HACC: A statistical overview of the Home and Community Care Program in Victoria 2002-03**. This report was compiled by the Aged Care Branch, Victorian Department of Human Services and released in August 2004 and provides an up-to-date account of HACC clients and service use.

Among the many reports on service coordination and assessment projects, four of relevance to this Consultation Paper are:

- Issues and options for scoping HACC services to families with a child/young person with a disability, Northern Metropolitan Region Councils, 2004

- Improving the focus on carer needs in initial contact and initial needs assessment. Westbay Alliance, Moonee Valley-Melbourne and Brimbank-Melton PCPs, 2003
- Development of a Priority of Access Tool for WMR Local Government HACC Providers, National Ageing Research Institute 2002
- Banyule-Nillumbik HACC, ACAS & PDSS Service Coordination Project, Banyule Council, 2000.

#### 1.4 The need for strategic directions now

The need to set strategic directions for assessment in the HACC Program now is prompted by four developments:

1. **The Victorian Minister for Ageing** has called for horizontal integration between HACC and related services in Victoria to enable more active interventions in supporting frail aged and disabled people to remain as independent, active, and as connected as possible in their own homes and communities. Links between HACC and acute, sub-acute and post-acute care have been a focus of attention in recent years, but moving in the direction of more active interventions will need greater links between primary care, community health and disability services, and rehabilitation and health promotion.
2. **The HACC Agreement** will be renegotiated over 2005. The strategic directions developed in the present project will contribute to reshaping HACC for the following agreement period and into the longer term future.
3. **“A New Strategy for Community Care: The Way Forward”** was released by the Australian Government Minister for Ageing in August 2004. Working within a framework of tiers of care, four actions are proposed to enhance access to services: improving consistency in approaches to intake to the basic tier care, comprehensive assessment for packaged care, identifying entry points to community care and a continuous electronic client record.
4. **The HACC MDS Version 2** will include dependency data items similar to those in the SCTT functional profile. It will be implemented in July 2005. This requires consistency in practice to support good quality data and positive outcomes for clients.

Against this background, the aims of this project are:

- To provide a broad overview of the principles, purposes, component tasks, and assessment practices that underpin the delivery of assessment and care management in the HACC program, and clarify the vocabulary of assessment, based on the Better Access to Services Framework;
- To identify any operational issues, conceptual issues, or practice concerns emerging from the overview described above, for example, lack of clarity between different components of a HACC assessment;
- To prepare a Consultation Paper on current and emerging issues for consultation with key stakeholders;
- To test the view of policy and practice issues related to assessment in the HACC program presented in the Consultation Paper with key practitioners and other stakeholders; and

- To make recommendations to the Department about the development of a Victorian HACC Assessment Framework that will clarify the requirements of assessment in the HACC Program, and will improve the consistency and quality of assessment activity. Recommendations will reference the national policy context and the Victorian context including Primary Care Partnerships and service coordination.

## **Part 2      What the data tell us about Assessment in the HACC Program**

This section highlights some findings from three sets of data on community care:

- Assessment activity reported in the HACC Minimum Data Set for April 2003-March 2004;
- *Who gets HACC: A Statistical Overview of the Home and Community Care Program in Victoria, 2002-03*;
- The ACAS Minimum Data Set for 2002-03.

### **2.1      How many clients received an assessment service?**

According to the HACC MDS, 65,340 clients received an assessment service. These clients account for 31% of the 213,071 people who received any kind of HACC service in the year to March 2004. Less than half of all new and returning clients are reported to have received an assessment, as defined by the MDS.

### **2.2      Regional patterns**

Variations between regions are evident in the proportion of all clients who received an assessment service. See Table 2.1:

- Five regions (three metropolitan and two rural) were close to the average (+/-5%). In these regions, between 26% and 36% of clients received an assessment.
- A markedly *higher* proportion of clients, around 40%, received an assessment in two rural regions, Barwon/South Western and Gippsland.
- Markedly *lower* proportions of clients, less than 23%, received assessment in two regions, Loddon Mallee and Northern Metropolitan.
- These variations explain the differences between the share of all clients and the share of assessed clients in each region. While these differences are not large in percentage terms, the lower share of assessed clients compared to the share of total clients in the Northern Metropolitan Region represents a substantial additional number of unassessed clients.
- While these regional proportions give a useful snapshot of the level of assessment activity, they need to be placed against the level of expenditure per capita of HACC clients in each region. For example, expenditure on the assessment and care management activity in Loddon Mallee is very low compared with other regions. They also raise questions about the flow of new clients compared with the stock of existing clients and how assessment and review are managed for each group.

### **2.3      Types of agencies reporting assessments**

The spread of assessment activity across agency types (Table 2.2) shows:

- Local councils play the largest role, accounting for fully 67% of all assessed clients.
- RDNS and Community Health Services have the next largest role, accounting for another 26% (divided 15% and 11% respectively). Special needs groups (Koori agencies, ethno-specific agencies and Interchange agencies providing respite to families of children with disabilities) together accounted for under 2% of assessed clients.

- The remaining agencies—hospitals, including bush nursing hospitals, other non-government agencies and Linkages agencies—accounted for just over 5% of assessed clients.

**Table 2.1: Reported assessment activity, by Region, Victorian HACCC MDS  
March 2003-04**

Region	Total clients		Assessed clients		
	No.	%	No.	% clients assessed	% all ass'd clients
<b>Rural</b>	<b>Col. 1</b>	<b>Col. 2</b>	<b>Col. 3</b>	<b>Col. 4</b>	<b>Col. 5</b>
Barwon/SW	19,538	9.2	8,330	42.5	12.7
Grampians	13,974	6.6	3,987	28.5	6.1
Loddon Mallee	19,937	9.4	4,075	20.4	6.2
Hume	13,313	6.2	4,705	35.3	7.2
Gippsland	14,990	7.0	6,301	42.0	9.6
<b>Metropolitan</b>					
Western	19,134	9.0	5,703	29.8	8.7
Northern	30,140	14.1	6,767	22.5	10.4
Eastern	35,283	16.6	12,852	36.4	19.7
Southern	44,301	20.8	12,444	28.1	18
<b>Interstate/Unknown</b>	2,426	1.1	176	7.3	0.3
<b>Total</b>	<b>213,071</b>	<b>100.0</b>	<b>65,340</b>	<b>30.7</b>	<b>100.0</b>

