SUMMARY REPORT

EVALUATION OF
AGED PERSONS' MENTAL HEALTH SERVICES'
RESPONSIVENESS TO THE NEEDS OF CONSUMERS
OF RESIDENTIAL AND COMMUNITY BASED
AGED CARE SERVICES

JUNE 2000

LINCOLN GERONTOLOGY CENTRE
LA TROBE UNIVERSITY
BUNDOORA, 3083
PHONE: 03 9479 3700

TABLE OF CONTENTS

Executive Summary	**i**
Part 1: Introduction	**1**
Background	1
Methodology	2
Part 2: Overall Evaluation Outcomes	**7**
Global Scores	7
Domain Scores	9
Performance within each Domain	10
Responsiveness to Consumers in Different Sectors	17
Influence of Contextual Factors	18
Part 3: Individual Indicator Outcomes	**20**
Part 4: Review and Recommendations	**38**
The Evaluation Methodology	38
Summary and Recommendations	39
Conclusion	41

Appendix 1: Evaluation Kit

Appendix 2: Aged care sector questionnaire

Appendix 3: Global Scores by Service and Domain Scores by Service

EXECUTIVE SUMMARY

This executive summary presents the aims, methodology and outcomes from the second round evaluation of the Aged Person's Mental Health Service's responsiveness to the needs of consumers of residential and community based aged care services.

The evaluation reported here is the second stage of a project that aimed to develop and encourage best practice in coordinating client care across the boundaries of the psychiatric and generic aged care sectors. More specifically the project aimed to:

- Conduct a review of the seventeen Aged Persons' Mental Health Services (APMHS)[1] across the State of Victoria in order to assess their responsiveness to the needs of clients who are also clients of residential and community aged care services;
- Provide a comparative analysis of the Services' performance in this area;
- Provide an analysis of changes in responsiveness over the two rounds of the evaluation; and,
- Provide information to each APMHS, which would be useful for the further development of their service quality.

The evaluation design used documented evidence as the basis for rating levels of responsiveness. The rationale for this methodology was based on the assumption that in order to promote ongoing service quality improvement, organisational structures, policies and procedures which underpin responsiveness to shared clients need to be in place.

The preferred methodology for both rounds of the evaluation incorporated the following elements:

(i) The use of an instrument which required each PGATS to rate themselves on those relevant activities and processes of intersectoral collaboration
(ii) The provision of documented evidence to support the self ratings.
(iii) Moderation of the self-ratings by an independent panel to ensure that a consistent approach to ratings was employed across all PGATS.
(iv) Collection of contextual information that could bear on the capacity of the PGATS to perform on the indicators in the evaluation instrument.
(v) Collection of qualitative information from nominated aged care agencies in each PGATS' catchment area to assist in the interpretation of self-ratings.

The self-rating tool used in the 2000 evaluation comprised 17 indicators categorised into four broad areas or domains of responsiveness:

- Domain One: Service Planning and Management
- Domain Two: Service Access
- Domain Three: Case Coordination and Management
- Domain Four: Education and Training

In response to a review following the 1999 evaluation, the self-rating tool used in the earlier evaluation had been modified slightly for the 2000 evaluation. Two indicators were omitted and minor changes were made to two others. A copy of the 2000 Evaluation Tool is included at the end of this report (Appendix 1).

Each indicator was rated on a five point scale with a rating of '1' referring to no evidence of the particular activity occurring to a rating of '5' referring to evidence of comprehensive action undertaken.

[1] Although the project addresses the Aged Persons' Mental Health Services, the evaluation focused on the Psycho-geriatric Assessment and Treatment Service (PGATS) components of these Services as these teams operate at the interface with the generic aged care sector.

An overall or global index of responsiveness was derived by summing ratings across the indicators. Domain or sub-scale scores were derived by averaging indicator ratings in each of the domains described above. Comparisons of global indices are also made between the 1999 and the 2000 evaluation results. To account for the fact that there were 19 indicators rated in 1999 and only 17 indicators rated in 2000, a 2000 ‘adjusted’ global score was calculated and reported where appropriate.

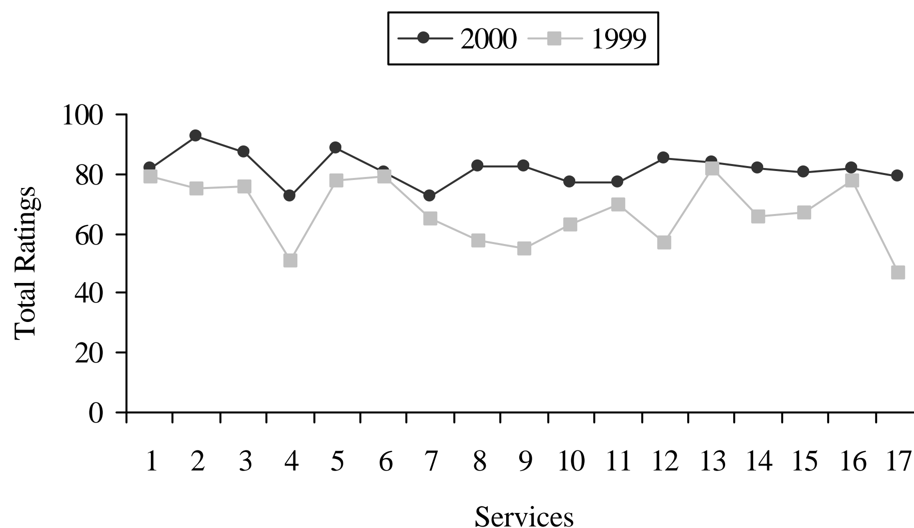
RESULTS

The average global score on the evaluation tool for the 2000 evaluation was 73.0 out of a possible 85 with an average indicator score of 4.3. This is a positive outcome which indicates that overall the sector has developed protocols and procedures that reflect and support the type of collaborative activities which underpin PGATS' capacity to be responsive to the needs of clients who are also clients of residential and community aged care services.

This very positive result is in the main supported by the feedback received from ACAS, community and residential agencies regarding the PGATS’ performance on the key responsiveness indicators.