**Table 2.2: Assessment activity by type of HACCC agency, 2003-04 Victorian  
HACCC MDS**

Agency type	Assessed	% of total assessed clients
Local Government	44,057	67.4
RDNS*	9,863	15.1
Community Health	7,330	11.2
Special needs agencies		
Interchange agencies	186	0.3
Ethno-specific	505	0.8
Koori	128	0.2
Other agencies: hospitals, include bush nursing centres	768	1.1
Other non-govt agencies	2,503	3.8
<b>Total</b>	<b>65,340</b>	<b>100.0</b>

\* RDNS only reports the assessment activity done by its hospital liaison nurses funded through the Assessment and Care Management funding type. Assessment hours for clients assessed at home are recorded as nursing hours in the HACCC MDS. This means that a greater proportion of RDNS clients are assessed than appears in Table 2.2.

## 2.4 Agencies funded for Assessment and Care Management

Assessment and Care Management (A&CM) is the name of a funded activity in the HACC Program in Victoria. A total of 191 agencies are funded to deliver A&CM, and they account for 98% of reported assessment hours. It should be noted that some of this funding may be passed on to subsidiary agencies. It should also be noted that the RDNS is counted as only one agency, although its centres are located across all DHS metropolitan regions.

The regional distribution of agencies funded for A&CM shows two distinct patterns (see Table 2.3):

1. In the Eastern and Western Metropolitan Regions, and Loddon Mallee, A&CM is concentrated in a small number of agencies, mostly local councils. In all the other regions, A&CM is dispersed across a much larger number and mix of agencies, particularly community health services and rural hospitals.
2. The number of agencies funded to deliver A&CM reflects historical patterns of funding rather than the size of the regional HACC populations or geographic area. Grampians and Hume, with small HACC target populations but large areas, have almost as many agencies involved in A&CM as the region with the largest target population (Southern Metropolitan), and almost twice as many as other large rural regions.

**Table 2.3: HACC Agencies funded for A&CM, by type and region, 2003-04**

Region Agency type	Number of Agencies by Region									Total
	Rural					Metropolitan				
	Barwon	Gram- pians	Loddon Mallee	Hume	Gipps- land	Western	North'n	Eastern	South' n	
Local Government	9	11	10	11	4	7	7	7	9	75
RDNS	-	-	-	-	-	*	1	*	*	1
Community Health and other health services#	7	16	-	18	11	-	10	-	8	70
Other, incl. Koori, ethno-specific, Linkages and other non-govt.	5	2	5	4	2	2	10	1	14	45
<b>Total</b>	21	29	15	33	17	9	27	8	31	191

\* RDNS counted as only 1 agency but covers all four metropolitan regions

# Includes 5 Bush Nursing Centres in Grampians

## 2.5 How does assessment help clients?

Clients and their carers can get a number of immediate benefits from assessment as a service in its own right, as well as gaining access to HACC services and advice on and referrals to other services.

An in-depth investigation of home-based assessment carried out as part of the Victorian Carers Project found a number of benefits. The benefits included obtaining information and advice from professional staff; understanding how the disabling conditions gave rise to their care needs; discussion of options for addressing these conditions; and reassurance as to their capacity to continue to stay in their familiar environment. These immediate outcomes of assessment all strengthen clients' and carers' independence and their capacity to act on their own behalf in care planning.

The importance of assessment as a service in its own right is demonstrated by the HACC MDS showing that only one service—namely home care, with 70,500 clients—reached more people than were reached by assessment (65,340 clients).

The HACC MDS also shows that most clients who receive an assessment go on to receive a support service. The following profile of clients using single and multiple services is taken from data in *Who gets HACC*. The analysis describes the existing pattern of service usage within current resource constraints.

### Single service users

- Just over half of all HACC clients (55%) used only one service type.
- The majority of these single service users received either home care (35%) or nursing (26%).
- Of all clients using these two services alone or in combination with other services, 47% and 58% respectively used that service only.
- The next most commonly used services were allied health (20%) and planned activity groups (13%). Close to 6 out of 10 of these clients used only these services.
- Smaller proportions of clients used property maintenance (16%) and meals (14%). Only around 1 in 3 of these clients used these services alone.
- Although only 10% of all HACC clients received personal care, 90% of these personal care clients were also receiving another service.

### Multiple service users

- 45% of all HACC clients used multiple HACC services. It should be noted that multiple service use is under-reported to the extent that the HACC MDS records only use of other HACC services and does not capture referrals elsewhere.
- By far the most common combination of HACC services (excluding combinations involving aids and equipment and volunteer support) was home care and property maintenance, followed by home care and meals.
- Personal care stands out as the one service that is almost always used in combination with another HACC service. Fully 90% of those receiving personal care used another service, most often nursing or home care.
- Most multiple service users are receiving services delivered by the same agency: a local council.

## Linkages clients

Linkages Packages are funded through the HACC Program at the level of \$11,556. They are intended to cover the cost of case management and additional services for people with relatively high levels of need. Linkages packages are delivered by 24 agencies, many of which also provide general HACC services. Linkages clients account for just under 2% of all HACC clients. The profile of Linkages clients is different in a number of areas:

- They were younger, 10% being under 20 and only 48% over 70, compared to 4% and 67% respectively for all HACC clients.
- They were more likely to have a carer, 65% compared to 40% of all clients. Presence of a carer was associated with higher use of services by Linkages clients.
- On average, Linkages clients received 34 hours of service a month. However, the majority of high-use HACC clients (defined as people receiving more than 40 hours of service a month) were not Linkages clients.

## Issues arising from the HACC MDS data

- The majority of clients (55%) use only one HACC service, but there is considerable variation in the nature and level of that service when carer roles and other factors are considered. What kind of assessment do these clients need? Do they receive an assessment that is commensurate with their needs and those of their carer?
- For clients using multiple HACC services, assessment should involve identification of needs and care planning across a range of HACC *and non-HACC* services. To what extent is this actually happening? Most people who are getting multiple HACC services are getting them from the council. Are councils assessing for the need for non-HACC services?
- The RDNS carries out a broad assessment followed by service-specific assessment for general nursing care, and specialist assessment for other specialist needs such as continence management or diabetes as required. Assessment in other agencies delivering nursing services (such as rural hospitals) identifies the need for nursing services and may also cover the need for allied health services, where these are provided by the same agency. What is the situation where the agency delivers nursing services only?
- To generalise, the relationship between assessment and service use can be described as a fairly close-knit web within and between local councils and nursing agencies (particularly in metropolitan regions) with a looser web extending across other agencies.
- Given these observations, the definition of assessment in HACC should emphasise a broad approach to establishing client need. It should emphasise the importance of an effective referral process when clients are assessed as requiring services from multiple providers, particularly non-HACC providers. Whilst the SCTT tools were developed to enable this referral process to occur, it is unclear whether the introduction of the SCTT has assisted or created barriers to this process.

## 2.6 Where do ACAS fit in?

Aged Care Assessment Services (ACAS) have an extensive role in assessing clients for community care, see Table 2.4:

- 8 out of 10 clients assessed by ACAS are living in the community at the time of assessment.
- For 2 out of 3 of these clients, ACAS assessment results in a recommendation to remain in the community with additional services, mostly services provided through HACC.

**Table 2.4: Community services used by and recommended for clients recommended to remain in the community, Victorian ACAS, July 2002-June 2003 (N=26,420)**

Service	% using at Assessment	% Recommended as a result of assessment	% increase
Home nursing (HACC)	16	22	16%
Home help/home care (HACC)	45	54	20%
Home delivered meals (HACC)	18	24	33%
Home maintenance (HACC)	13	22	69%
Day Centre/Day Respite (HACC)	9	17	88%
Home Respite (HACC)	5	13	160%
Community Rehab Centre	5	14	180%
Residential respite	8	41	412%
CACP or HACC Linkages*	10	30	200%
Carer Allowance	8	11	38%

\* The ACAS MDS does not distinguish between recommendations for CACP and Linkages

Three other aspects of ACAS involvement in community care warrant note:

- Four out of 10 clients assessed by ACAS who were living in the community were *not* using services at time of assessment. Also, 38% of all ACAS clients have relatively low dependency (being rated as ambulant, continent and not confused). These figures suggest that *some ACAS clients could be diverted to a HACC agency for initial assessment.*
- An ACAS recommendation is required for access to a CACP. Many more people are recommended for a care package than there are places available. However, an ACAS recommendation is not required for a Linkages Package. Many clients appear to continue to receive HACC services for a considerable time and receive levels of service at least equivalent to packages.
- There appears to be scope for closer coordination between HACC and ACAS assessment to achieve a trade-off that could (a) reduce the number of apparently low need clients approaching ACAS, and thereby reduce the rate of clients subsequently returning to ACAS for reassessment and (b) address the number of high need clients who appear to continue to receive HACC funded services after they have been assessed as eligible for packaged care.

## 2.7 Implications of variations in assessment practices

The analysis of the HACC MDS and other data shows three sets of variations in the way that assessment is delivered: in the roles of different HACC agencies, between regions, and between ACAS and HACC agencies.

Some of these variations reflect very real differences between regions in geography and service configurations, such as the number and size of councils in a region. There is no one "right" or "better" way of delivering assessment. Questions do arise however about the differences for clients.

In some regions, the funded activity A&CM is concentrated in a small number of agencies, primarily local councils and district nursing agencies. Assessment staff in these agencies will see a larger number and greater diversity of clients. In other regions, where the funded activity A&CM is spread across a much larger number of agencies, it is likely that staff in any agency will conduct only a small number of assessments.

As well as giving rise to possible differences in the practice of assessment within any one agency, these characteristics raise questions about the nature of the relationships between agencies.

Variations in assessment roles of different agencies in each region have a number of potential implications for clients' access to services and for service coordination. In looking to consolidate complementary roles in assessment, the Consultations provide the opportunity to review the kinds of relationships that have developed between agencies that have *major* roles in assessment—local councils, nursing and allied health agencies—and other agencies, including those serving special needs groups.

Two areas need to be explored to identify strategic directions for future development.

- There is a need to identify the extent to which current practice provides a basis for a “lead and link” model. In such a model, agencies that are funded for A&CM could take a lead role in assessing clients, in conjunction with other agencies. This would ensure that the full range of client risk and need for services is identified and that appropriate referrals are made.
- Current interactions between agencies with major roles in assessment and ACAS need to be clarified. Clearer referral pathways could be consolidated to respond to clients who at assessment are found to have complex care needs and unresolved clinical problems, and who may need high levels of service.

#### **Issues for Consideration 1: Access to Assessment in your region**

1. Are HACC clients getting the right assessment by the right agency at the right time?  
If not, in what circumstances and/or for which clients are there concerns?  
Does the spread of agencies funded to deliver A&CM in your region work effectively?
2. Lead and Link Model: Are there models where A&CM agencies provide a broad needs based assessment for other agencies? What other types of links are there between A&CM agencies and agencies not funded for A&CM?
3. Should *all* clients receiving a HACC-funded service receive a broad needs-based assessment rather than only being assessed for a specific service? Consider the nature of the HACC target group and the level of disability typical of people getting priority access in your region.
4. Are there clearly defined pathways for clients requiring a comprehensive assessment (however defined, including referral to ACAS). In your experience, what models are effective?

## **Part 3 Mapping elements of Service Coordination to HACC assessment practice**

### **3.1 Clarifying the PCP Service Coordination Framework**

A key task for the Consultations is to identify how the elements of the PCP Service Coordination Framework map to current assessment practice in HACC, and whether clarification is necessary.

How do the concepts of Initial Needs Identification (INI), Service Specific and Specialist Assessment, Comprehensive Assessment and Care Planning (that is, the Service Coordination Framework) map to the concept of assessment as described in the HACC Program Manual? Evidence from recent studies is that there is persistent confusion in both language and practice in regard to Comprehensive Assessment.

For the sake of convenience, the issues for consultation are divided between:

- issues that arise in relation to INI, Service Specific and Specialist Assessment and the way they map to a broad needs-based assessment in HACC, and
- issues that arise in relation to Comprehensive Assessment.