The services made significant improvements in responsiveness over the two evaluation periods. The average global rating increased by approximately 14 points and the average indicator score increased from 3.5 in 1999 to the 4.3 observed in 2000. This result indicates that the overall level of performance in the areas of responsiveness has improved to the point where action is now more likely to be occurring on a systematic basis as opposed to the previous year where much activity was ‘one-off’ or piecemeal. Moreover this improvement has been across the system: all teams showed improvement over the evaluation period. These changes in global scores from the previous year are shown in the Figure below.

Comparison of 1999 and 2000[1] global scores



[1] Adjusted 2000 global index

Results indicate not only an overall improvement in responsiveness but also less variability between services in 2000 than was the case in the earlier evaluation.

A comparison of Domain scores over the two rounds of the evaluation results show that the two key areas where improvement occurred were case management and coordination, and clinical education. In the area of case management, for example, improvement in collaborative involvement with community care providers and ACAS reflected substantial efforts by PGATS to evidence and improve their work in this area. Likewise the gains in the provision of clinical education occurred more in these two areas than with residential care providers, again demonstrating successful efforts by PGATS' to improve their responsiveness to these two sectors.

Evidence provided to the Panel as well as feedback from ACAS and the other generic aged care agencies suggest that improvement in responsiveness reflect actual changes in practices.

Notwithstanding overall improvements, comments from teams and generic agencies suggest that the capacity of many teams for improvement in responsiveness is limited by resources available to the team. The relative rankings of the teams, particularly the low ranking of the smallest teams at least in part reflects this factor.

RECOMMENDATIONS

The two rounds of the evaluation have been effective in promoting the development or refinement of protocols and processes which are likely to facilitate PGATS' responsiveness to the needs of clients who are also consumers of generic aged care services. In order to maintain and further improve service quality in this area, it is recommended that internally driven quality improvement activities which address some or all of the key responsiveness indicators used in the evaluation be put in place.

Development of a quality improvement framework

Specifically, it is recommended that a quality improvement framework be developed which addresses PGATS' ongoing responsiveness to the needs of consumers of generic aged care services.

The quality improvement framework could include the following elements:

- key processes for achieving a more responsive service including organisational commitment, vision and planning, and, participation by key consumer groups e.g. aged care agencies, GPs and client/carer at a variety of levels.
- indicators or areas of responsiveness.
- monitoring of responsiveness.
- evidence of service improvement as a result of monitoring and QI activities.
- reporting/accountability procedures.

Aged care agency and client/carer participation in service development

PGATS, like any other service providers, should be encouraged to involve consumers, including clients/carers, aged care providers and GPs, in strategic planning and service development and have to account for the extent to which these groups have been involved in these activities.

Quality improvement activities should incorporate qualitative feedback from all PGATS consumers as noted above. The Mental Health Branch has conducted annual client/carer satisfaction surveys which address a range of client/carer issues. The experience of this evaluation

design suggests that feedback from agencies has been one of the most useful influences on service development and delivery.

In addition, feedback should be sought from clients and families themselves in relation to the effectiveness of the collaborative relationship between PGATS and generic aged care services. This is an area that was not included in this evaluation for a variety of reasons, but should in the future be central to any service evaluation as responsiveness is only desirable if it produces better outcomes for clients and carers.

Areas of responsiveness should incorporate the indicators in the 2000 Evaluation

The indicators developed for the 1999 and 2000 evaluations should be considered as the initial set of indicators around which quality improvement activities are focussed. The indicators used in the two evaluation rounds were derived from a comprehensive review of service requirements and broad consultation and they have been generally accepted as encompassing the main elements of service responsiveness.

Information exchange between PGATS

Consideration should be given to establishing processes or structures that would facilitate discussion and sharing of ideas regarding quality improvement between the Services. Again the current evaluation demonstrated that interchange between teams was very useful in promoting good practice across the sector.

CONCLUSION

In conclusion, this Evaluation process, developed as part of Mental Health Branch's Quality Incentive Strategy, has provided a good foundation for quality improvement in services to clients who are also consumers of generic aged care services. Focus on integration and coordination of services around individual clients is consistent with the Department's Primary Care Partnership reforms. This is clearly an extremely important area for ongoing quality improvement aimed at achieving the best outcomes for individual clients.

Finally, we would like to thank the PGATS themselves for contributing to the development of the tool, for their feedback in revising the tool and for the substantial effort that individuals have put into developing protocols and procedures which evidence their responsiveness to the aged care sector. Preparing such high quality submissions is extremely time consuming, and the PGATS are to be congratulated for finding the time to do this amongst the many other demands placed on their time. It is hoped that in the long run this process will result in better collaborative relationships with aged care and community providers which in turn result in better outcomes for clients.

PART ONE: INTRODUCTION

BACKGROUND

The project has the broad aim of developing and encouraging best practice in coordinating client care across the boundaries of the psychiatric and generic aged care sectors. More specifically the project aimed to:

- Conduct a review of the seventeen Aged Persons' Mental Health Services (APMHS)[2] across the State of Victoria in order to assess their responsiveness to the needs of clients who are also clients of residential and community aged care services;
- Provide a comparative analysis of the Services' performance in this area; and,
- Provide information to each APMHS, which would be useful for the further development of their service quality.

Over the last several years, Victoria's public mental health services have undergone significant reform aimed at improving the provision of mental health care so that services are more effective and responsive to consumer needs.

Starting in the 1996/97 financial year the Mental Health Branch has conducted a wide ranging Quality Incentive Strategy providing financial incentives for the provision of high quality mental health services. The Quality Incentive Strategy complements the work being undertaken on performance indicator development and consumer outcome measurement and was designed to add significantly to the range of data available to inform policy and service development. As an ongoing initiative of the Mental Health Branch, each financial year service responsiveness to specified consumer issues has been measured; initially evaluation focussed on adult mental health services and more recently the child and adolescent and aged persons' mental health services have been the focus of evaluation efforts.

The measures specified for 1998/99 included an evaluation of the service responsiveness of aged persons' mental health services to the needs of consumers who are also clients of residential and community aged care services. The evaluation was to be conducted over a two year period. The first round evaluation in February 1999 and the second round in February 2000.