Chart 3.1 maps the elements of service coordination to HACC assessment (as described in the HACC Program Manual). The chart identifies the purpose and outcome of each element of assessment.

**Chart 3.1: Features of elements of PCP service coordination and HACC Assessment and assessment practice**

<b>Service Coordination Element</b>	<b>Purpose and common features</b>	<b>Outcomes</b>	<b>HACC Assessment (HACC Program Manual)</b>
Initial contact	Point of contact for information about HACC and other services in wider primary care system  Information is comprehensive, reliable and accurate Facilitate access to INI	Provision of information on wide range of supports  Redirection of clients who are clearly not eligible for HACC to other services or activities.	Act as an entry point to both HACC and broader service system Receive and make referrals
Initial Needs Identification and Care Planning	Initial screen which will determine risk, eligibility and priority for service and service requirements  Broad ranging, goes beyond HACC services, but limited in depth May be by phone or face to face, at centre or in home  As far as possible identifies full range of need including health promotion and self help, illness prevention	Care plan includes: – Formal referrals using the SCTT and advice to clients/carers about alternative service or activity options.	'Assessment of individual's needs for community support services – both HACC and non HACC plus assessment of strengths and abilities aimed at maximising individual's independence.'  This incorporates: – Inter agency protocols – Key service links – Assessment and Care Management for other agencies
Service Specific and Specialist Assessment and Care Planning	Determine particular service requirements; adapt service provision to assessed need  Develop individual service plan (eg home care) or clinical /discipline specific plan (eg nursing)  Focus is on clients who are likely to receive service/s from assessing agency.  Breadth and depth vary for individual clients as required to respond to identified needs.  Centre based or in home	Care plan includes: – Details of services to be delivered by assessing agency to meet clients and carer needs – Assessment and resolution of OH&S issues	Service Specific Assessment Clinical Assessment Personal care needs Nutritional risk screening and monitoring Respite Planning Care Management Review and reassessment
Comprehensive Assessment and Care Planning	Most intensive level of inquiry for clients with unclear or complex needs who may require in depth problem investigation, clinical intervention, screening for rehabilitation potential and restorative opportunities identified.  Identification of the full range of care options  Multi-dimensional in breadth, and multi-disciplinary team of staff	Referral to rehabilitation and restorative care to maximise functioning and independence.  Care plan able to cover full range of service options, including recommendations for CACPs, EACH, residential respite or permanent admission.	Comprehensive Assessment  Consistent with National Framework for Comprehensive assessment in HACC  Delivered by agencies that meet criteria set out in National Framework.  Multidimensional, broad in scope, independent from service provider perspectives

In developing strategic directions for assessment in the HACC Program in Victoria, it is necessary to take account of the types of assessment that may be associated with the tiered structure of community care proposed by the Australian Government in its Community Care Review. The broad relationship between the elements of service coordination and these tiers is set out in Chart 3.2.

The Commonwealth's framework emphasises the important role that 'Early intervention and Information' plays in the community care sector. The proposal for this 'tier' is to identify clear, but multiple, points of entry to the community care system. It is not clear at this stage how the Commonwealth is defining the scope and scale of this function.

It is an objective of the PCP initiative that members agencies of PCPs should provide this function.

**Chart 3.2: Relationship between elements of Service Coordination in PCPs in Victoria and Tiers of Community Care proposed by the Australian Government**

Elements of Service Coordination in PCPs in Victoria	Tiers of Community Care proposed by the Australian Government		
	Early Intervention and Information	Basic Care	Packaged Care
1. Initial contact	Access		
2. Initial Needs Identification			
3. Service Specific Assessment		Intake Assessment	
4. Specialist Assessment			
5. Comprehensive Assessment			Comprehensive Assessment (National Framework)
6. Care Planning (this can occur at all stages of the process)			

### 3.2 Experience with initial contact

Initial contact with HACC agencies occurs in different ways depending on the range of services that each agency provides. The HACC agencies with major roles in assessment are generally well known in their local communities, notably Councils, Community Health Centres and district nursing services. They are readily identified as points of entry to services in general, if not to particular kinds of services. These agencies manage initial contact in different ways to take account of the range of services offered, including services beyond HACC, and the flow of inquiries coming to them. Four broad patterns can be identified:

- Many large Councils have a customer service desk or a phone line that directs enquirers to the appropriate department within the Council or to other relevant services in the community.
- In Community Health Centres that offer a wide range of health services to the community at large, initial contact will stream the enquirer to the relevant services within the Centre, including HACC services, and will offer information about other possible sources of assistance, again including HACC services provided by other agencies.
- The nature of services provided by district nursing services is generally recognised

in the community, but where an enquirer is seeking another kind of service, the nursing agency will direct them to the relevant agencies.

- Agencies providing other services—for example, Planned Activity Groups or services involving volunteer support—generally have a good profile in their particular community and are known to other HACC agencies. If so, they are able to provide an important point of entry to wider primary care and community services. This is particularly so for ethno-specific agencies and the role they play for members of their community.

Leaving aside the particular features of agencies in different categories, most HACC-funded agencies appear to have adopted similar practices in two important areas of initial contact.

First, they are increasingly good at providing information on the full range of services provided by PCP member agencies. Membership of PCPs promotes this sharing of information, through the development and use of electronic service directories. However, if a small HACC agency is not a member of a PCP, can it be expected to have the capacity (e.g. IT to support the Electronic Service Directory) to provide access and information to the wider service system?

Second, HACC agencies adopt an inclusive approach to establishing whether the individual comes within the HACC target population. Other than clients who are clearly not eligible for HACC-funded services, and are directed elsewhere, initial contact streams clients to an initial needs identification by whichever agency is most relevant on the basis of their inquiries.

### **3.3 Current practice in Initial Needs Identification (INI), Service Specific and Specialist Assessment and Care Planning**

All HACC agencies are expected to conform to the policies set out in the HACC Program Manual, but these policies allow agencies considerable flexibility in the delivery of assessment. They assume the exercise of professional judgement to reach the best outcome for clients.

While common approaches are gaining ground in INI, there appear to be differences in the ways that agencies proceed to assessment and care planning.

A key question is whether the process of INI as described in the Service Coordination Framework (and expressed through the SCTT tools) supports good practice in assessing an individual's need for community support services—both HACC and non HACC—while also assessing the person's strengths and abilities in order to maximise independence, as set out in the HACC Program Manual.

It appears that there are differences between agencies in the extent to which they (a) mainly offer advice about services and options, or (b) make formal referrals to other service providers. The SCTT may be used when formal referrals are made. However, many agencies prefer to offer advice to clients about services and activity options, leaving it up to the client and carer to take the initiative to contact the relevant services. While many HACC agencies referred to ACAS for specialist or comprehensive assessment, there is also variability in this area.

This raises a question about the optimal balance to be struck between two valid approaches:

- respecting and supporting people's right and capacity to self manage;
- relieving clients of the onus of finding their way around the service system and the need to tell their story multiple times.

Chart 3.3. summarises the different roles that agencies appear to play in the overall structure of assessment. It tabulates differences in practices in INI, service specific and specialist assessment, and care planning. The matrix provides a generalised schema, so particular agencies' practices are not specifically identified.

A key goal of the consultations is to test the extent to which the matrix identifies key components of assessment processes and practices. The commonalities and differences described briefly below will need to be clarified in the Consultations. The aim is to find strategies for consolidating the complementary roles of different agencies in the overall framework of service coordination.

An important question concerns the links with other agencies that should be in place in order to complete an INI and assessment. While one recent report suggests there are strong links between nursing agencies and ACAS, less is known about others, such as links to GPs and rehabilitation services. How can they be strengthened?

**Community Health Services (CHS)** appear to be adopting a stand alone process for INI that spans all services provided by the CHS. INI appears to be carried out by a worker face to face with the client in the CHS or possibly by phone, and leads on to either service specific assessment or specialist assessment by the relevant health practitioner within the agency. INI or either of the assessment processes may lead to comprehensive assessment for clients with very complex needs, especially where there is uncertainty as to the nature of the client's problems.

**RDNS** carries out a broad needs-based assessment followed by service specific assessment for general nursing care and specialist assessment for other specialist needs such as continence management, stomal therapy, diabetes etc. as required.

**District Nursing Services** conduct assessment mainly with a view to establishing needs for clinical nursing. Once clinical needs have been identified, agencies proceed to the relevant service-specific assessment and care plan. However, it is unclear how commonly these nursing agencies identify the breadth of needs or the extent of referrals to other HACC and non-HACC services.

**Chart 3.3: Schema of emerging approaches to service coordination and assessment practice in HACC agencies**

Community Health Centres	District Nursing Agencies	Other agencies	Local Councils and RDNS		
Initial contact	Initial Contact	Initial Contact	Initial Contact		
Initial Needs Identification	Identification of need for nursing and/or allied health and other HACC or non HACC services	Identification of need for own agency service/s and other HACC or non HACC services	<b>Integrated INI/Broad needs assessment/ Service Specific/ Specialist Assessment and Care Planning</b>	Broad needs based assessment for <ul style="list-style-type: none"> <li>• Confirming eligibility to receive HACC services</li> <li>• Priority of Access</li> <li>• Nursing needs</li> <li>• Personal Care</li> <li>• Nutritional Risk</li> <li>• Carer needs, incl. referral to Centrelink for Carer Allowance</li> <li>• Fees</li> </ul>	
Service Specific Assessment	Assessment for nursing and allied health, involved in assessment for Personal Care for some clients	Assessment for own agency service/s			
Specialist Assessment	As above	By referral			
Care Planning	Nursing Care Planning, referrals for other services	Care Plan for own agency service/s, referrals for other services		<b>Care Plan</b> , for HACC services provided by Council includes <ul style="list-style-type: none"> <li>• OHS assessment</li> <li>• Review schedule</li> </ul> For Services provided by other agencies <ul style="list-style-type: none"> <li>• Advice and information</li> <li>• Formal referrals →</li> </ul>	<b>Formal Referrals for</b> <ul style="list-style-type: none"> <li>• Nursing</li> <li>• HACC Allied Health Assessment and services</li> <li>• non-HACC services, e.g. PAV, Respite for Carers.</li> </ul>
↓ ↓ ↓ Comprehensive Assessment Including option of referral to ACAS				Comprehensive Assessment Including option of referral to ACAS →	<b>Referral to ACAS</b> <ul style="list-style-type: none"> <li>• problem resolution, e.g. falls, psychogeriatric</li> <li>• further clinical ass'mt</li> <li>• care package</li> <li>• residential care</li> </ul>

**Local Councils** widely describe their practice as one that integrates INI, a broad needs-based assessment, Service Specific and possibly Specialist Assessment. In contrast to the approach in Community Health Centres where INI can usually point to the particular service that is needed, this is often not the case for clients needing care at home. Rather, it is frequently not possible to reach decisions on the services that can best meet client needs until late in the assessment process and only after a wide range of options have been canvassed with the client and carer.

For example, if INI and application of the SCTT Nutritional Risk Screening Tool finds that a frail elderly client is at risk of poor nutrition, the responses to be canvassed might include delivered meals, centre based meals, home care to assist with shopping and food preparation, volunteer support to increase social contact, referral to community transport to enable the client to resume their own shopping. If a carer is available the assessment will establish the contribution that the carer can make to providing meals and social support. The care plan could include a mix of all these responses.

If a client has a medical condition such as diabetes, special attention is needed to dietary requirements and maintaining mobility. A care plan developed by a local council could include referral for a specialist assessment by a dietician and/or a podiatrist, with a date set for review so that the care plan could be modified in the light of the specialist assessment. This example illustrates how specialist assessment could be integrated with the sort of broad needs-based assessment that is evident in good practice in local councils.

### **Use of SCTT tools**

Mandating service coordination in the HACC Program has increased use of SCTT tools in Local Councils for INI and referral to other agencies. The SCTT tools are used either alongside or instead of other tools for collecting and recording the range of information canvassed in a broad needs based assessment. However, the SCTT is not being used uniformly, and not all relevant profiles are being used as fully as they might be.

For the purposes of carrying out a broad needs based HACC assessment, the SCTT profiles have gaps – for example, with regard to carers, needs for aids and equipment, need for property maintenance and home modification. In some PCPs these gaps have been filled by agencies that have collaborated to develop further profiles, but their wider take-up is not known. Other gaps in the SCTT need to be identified and addressed.