This is the second year of the evaluation of APMHS's responsiveness to the needs of consumers of residential and community services. In carrying out this project, the Lincoln Gerontology Centre developed a methodology and an evaluation tool in 1998/99 in preparation for the first round evaluation.

[2] Although the project addresses the Aged Persons' Mental Health Services, the evaluation focused on the Psycho-geriatric Assessment and Treatment Service (PGATS) components of these Services as these teams operate at the interface with the generic aged care sector.

METHODOLOGY

The project required the development of a methodology, including data collection tools and incorporation of qualitative data, to evaluate service responsiveness. A more comprehensive description of the methodology including instrument development is contained in the 1999 reports and a summary only is presented here.

It was recognised that the evaluation methodology needed to be developed in consultation with the APMHSs and other stakeholders in order to maximise quality improvement outcomes. Intensive consultations were held with the following groups in the development of the evaluation tool:

- Department of Human Services
- PGATS
- Generic aged care sector

As indicated above, this evaluation focused on the responsiveness of the PGATS' component of APMHS. This report will therefore refer directly to PGATS not APMHS.

EVALUATION DESIGN

The evaluation was designed to measure PGATS' responsiveness to consumers of aged care services using documented evidence as the basis for rating levels of responsiveness. The rationale for this methodology was based on the assumption that in order to promote ongoing service quality improvement, organisational structures, policies and procedures which underpin responsiveness to shared clients need to be in place.

The preferred methodology incorporated the following elements:

(i) The use of an instrument which required each PGATS to rate themselves on those relevant activities and processes of intersector collaboration which facilitate responsiveness to the needs of consumers who are also clients of the generic aged care sector.
(ii) The provision of documented evidence to support the self-ratings.
(iii) Moderation of the self-ratings by an independent panel to ensure that a consistent approach to ratings was employed across all PGATS.
(iv) Collection of contextual information regarding local organisational and environmental factors that could bear on the capacity of the PGATS to perform on the indicators that form part of the evaluation instrument.
(v) Collection of qualitative information from nominated aged care agencies in each PGATS' catchment area to assist in the interpretation of self-ratings.

THE EVALUATION TOOL

The evaluation tool consisted of two parts: The first part, Part A, was designed to collect contextual information including questions on service location, staffing, organisational arrangements with ACAS, and client living arrangements. The second part, Part B, comprised the Self Evaluation Instrument. This required the teams to rate themselves, and provide supporting documentation, on a series of activities or indicators in each of following four key domains:

Domain One: Service Planning and Management

This domain covered the extent to which service planning and management achieves integration and coordinated care between PGATS and the Aged Care Assessment Services (ACAS), residential and community care service providers.

Domain Two: Service Access

This domain covered both PGATS' availability and accessibility, target group definition, timely and consistent responses to referrals and requests for secondary consultations.

Domain Three: Case Coordination and Management

This domain addressed ways in which PGATS ensures continuity of care, minimisation of duplicate processes, shared development of care plans, interagency case conferences, collaborative case management with aged care providers, management of complaints and crisis management.

Domain Four: Education and Training

This domain sought to identify the extent to which PGATS provide ongoing education and training opportunities to its own workers and clinical education to workers in the aged care sector.

Indicators of key activities which reflected performance in each of these domains were developed according to two criteria, viz. (a) the likely importance or key nature of the particular activity for intersector collaboration and hence capacity to be responsive to client needs and, (b) the likelihood of being able to reliably measure this indicator.

The instrument reflected three additional considerations:

(i) it was decided that at least for some indicators, the PGATS' relationships to the community aged care sector, residential aged care sector and ACAS would need to be rated separately,

(ii) consistent with good measurement theory, the importance of an activity would be reflected in terms of the number of indicators that could be rated rather than by developing differential weightings for indicators, and

(iii) quality improvement indicators would be incorporated into each domain where appropriate rather than considering quality improvement as a separate domain.

The 1999 version of the evaluation tool consisted of nineteen key activities or indicators. Three of these indicators were in the domain of Service Planning and Management, five were in the domain of Service Access, six in the Case Coordination and Case Management domain and five were related to Education and Training.

In response to a review of the instrument and feedback and consultation with stakeholders following the 1999 evaluation (see below), the instrument was modified slightly for the 2000 evaluation. Two indicators, one from the Service Planning and Management domain and one from the Education and Training domain, were omitted for the 2000 version and minor changes were made to two others. A copy of the 20000 Evaluation Tool is included at the end of this report (Appendix 1).

Each indicator was designed to be rated on a five point scale with a rating of '1' referring to no evidence of the particular activity occurring nor of a documented plan to develop the activity, and a rating of '5' referring to evidence of systematic and comprehensive action undertaken. In

addition to these broad generic criteria, for each rating point a detailed rating Guide for each specific indicator was developed which provided examples of the type of evidence required to support the ratings.

An overall or global index of responsiveness was derived by summing ratings across the indicators. Domain or sub-scale scores were derived by averaging indicator ratings in each of the domains described above. Comparisons of global indices are also made between the 1999 and the 2000 evaluation results. To account for the fact that there were 19 indicators in 1999 and only 17 indicators in 2000, a 2000 'adjusted' global score has been calculated and reported where appropriate. The adjustment is simply a multiplication of the 2000 global score by a factor of 19/17 to derive a score that can be compared with the 1999 index.

IMPLEMENTING THE YEAR 2000 EVALUATION

Refining the evaluation tool

Representatives from all teams were invited to a forum held by the Mental Health Branch on 25th of August 1999, at which the consultants presented an overview of the 1999 evaluation and sought feedback on both the process and content the evaluation. Following this forum the consultants wrote to all teams describing the timelines and processes for the next evaluation round and inviting comments on how the evaluation could be improved; most teams were also contacted by telephone. In light of feedback received from these activities and the consultants' own internal review, minor modifications to the evaluation kit were proposed for 2000 evaluation. These proposals were circulated to the Department and all teams for comment in mid-November 1999. The final modifications to the instrument for the 2000 evaluation included:

- Minor changes to the generic criteria for ratings 2 and 3 in order to clarify the difference between these ratings;
- A reduction in the number of indicators from 19 to 17 as a result of omitting one of the indicators in the Service Planning and Management domain and combining two indicators in the Education and Service domain;
- Change of wording of some indicators to make meaning more explicit;
- Provision of more explicit guidance about the quantity and type of evidence required to rate a 3, 4 and 5 particularly for domain three indicators; and,
- Revisions to the Guide to completing the ratings to include examples of the types of evidence provided by teams who scored well in the 1999 round.