It should be recognised that the SCTT is designed to support the process of INI and referral. It was *not* designed as an *assessment tool per se*. This raises a question: In order to obtain improved quality and consistency in assessment practice in HACC, should there be a greater level of guidance for practitioners by way of recommended *assessment tools* that cover the required domains and areas of need?

### **Service Specific and Specialist assessment**

The distinction between service specific and specialist assessment can become blurred. For example: a council may make a referral to a nursing agency for what it regards as a specialist clinical nursing assessment for a client with an unstable medical condition. If the same client had been referred by their GP, the nursing agency may regard this as a service specific assessment. The outcome for the client is likely to be similar. Is there any value in retaining the distinction between service specific and specialist assessment in the Service Coordination Framework?

**Issues for Consideration 2: Furthering common practice  
in Initial Contact, INI, Service Specific Assessment,  
Specialist Assessment and Care Planning**

1. Initial Contact and access to information:
  - What has been the impact on clients of any changes your agency has made in initial contact as a result of the PCP service coordination framework?
  - Information provision: Should the provision of information and access to the wider service system be consolidated to a clearly identified group of agencies delivering HACC services?
  - Establishing eligibility: Does IC and INI as practised in your PCP and your agency contribute to better consistency in establishing eligibility for HACC services? Do people find out more quickly whether they are eligible?
2. In your experience of assessment practice, what impact has the implementation of Service Coordination had on your approach to broad needs based assessment?
  - How effective are the SCTT profiles in supporting good practice in the assessment of a broad range of client (and carer) needs, strengths, and abilities?
  - Should the HACC program provide more guidance regarding a broad needs based assessment in order to achieve consistency and improve quality?
  - Are service specific assessment and specialist assessment sufficiently different in practice to warrant labelling as separate elements in the service coordination framework?
3. Do you have a systematic way of allocating priority of access to services for people waiting to receive services? How can we take this forward?
4. In your referral practices, do you feel that the appropriate balance is being struck between (a) respecting and supporting people's right and capacity to self manage and (b) removing from clients the onus of finding their own way around the service system (by using the SCTT to make referrals)?
5. In looking to "lead and link" models, what links with other agencies do you call on in completing an INI and a broad needs-based assessment? What are the other links are important to you (e.g. to GPs, hospitals, rehabilitation services) and how can they be strengthened?
6. What are the professional development requirements for staff engaged in HACC assessment?

## Part 4 Assessment and diversity in HACC clients

The HACC Program is characterised by its diverse client group. Clients are diverse in age, in needs, and in cultural backgrounds. This poses opportunities and challenges in the effective delivery of assessment. While a number of strategies have been promoting convergence of good practice in areas where assessment requires more expertise or collaboration between agencies, there are other areas where practice diverges and good practice has not been resolved.

### 4.1 Areas of developing practice

There are three areas in which practice is developing:

1. The Municipal Association of Victoria and the RDNS have developed a protocol template for referrals from local government to the RDNS. These are referrals for personal care assessment for clients with unstable health/complex care. The protocol only covers metropolitan regions. Its impact needs to be evaluated.
2. A resource kit developed by the Carers Association Victoria, and the Carer Profile developed by three PCPs in the Western Metropolitan Region, have promoted the involvement of carers in assessment. The take-up of these tools is not known.
3. The Culturally Equitable Gateways Strategy and the Koori Assessment Coordinators are addressing ways of making assessment more responsive to clients with special needs. The agencies serving these groups are working with local councils to develop culturally appropriate assessment practices. While these are recent initiatives, early experience will be valuable in informing future directions. There is longer experience of assessment for people with dementia and other cognitive impairments, in line with the dementia pathways approach developed in the late 1990s, such as the Cognitive Dementia and Memory Services (CDAMS).

### 4.2 Remaining areas where development is required

1. The scope of assessment of care needs of **younger people with disabilities and their carers** stands out as the most problematic area of assessment in HACC. These problems are compounded by lack of clarity in relationships to assessment processes among disability services. Most disability agencies are not members of PCPs and many HACC agencies are not involved in the various disability networks that operate across the state. While the problems are readily recognised and have been well documented, solutions are lacking.
2. The **diversity of assessment processes among related programs** poses problems for HACC clients and agencies. While processes are well defined for some programs such as Personal Alert Victoria, some difficulties have been experienced in practice. In other programs, assessment processes and access pathways are less clear and may limit referrals for services such as those provided through the National Respite for Carers Program and Community Rehabilitation Centres. The Australian Government's recent proposals for common arrangements across all its community care programs provide some pointers for future strategies, but these need to be tested against experience.
3. The function of HACC services in preventing further loss of functioning is well recognised. However, the scope of HACC services to provide secondary prevention,

or to link into it, is underdeveloped. It is beyond the scope of the HACC Program to provide primary prevention services for the whole population. In relation to both self help initiatives and the need for specialist assessment prior to HACC service provision (e.g. an OT assessment) there is a need for more systematic links between HACC assessment and allied health practitioners. The opportunity for a more active model of service delivery is part of the forward agenda for the HACC program. What implication does this have for the HACC workforce and assessment practitioners?

**Issues for consideration 3:  
Assessment and client diversity**

1. What initiatives or practices has your agency developed in the following areas:
  - To assess clients and develop care plans for clients with unstable health conditions for personal care?
  - To involve carers in assessment, including using the Victorian Carers Association resource kit and the Carer Profile developed in Western Metro Region?
  - To provide culturally appropriate assessments for clients in special needs groups?
2. What initiatives or practices has or is your agency developing to assess the needs of younger people with disabilities, especially those under the age of 18 and their families?
3. Does your approach to assessment routinely identify opportunities for promoting independence and self help for clients and carers, and engage them in health promotion activities?
  - What links, relationships or protocols do you have with other HACC agencies (eg HACC funded allied health practitioners in Community Health) and non-HACC agencies (GPs, acute, sub-acute and post acute agencies) in order to identify opportunities for improving the functional status of your clients?
  - What are the workforce implications of the HACC program moving toward a more active model of service intervention?

## **Part 5 What is Comprehensive Assessment?**

### **5.1 Definition of Comprehensive Assessment**

The PCP Service Coordination framework describes the key features of Comprehensive Assessment as:

- A face-to-face interaction with a client that involves the most intense level of inquiry, and incorporates an advanced dimension of history taking, examination, observation and measurement or testing.
- Occurring where consumers have multiple, complex or unclear needs or with consumers who require long term and/or intensive service provision.
- An intensive processes of inquiry requiring analysis and interpretation of the assessment information and a clinical judgment, diagnosis and differential diagnosis.
- Building on information gathered through the Initial Contact and Initial Needs identification elements.
- Having transparent links with the other face to face assessment elements (service specific and specialist).
- Linking directly into care planning.
- Undertaken by a range of competent and experienced workers with a multi-disciplinary focus and a broad range of expertise.

### **5.2 Diversity in current practice**

Evidence that Comprehensive Assessment means different things to different agencies is clear from two recent surveys:

1. In the survey conducted by the Victorian Auditor General, 78% of Councils reported that they conducted comprehensive assessments.
2. The MAV/DHS survey defined Comprehensive Assessment as in the Service Coordination framework. While the overall proportion of Councils conducting any comprehensive assessments was similar to that reported by the Auditor General, at 75%, the survey found that "comprehensive assessment" had a variety of meanings that were not always consistent with the Service Coordination framework, and there was considerable variation in practice:
  - 20 Councils (25%) did not conduct any comprehensive assessments but referred clients with indications of complex needs for ACAS assessment.
  - 23 Councils (30%) undertook comprehensive assessments selectively for clients presenting with multiple, complex or unclear needs.
  - 24 Councils (30%) reported that it was their routine practice to conduct comprehensive assessments for all clients.
  - 11 Councils (15%) described their assessments as comprehensive but their practice did not meet all the definition criteria.

Looking at practices across different types of councils, outer metropolitan councils were most likely to report that they conducted comprehensive assessment routinely for all clients, while inner metropolitan councils, regional cities, large and small shires were either more selective or did not conduct comprehensive assessments at all, instead referring clients to ACAS.

When taken together with the account of ACAS involvement in assessment for community care given in Part 2.6, it is apparent that ACAS have widespread, if unevenly developed, relationships with HACC agencies in assessment of clients with multiple, complex or uncertain care needs.

### **5.3 Identifying strategic directions for Comprehensive Assessment**

In considering strategic directions for Comprehensive Assessment in HACC, the Consultations are expected to make a critical contribution to clarifying the fit between current practices in HACC agencies and the following three domains:

1. Comprehensive Assessment as an element of service coordination set out in the PCP Service Coordination framework;
2. The National Framework for Comprehensive Assessment in HACC; and
3. Australian Government arrangements that already apply for ACAS assessment for access to residential care. These include residential respite, CACPs and EACH packages.

The proposals put forward for Comprehensive Assessment in the tiered model of community care are largely based on the Aged Care Assessment Program. While ACAS assessment in general is described as comprehensive, this does not mean that a single, standard format is being followed for all clients. In practice, assessment is tailored to individual clients. In its proposals for different approaches to assessment associated with tiers of community care, the Australian Government recognised the need for alternative arrangements for comprehensive assessment for younger people with disabilities.

When these three frameworks for Comprehensive Assessment are mapped against each other, it is clear that they have much in common. Review of these frameworks and material on current practices has identified seven major considerations that need to be taken into account in moving to formalise Comprehensive Assessment in HACC. Formalisation can usefully be seen as defining what does, and what does not, come above the line that separates Comprehensive Assessment from the other elements of service coordination in Chart 3.3.

#### **1. Who should be referred for Comprehensive Assessment?**

There is widespread recognition that clients with multiple, complex and unresolved care needs should have access to assessment that is different to other HACC clients. Clients with these care needs are generally identified in the course of INI and related assessment, and a decision made on the basis of all the information that has been collected, not simply by applying a standard measurement scale.

The Victorian HACC Program Manual calls attention to some of the characteristics of clients with high needs. The option of referral to an ACAS has always been available to HACC agencies and clients, and is mandatory for clients seeking a CACP or EACH package, or admission to residential care, including for respite care.

Two indicators of the number and proportion of HACC clients who might be referred for a formalised comprehensive assessment are:

- In 2002-03, some 10 percent of all HACC clients (19,142 people) received personal care and at least one other service.
- ACAS recommended some 8,000 people for a package-level of care in the same year.

## ***2. Is cost of care an indicator of need for comprehensive assessment?***

One of the main reasons for the introduction of mandatory assessment by an ACAS as a prerequisite to admission to residential care in the mid 1980s was to ensure that only clients needing care at this level of cost were admitted. There are now a number of clients in the community whose use of services approximates or exceeds the cost of the lowest level of hostel care. A cost of \$9,041 is equivalent to the lowest care benefit in residential care (RCS 7 in low care), and can conveniently be taken as a threshold for defining "high cost" clients.

Duration of use of services is clearly related to cost. Analyses carried out by DHS indicate that in 2002-03 some 60,500 HACC clients received on-going support defined as appearing in the HACC MDS for all four quarters in a year; 4% or some 2,500 of these ongoing clients reached the high-cost threshold of \$9,000.

Just over 2,000 of these high-cost clients were in the range \$10-39,000; of these, 1,400 were Linkages clients, and Linkages clients had a markedly higher average cost, \$16,700, compared to other high-cost clients.

While the majority of the high-cost clients were aged 70 and over, younger clients were over-represented among the 200 clients in the very high cost group who received services costing \$40,000 a year or more.

High-cost clients who remain in HACC are outnumbered at least 3 to 1 by the 6,571 CACPs in Victoria in 2001-02. This ratio is even higher if limited to frail aged HACC clients, and taking account of the increase in CACPs since mid 2002. There is however no information available as to how many of the frail aged, high cost HACC clients have been assessed for a CACP and are waiting for a place to become available, or on whether some of these clients may have been offered, but declined, a package for one reason or another. Nor is there any information on how many younger, high cost clients are also receiving services from other disability services.