The finalised evaluation kits were forwarded to all teams by 18th December 1999 with a deadline of 1st of March 2000 for receipt of completed submissions. This allowed more time for teams to complete their submissions compared to the first round evaluation in 1999. Consultants contacted all teams to assist in preparation of submissions.

Survey of relevant generic aged care agencies

Each PGATS was invited to provide an updated list of the residential and community care aged care agencies with which they have regular contact regarding client referrals and clients in common. A minimum of six residential care agencies and four community agencies were requested; the PGATS were also asked to identify their local ACAS. At least four residential care providers, three community based providers, and the relevant ACAS in each PGATS' catchment were surveyed and invited to comment on aspects of responsiveness and make suggestions of areas that could be improved.

The survey solicited the agency's views on the areas of collaboration with the local PGATS relating to responsiveness to client needs. A selection of indicators from the evaluation tool

formed the basis of the questionnaire instrument but qualitative information on good practice and areas that could be improved rather than numerical ratings was sought.

A copy of the aged care sector questionnaire is included as Appendix 2.

Operation of the evaluation panel

The Panel consisted of three voting members, Dr Frank Charlton, Ms Susan Koch and Ms Sue Rosenhain, and two non-voting members, Associate Professor Peter Foreman and Ms Heather Russell. This was the same Panel as that used for the 1999 evaluation.

Dr Frank Charlton is a Research Fellow at the Lincoln Gerontology Centre, La Trobe University. He is a graduate of Melbourne University and the University of Oregon where he completed his doctoral studies. In the 8 years he has been with the Lincoln Gerontology Centre he has undertaken a range of research and evaluation projects in the aged care area. These include the ongoing evaluation of the Victorian Aged Care Assessment Program and the national evaluation of the Transition Care Packages pilot projects. In 1997 he led a project to develop a national framework for comprehensive assessment in the HACC Program. Dr Charlton brought to the panel a high level of expertise in evaluation methodology.

Ms Susan Koch is a senior lecturer in the School of Nursing at La Trobe where she currently has the role of Director of Undergraduate studies. Ms Koch’s research activities have been in the area of care of older people with dementia and she has undertaken consultancies in quality improvement in nursing home care. Ms Koch is a member of the Alzheimer's Association (Vic) Management Committee and a member of a local Care Support Group. She brought to the panel both a good understanding of client issues in the area of psychogeriatric care and of service quality issues in this field.

Ms Sue Rosenhain is currently employed as Service Manager, Health Promotion and Quality with Eastern Access Community Health. She has graduate qualifications in Health Education and has undertaken formal training in Quality Management in Health and Quality Review of Community Health and Support Services. Ms Rosenhain has been a reviewer for the Australian Health and Community Services Standards Program (formerly CHASP) from 1990 -1997 and a Review Manger for the Quality Improvement for Community Services Accreditation program during 1998/00. In these roles Ms Rosenhain has been extensively involved in reviewing health organisations in the areas of quality standards and performance indicators.

The Panel had been briefed and given a copy of the Evaluation Kit that had been previously distributed to the PGATS. When submissions from Services were received they were first checked by the consultants for completeness (and omissions followed up where necessary), copied and sections forwarded to Panel members who independently read them prior to the meeting. Panel members were asked to focus on the relationship between documentary evidence and self-rating of indicators. This involved reviewing all material supplied for each indicator and evaluating the self ratings against the following criteria:

- The relevance and scope of the evidence with respect to the indicator,
- The rating guidelines supplied for each indicator, and
- Consistency across the 17 Services.

Panel members were requested to identify self-ratings they felt were inappropriate in light of these criteria.

The Panel met at La Trobe University on March 15th and 22nd. Panel members reviewed all self-ratings. The Panel's task was to ensure that a consistent approach to the relationship between

documentary evidence and rating of indicators was being applied. Panel decision-making was by consensus rather than voting.

In general there was a substantial degree of agreement between self-ratings and Panel judgements; The Panel review resulted in 89 of the 289 self-ratings being revised (18 ratings were upgraded, 71 were downgraded).

All amended ratings were forwarded to the relevant services for comment. Comments or further documentation or both were received in regard to 20 of the 89 proposed changes and the Panel modified seven ratings as a consequence.

PART TWO: OVERALL EVALUATION OUTCOMES

The general standard of the submissions was high with teams obviously going to a great deal of effort to both describe their activities on each indicator and to gather the relevant documentation to support the self-ratings. Compared to the first round evaluation, the submissions were better organised and, in general, included a broader range of relevant documentation.

Consistent with the aims of the evaluation the Panel looked for a range of evidence for each indicator including demonstrated use of protocols, local applications of auspice protocols and policies and up-to-date policies and procedures.

GLOBAL SCORES

The average global score on the evaluation tool was 73.0 out of a possible 85. The scores ranged from 83 to 65 with a standard deviation of 4.62. Over all 17 indicators, the State wide average rating was 4.3. This average can be interpreted by reference to the generic criteria used for the five point rating scales on the evaluation instrument:

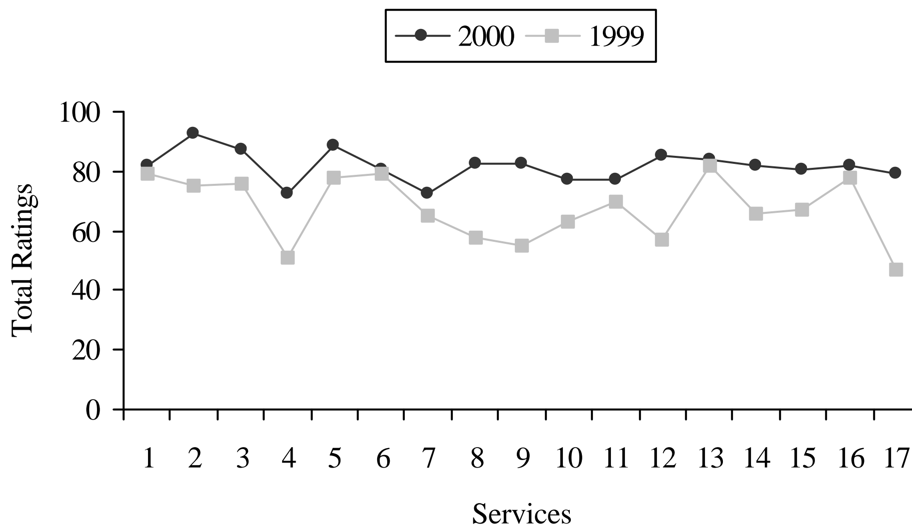
- A rating of 'four' was defined generically as, *Systematic action taken to address the indicator but limited in scope,* meaning that objective evidence showed the indicator was being systematically addressed but not in all relevant cases, locations or circumstances.
- A rating of five was defined generically as, *Action taken to address the indicator which is comprehensive*, meaning that the evidence suggests that the indicator is being systematically addressed across the range of possible applications of that indicator.

System wide an average global rating of 73.0 is a very positive outcome. This result indicates that the sector as a whole is implementing organisational practices and procedures that underpin PGATS' capacity to be responsive to the needs of clients who are also clients of aged care services.

Comparison with 1999 performance

As measured by the methodology employed in this evaluation, the Aged Persons' Mental Health Services have demonstrated a commendable degree of responsiveness to the needs of consumers of residential and community based aged care services. A comparison with performance on the instrument in 1999 indicates that overall the services have made significant improvements in responsiveness since the previous evaluation. The average global rating has increased from 67 to 82 (adjusted to take account of lesser number of indicators on the 2000 instrument) with the average indicator score increasing from 3.5 in 1999 to 4.3 in 2000. Moreover, this improvement was across the system: all teams showed improvement over the evaluation period. These changes are illustrated in Figure 1 below.

Figure 1: Comparison of 1999 and 2000 global scores



Not only has the overall level of performance increased but variation across all teams has substantially reduced from 1999 to 2000. In 1999 the global scores ranged from 47 to 82 with a standard deviation of 10.9; in 2000 the range of global scores was 65 to 83 and the standard deviation 4.62. In other words, as well as an overall improvement, the difference in scores between the teams has narrowed.

It was to be expected that scores would improve as services became more familiar with the evaluation requirements and benefited from the experience of putting together the first submission. As we noted in the 1999 report "…..We would therefore expect a significant improvement in scores and a narrower range of scores in the next evaluation round as teams focus their attention on their activity in this area and documenting this activity" (p.19 Individual Reports 1999).

It is the case that the 2000 submissions were, overall, better organised and demonstrated better use of available documentation. There is little doubt that at least part of the improvement reflected in the above graph can be attributed to improved preparation and presentation of submissions. More importantly, improvement is due to the teams evidencing real changes in processes, procedures and practice. The Panel noted that many teams had included new protocols for various indicators in the 2000 evaluation. In discussion with teams during site visits by the consultants it was apparent that many teams had been reviewing their documented procedures and in some instances sharing of effective protocols and procedures between teams had occurred.

Although all teams improved their performance, improvements were not equally distributed across the teams with a clear trend for the lower scoring teams in 1999 to show the greatest gains. This is illustrated in Table 1 below.

Table 1: Gains in Global Index from 1999 to 2000 for each PGATS

Global Index 1999	Global Index 2000 (adjusted)	Change
47	79	32
51	73	22
55	83	28
57	85	28
58	83	25
63	77	14
65	73	8
66	82	16
67	80	13
70	77	7
75	93	18
76	87	11
78	82	4
78	88	10
79	80	1
79	82	3
82	84	2

Table 1 shows the 1999 and 2000 global indices for each of the seventeen PGATS and the change in scores over the two evaluations. Scores are arranged from lowest scoring to highest scoring teams on the basis of 1999 evaluation.

DOMAIN SCORES

Table 2: Average Domain scores for both 1999 and 2000 evaluations

	Mean 1999 Score	Range 1999	Mean 2000 Score	Range 2000
Domain 1 Planning and Management	3.8	2.7 – 4.3	4.7	4.5 – 5.0
Domain 2 Service Access	3.8	2.8 – 4.8	4.2	3.4 – 5.0
Domain 3 Case Coordination and Management	3.4	1.7 – 4.2	4.3	3.8 – 5.0
Domain 4 Education and Training	3.3	2.4 – 4.4	4.2	3.3 - 5.0

Table 2 presents the average and range of domain scores across all seventeen PGATS.

This Table suggests that improvements have occurred in all domains with more or less equal gains in the Planning and Management, Case Coordination and Management, and Education and Training domains. In the Service Access domains gains were approximately half of that noted in

the other three domains. This is partly a ceiling effect in that domain two was one of the two highest scoring domains last year so there was less overall capacity for improvement. The result is also due to changes in the evidence that was required for two indicators in this domain compared to the previous year. With Indicator 2.1 (target group identification and communication), the panel expected to see not only good communication of the target group to the aged care sector but evidence of a negotiated process when clients are not accepted as PGATS clients. Many teams did not evidence this element of the indicator and therefore did not rate a '5'. Likewise Indicator 2.5 (quality improvement activities in service access) changed slightly from the 1999 Evaluation to include monitoring of client characteristics of the PGATS catchment. Many teams did not evidence this activity.

As with the global score, there is less variability within domain scores obtained in the 2000 evaluation compared with those recorded in the 1999 evaluation round.

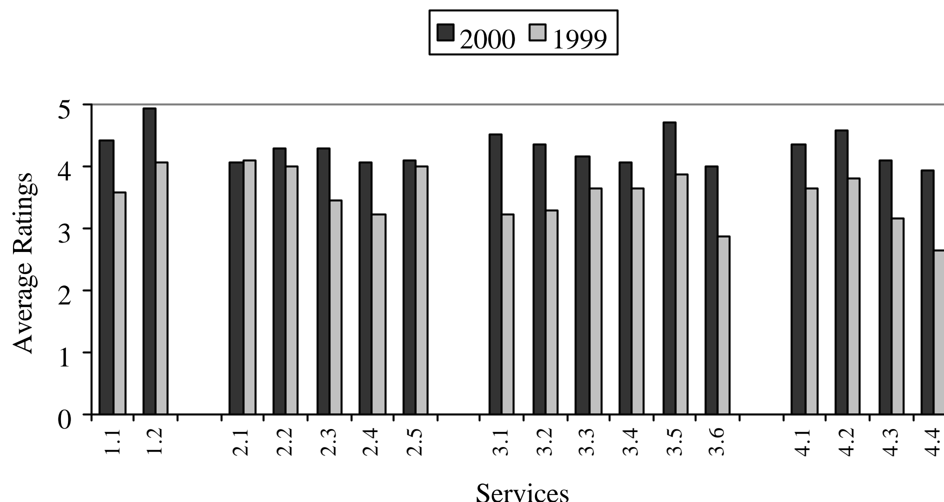
PERFORMANCE WITHIN EACH DOMAIN

To provide an overview of how the sector was performing within each of the four domains or areas of responsiveness, the average scores on each of the 17 indicators are reported in Figure 2 below. 1999 averages are included for comparison.

A summary is presented of the overall performance in each of the four domains of Service Planning and Management, Service Access, Case Coordination and Case Management and Education and Training.

What was identified as good practice in each of the seventeen indicators is also presented in this section to provide a benchmark to facilitate interpretation of the rating scores.

Figure 2: State Average Indicator scores for 1999 and 2000 evaluations



Domain One: Service planning and management

Table 3: Average and range of indicator ratings in the Service Planning and Management domain

	Indicator	Average	Range
1.1	The service has a strategic plan for developing and improving cooperative and collaborative links between PGATS and the aged care sector	4.4	4-5
1.2	Participation in management and/or service planning and development activities via meetings with ACAS, residential and community care provider managers or via regional or sub regional aged care forums.	4.9	4-5

Table 3 presents the performance of the sector on the indicators that made up the Service Planning and Management domain.

Good practice

High scoring teams on domain one indicators evidenced the following processes or practices in their submissions.

- Indicator 1.1: A relevant strategic plan, which included a time line and action components; evidence that others contributed to the development of the plan, and evidence that elements of the plan were in place.

- Indicator 1.2: Activities and meetings attended which covered a cross section of providers and which involved a wide range of staff, and evidence that the meetings were relevant to the strategic plan.

Summary of system performance in the Service Planning and Management domain

This was the highest scoring domain indicating that appropriate planning processes appear to be well established and documented in Services. Participation in service development and aged care provider meetings was the highest scoring indicator across all domains, suggesting regular participation by PGATS in ACAS, community and residential providers' forums. The average rating for strategic planning was only slightly lower than this. Strategic planning for responsiveness to consumers in the aged care sector was evident in all teams with only little variation in the explicitness and comprehensiveness of planning across teams. This finding augurs well for the maintenance of responsiveness in the future.

Domain Two: Service Access

Table 4: Average and range of indicator ratings in the Service Access domain

	Indicator	Average	Range
2.1	The service has clearly identified and communicated the PGATS' target population to the aged care sector together with written protocols for negotiating positive outcomes for clients where referrals are not accepted by the service.	4.1	3-5
2.2	Provision of a timely, appropriate and consistent response to consumers who are referred from ACAS, residential care and community care	4.3	3-5
2.3	Referral processes between ACAS and PGATS avoid duplicate procedures	4.3	3-5
2.4	Secondary consultation: Evidence that the PGATS provide assistance to ACAS, community service providers or residential care providers about clients of these agencies where the clients are not registered or seen by the PGATS	4.1	3-5
2.5	Quality Improvement: Evidence that PGATS identify the characteristics of client target group in their catchment and monitor the effectiveness of their service access processes. Evidence that data from both these sources is used to improve responsiveness	4.1	3-5

Table 4 presents the performance of the sector on the indicators that made up the Service Access domain.

Good practice

High scoring teams on domain two indicators evidenced the following processes or practices in their submissions:

- Indicator 2.1: More than one piece of evidence for communicating their target audience e.g. brochures, or protocols which included a statement about a negotiated process to achieve positive client outcomes where referrals are not accepted as registered clients. Other evidence included communication of the target group via meetings or seminars.
- Indicator 2.2: Target response times, consistency of approach, referral processes, and coverage of ACAS, community and residential care. Evidence of monitoring responsiveness targets.
- Indicator 2.3: Processes such as common referral forms, common assessment forms, common intake systems, joint assessments, common client files, and guidelines for transfer of information.

- Indicator 2.4: Guidelines for provision of secondary consultation, evidence of provision of secondary consultation to ACAS, residential care, community care and evidence of monitoring secondary consultations.

- Indicator 2.5: Evidence of monitoring client characteristics across the service, access issues, response times, and secondary consultations. QI activities that were wide in scope, systematic rather than 'one off', and resulted in consultations with the aged care sector to improve processes.

Summary of system performance in the Service Access domain

Although levels of performance on these indicators were quite high, this domain showed the least improvement from 1999 to 2000 for reasons cited above. This result suggests that there may be room for further improvement on these indicators. A review of the Panel comments indicate this could occur in two areas in particular:

- Better documentation of protocols for negotiating positive outcomes where referrals are not accepted by the service
- Building the monitoring of response times and secondary consultations into quality assurance mechanisms as well as systematising quality improvement activities in consultation with the aged care sector.

Whilst the qualitative survey feedback noted the need of improvements in service access in at least some teams, there were also very positive comments about PGATS timely response to referrals, their accessibility, and their willingness to provide secondary consultations and advice: *Staff are always available for secondary consultation and are very willing to discuss concerns* (Community agency).

The evaluation showed that improved documentation of referral processes between ACAS and PGATS has occurred, a result confirmed by feedback from ACAS.