There appear to be good grounds for including cost of services as a trigger for comprehensive assessment. For frail aged clients, assessment by an ACAS would ensure that all clients with this level of need not only receive a consistent assessment but that they are given an equitable opportunity for access to a CACP or EACH. The need for similarly consistent assessment for younger clients is very apparent. The exact cost threshold at which referral for comprehensive assessment is triggered needs careful consideration, because the cost of care received by many HACC clients is severely constrained and may not reflect their full care needs.

## ***3. What factors should trigger comprehensive assessment?***

In the tiered structure for community care proposed by the Australian Government, access to the package level of care is conditional upon a comprehensive assessment. This arrangement is in line with current ACAS assessment for access to a CACP or EACH. The Victorian HACC Departmental Advisory Committee considered the possible triggers for referral for a comprehensive assessment to gain access to the package level of care.

It concluded that:

- No single criterion provides an adequate trigger, nor do strict eligibility criteria have to be specified.
- There is a need for HACC providers and ACAS to collaborate in referrals and assessment for the package level of care so that they have a shared understanding of the value of a care package, in both dollar terms and the extent of care that can be provided.
- Access to funded case management should not necessarily be tied to a care package, so that a client could receive a package with only a very small part of case management, while others who did not receive a care package could receive case management.
- Taken together, the conclusions mean that referral for comprehensive assessment should not be limited to clients who meet particular criteria or those who only want to gain access to a care package. The referrals should also be made when it is considered that a client could benefit from more in-depth assessment in a number of areas. This conclusion matches the situation that currently applies insofar as any client who is frail aged may seek an ACAS assessment.
- As high costs of care can be taken as a summary indicator of a combination of all the factors that might be triggers for a comprehensive assessment, the question that arises is not so much about limiting access to comprehensive assessment, but whether all HACC clients whose cost of care reaches a defined threshold should receive the same kind of comprehensive assessment and how such a requirement could be implemented.
- These considerations warrant further discussion.

#### ***4. Which agencies have the capacity to carry out comprehensive assessment?***

The National Framework for Comprehensive Assessment in the HACC program set out a number of criteria for agencies that equipped them to carry out comprehensive assessment. They were:

##### **A. Agency approach offers:**

- range of staff skills to able to provide multi-dimensional assessment;
- appropriate access and entry points to assessment and continuity of care;
- independence from service provision; and
- common objectives between assessors.

##### **B. Infrastructure characteristics**

- organisational capacity and commitment;
- coverage of geographic area;
- operational framework with systems for referral, case allocation and information sharing;
- training
- reporting
- management structure
- facilities
- quality assurance

These criteria mesh closely with the scope of practice required for comprehensive assessment in service coordination. Application of these criteria in the field provides one approach to identifying agencies that could be designated to take on formal comprehensive assessment. In particular, few HACC agencies have a multi-disciplinary assessment team (including health professionals) comparable to the capacity of ACAS.

## **5. *What tools can support comprehensive assessment?***

The SCTT provides a guide for common practice for collection and transfer of standard information for service coordination, but the SCTT is emphatically NOT an assessment tool.

No single assessment tool or set of tools is mandated for ACAS assessment, although a common suite of tools or “tool kit” are widely used by ACAS, including the Barthel Index, the Mini Mental State Examination and the Geriatric Depression Scale. As well as training in the use of these tools, frequent practice is important in maintaining clinical skill. Again, the tools are aids to decision making that also take a range of other considerations into account, including information gathered in case conferences with carers and other service providers as required. Comprehensive assessment may extend over a considerable time period, and reassessment will be likely in the ensuing 12 months.

DHS has commissioned a project to review existing, validated schedules that provide a single tool for comprehensive assessment with a view to possible use in Victoria. The project findings have not yet been released and in the event that a suitable tool is identified, several further steps would be required before any decision is made as to whether a single tool is recommended for comprehensive assessment.

## **6. *Should comprehensive assessment be independent from service provision?***

ACAS assessments are independent from service delivery as they have no direct part in delivering the services that they recommend. The extent of independence of assessment from service delivery in HACC agencies varies in accord with the model of functioning that has been adopted, ranging from varying degrees of separation in in-house models to external contracting of various components of assessment and/or service delivery. It needs to be recognised that the advantages of independence of assessment are reduced where recommendations on care are made without reference to likely availability of services overall or without any follow-up to ensure that recommended services are delivered to individual clients. Thus, only those who have an ACAS approval can gain admission to a residential care place, but approval does not guarantee that a place will be available, and waiting lists result while these clients continue to be supported through other programs. Similarly, an ACAS recommendation for HACC does not confer any priority of access ahead of clients who have not been assessed by an ACAS.

Recommendations for CACPs are well in excess of available places, so that many clients remain as HACC clients while waiting for a CACP. This is recognised as giving rise to problems for clients and providers. Clients whose need for higher levels of support have been formally recognised in the recommendation for a CACP could reasonably expect to be able to receive such services. While HACC agencies seek to balance such claims against the allocating of resources to meet the needs of other clients, there is no formal ceiling set on the amount or cost of services that a “standard” HACC client can receive. CACP providers face the problem of deciding which among the many clients on the waiting list maintained by the ACAS has the highest priority for admission when a package becomes available. There is a particular tension when providers deliver Linkages as well as other packages as Linkages do not require ACAS assessment or any other form of mandated assessment that is independent of service provision.

## 5.4 Developing options for Comprehensive Assessment

ACAS currently meet the criteria for agencies having the capacity to carry out Comprehensive Assessment set out in the National Framework. Their practice is in accord with the definition of Comprehensive Assessment set out in the Service Coordination framework, and they currently have a considerable role in assessing clients for community care. Referral to an ACAS is not however the automatic or only option for developing a more consistent approach to Comprehensive Assessment in HACC.

### **Issues for Consideration 4: Comprehensive Assessment**

1. On the basis of your experience:
  - who is now and who should be referred for Comprehensive Assessment?
  - what factors are and should be triggers for Comprehensive Assessment?
  - what difference should Comprehensive Assessment make for clients?
  
2. How can your experience inform the formalisation of models for Comprehensive Assessment in HACC, giving consideration to:
  - the need for independence from service provision;
  - how your existing interactions with other agencies and ACAS can be built on to develop preferred models for Comprehensive Assessment; and
  - adjustments in roles of your agency and ACAS that would be required to give effect to the preferred options.