Domain Three: Case Coordination and Case Management

Table 5: Average and range of indicator ratings in the Case Coordination and Case Management domain

	Indicator	Average	Range
3.1	Collaboration and shared processes occur in the assessment and care plan development of clients (including carers if applicable) where clients are also clients of the ACAS.	4.5	3-5
3.2	Collaboration and shared processes occur in the assessment, care planning and case management of clients (including carers if applicable) who are also clients of community aged care services	4.4	4-5
3.3	Collaboration and shared processes occur in the assessment, care planning and case management of clients (including carers if applicable) where clients are also residents in aged care facilities)	4.2	3-5
3.4	Strategies and processes are in place for the provision of crisis management to clients living in the residential/community aged care sector	4.1	3-5
3.5	Strategies & processes are in place for the resolution of complaints that arise out of management of clients who are also supported by aged care agencies.	4.7	4-5
3.6	Quality Improvement: Evidence that collaborative processes for case coordination and case management are monitored and data utilised to improve service responsiveness.	4.0	2-5

Table 5 presents the performance of the sector on the indicators that made up Case Coordination and Case Management domain.

Good practice

High scoring teams indicated their performance on domain three indicators by evidencing the following processes or practices in their submissions:

- Indicator 3.1: Two or more de-identified case notes together with evidence of protocols for joint or shared processes of more than one type e.g. joint/shared assessment, common assessment tools, guidelines for transfer of information, and attendance at case conferences.

- Indicator 3.2: Collaborative processes followed all the way through from referral to discharge. Two or more de-identified case notes together with evidence of protocols for joint or shared processes of more than one type eg. joint/shared assessment, collaboration over care plan development, guidelines for transfer of information, and attendance at case conferences. Evidence included excerpts from policy and procedures manuals, program planning/business plans. Evidence of PGATS' role following transfer from acute settings.

- Indicator 3.3: Collaborative processes followed all the way through from referral to discharge. Two or more de-identified case notes together with evidence of protocols for joint or shared

processes of more than one type eg. joint/shared assessment, collaboration over care plan development, guidelines for transfer of information, and attendance at case conferences. Evidence included excerpts from policy and procedures manuals, program planning/business plans. Evidence of PGATS' role following transfer from acute settings as well as knowledge of consumer rights in aged care.

- Indicator 3.4: Response times for crisis management, monitoring of crisis situations, guidelines/protocols for differentiating between urgent/non-urgent clients, evidence of arrangements for 24 hour coverage and feedback/debriefing of aged care staff.

- Indicator 3.5: Local policies for consumer complaints procedures, evidence of processes for the resolution of complaints, consumer policies with review dates, statement of rights and responsibilities, and information folders for consumers.

- Indicator 3.6: Evidence of a quality improvement cycle for collaborative assessment and case management which included systematic review of written policies and protocols followed by evidence of improvements made.

Summary of system performance in the Case Coordination and Management domain

Results in this domain showed substantial improvement from those obtained in the 1999 evaluation. An examination of the submissions indicated marked improvement in documentation of collaboration and shared processes in the management of clients who were receiving services from other sectors. Improvement here probably also reflects the clarification of what types of evidence were required to substantiate ratings for the 2000 evaluation. Scoring on quality improvement activities in this domain (average score of 4.0 compared to 2.9 in 1999), indicates that more systematic attention is being paid to monitoring and evaluating PGATS' coordination and case management of individual clients who are also clients of the generic aged care sector. However, further developments in this area are possible. Survey responses suggested that in some teams at least, the quality of collaboration varied across team members. Processes for the management of complaints and crises are generally well documented in all services, but responses from the qualitative survey raise questions about the extent to which these guidelines are being communicated across the sector e.g. '*I don't know of formal procedures for complaint'* (Community agency) , *' ..have not seen documentation for clear strategies for crisis '(*SRS).

Domain 4: Education and Training

Table 6: Average and range of indicator ratings in the Education and Training domain

	Indicator	Average	Range
4.1	PGATS staff participate in continuing education and training on social and medical aspects ageing and are kept up-to-date with developments and local service availability in the aged care	4.4	3-5
4.2	Provide professional clinical education sessions for residential aged care providers	4.6	3-5
4.3	Provide professional clinical education sessions for community care providers	4.1	3-5
4.4	PGATS include ACAS in professional clinical education sessions organised within their auspice's clinical program	3.9	3-5

Table 6 presents the performance of the sector on the indicators that made up Education and Training domain.

Good practice

High scoring teams indicated their performance on Domain Four indicators by evidencing the following processes or practices in their submissions:

- Indicator 4.1: Evidence of a continuing education and training policy, identified resources, a systematic program of staff education and training, an aged care resource file, evidence of attendance at aged care forums and information sessions, transfer of information to other staff. Evidence that these programs and resources are reviewed and updated accordingly.

- Indicators 4.2 and 4.3: Evidence of a cycle of systematic assessment of clinical education needs for each sector, training programs provided which are specific to these local area needs and provided within an overall plan and framework, and evaluation of these programs.

- Indicator 4.4: Evidence of a regular program of clinical education, planned in conjunction with ACAS and evaluated and updated accordingly.

Summary of system performance in the Education and Training domain

Substantial improvement over the 1999 performance was recorded in the education and training domain. The pattern of results showed more evidence of residential care providers (average indicator score 4.6) receiving formal clinical education than community agencies (average indicator score 4.1) or ACAS (average indicator score 3.9). It was particularly pleasing to note that, unlike 1999, a number of teams were scoring '5' on these indicators. This suggests that in these teams the education programs were being provided within an overall framework, based on a needs analysis of the aged care sector, and that programs were reviewed and evaluated. Again, however, comments received in the survey suggest that the promotion of these programs to all relevant providers may not be occurring in some areas. Some providers were not aware of education sessions offered by the PGATS, or commented that they would like to be involved in planning the content of education sessions.

RESPONSIVENESS TO CONSUMERS IN DIFFERENT SECTORS

The evaluation tool includes some indicators that refer to PGATS' relationship with specific elements of the aged care sector, i.e. some of the collaborative activities and process assessed by the tool are specific to ACAS, the aged care residential or community aged care sectors. Indicator 3.1 refers to collaborative and shared processes in the assessment and care plan development where clients are also clients of the ACAS. Indicator 2.3 addresses duplicate referral procedures between PGATS and ACAS. Indicator 3.2 refers to comparable collaboration and processes in relation to clients who were also clients of community aged care services. Indicator 3.3 tapped these relationships with the residential care sector. Similarly, within Domain 4, indicators 4.2, 4.3, assessed the extent to which the Service provided professional clinical education to residential aged care providers and community care providers respectively and 4.4 related to the extent to which the teams included ACAS in their professional education sessions. These specific indicators allow a comparative analysis of responsiveness to clients in the three service sectors. The 1999 evaluation suggested that PGATS' were more responsive to the needs of consumers in the residential sector who are also clients of PGATS both in case collaboration and provision of clinical education, than they were to the needs of consumers in community care settings. Table 7 below presents the 2000 data on these sector-specific indicators.

Table 7: Mean scores for ACAS, community and residential agency specific indicators

Indicator	ACAS	Community	Residential
Minimise duplicate processes	4.3	-	-
Case collaboration	4.5	4.4	4.2
Provision of clinical education	4.1	4.1	4.6

Table 7 presents the average rating over all seventeen PGATS of those indicators specific to relationships to ACAS, community aged agencies and residential aged care organisations.

The results show that, with regard to the case collaboration indicators, the bias apparent in the 1999 findings is no longer evident; collaborative activities with the community sector look to have improved. Given that the average breakdown of PGATS' clients' living arrangement is 56.8 per cent living in the community, 37.3 per cent living in residential care and 5.9 per cent in inpatient care this is a very positive development and suggests that the feedback from the 1999 evaluation report has had an impact on team practices in this area.

Results from the first two ACAS indicators, minimisation of duplication and shared processes in case coordination and management, scored 4.3 and 4.5 respectively, close to the overall average indicator score and comparable to average scores for the other sectors. Results shows that documented processes between ACAS and PGATS have increased significantly since the last evaluation (See Figure 2).

Part A of the Evaluation Tool asked teams to note the number of referrals received *from* ACAS in the past six months. The average number of referrals was 30.1 although if one outlier of 144 is excluded the average is 22.5. Of the thirteen teams who were able to provide information on referral *to* ACAS the average number was 19.4. This data is evidence of significant crossover of clients between these two areas and confirms the need for good communication, minimisation of duplication and good collaborative effort in assessment and care planning.

As in the 1999 evaluation the results from this round suggest that in the provision of clinical education, PGATS were still more responsive to the needs of consumers in the residential sector than they were to the needs of consumers in community care settings or ACAS. However substantial improvement has occurred over the previous year in the provision of education to both community providers and ACAS, which is a very good result.

INFLUENCE OF CONTEXTUAL FACTORS

Given the different context within which each PGATS operates, it was agreed with stakeholders that information should be collected on contextual factors which could influence the capacity of a Service to be responsive to the needs of consumers. It was also agreed that these factors be taken into account in interpreting the evaluation outcomes. Key contextual factors identified were: varying size of teams (which was thought to impact on formal versus informal nature of collaboration with other sectors), co-location with ACAS, and auspice arrangements particularly where there had been recent changes.

Each Service was asked to provide contextual information on their service in Part A of the Evaluation Tool. This information included location of the service, name of auspice, staffing composition and EFT, number of registered clients in current case load, living arrangements of current clients, organisational arrangements with ACAS and number of referrals received from ACAS.

The key contextual factors and their relationship to ratings in each domain are summarised in Table 8 and discussed under specific headings below.

Table 8: Average domain scores and global scores for PGATS grouped by contextual factors

	Domain 1	Domain 2	Domain 3	Domain 4	Global Score
Geographical location					
Metropolitan	4.7	4.1	4.3	4.4	74.3
Rural	4.7	4.2	4.2	4.1	71.5
Co-location with ACAS					
Co-located	4.7	4.14	4.2	4.3	73.0
Not co-located	4.7	4.2	4.4	4.1	73.0
Size of PGATS based on clinical EFT					
Large	4.7	4.3	4.4	4.2	74.6
Small	4.6	4.1	4.2	4.2	71.6

The Table shows the average domain scores and global scores for PGATS grouped according to geographical location, co-location arrangements with the ACAS and size of the clinical team.

Geographical location

Results in Table 8 suggest that geographical location has a small impact on the total global scores with rural located teams scoring slightly lower overall. An examination of domain scores suggests that these differences are mainly occurring in the Education and Training domain with rural based teams scoring lower. An examination of individual indicator scores within this domain indicates

that the rural based teams score lower on all education and training indicators except for 4.2 (provision of clinical education sessions for residential aged care providers).

Co-location

Overall, nine teams defined themselves as co-located with their ACAS and eight as not co-located.

The results shown in Table 8 indicate no overall difference between co-located and non-co-located teams and only very slight differences on domain scores. This finding is somewhat at odds with comments received in the survey, generally supporting the view that co-location was an important factor in facilitating collaboration between PGATS and ACAS. For example. '*the fact that both teams are co-located in the same workplace allows a lot of informal discussion to occur'*(ACAS). What may be happening here is that the formal documentation is not adequately reflecting the quality of interaction and collaboration that actually occurs between co-located teams.

Size

Size of service was based on the clinical EFT rather than number of registered clients as clinical EFT was considered to be a more reliable measure of size. (Data provided by the teams showed little relationship between reported number of registered clients in their current caseload and staffing levels).

The clinical EFT ranged from 3.5 to 18.2, with a median of 10.1. Using the median clinical EFT to form two groups, the smaller services were compared to the larger. There was a clear trend in mean domain and global scores for the larger services to score better than smaller services. These differences are not statistically significant (i.e. they not large enough to rule out chance explanation).

Three of the four teams that ranked lowest on the 2000 evaluation tool combined characteristics of both size (these teams had the smallest EFT i.e. 5 EFT) and non-metropolitan location. This finding suggests that it may be difficult for very small teams in rural locations to find resources to both review and develop policies and procedures and to carry out the quality improvement activities that would be more routine in a larger organisation. However this conclusion needs to be treated with some caution as two of these teams were involved in structural and/or management changes over the evaluation period which could also have influenced the evaluation outcomes.

In conclusion, an average global rating of 73.0 out of a possible 85 on the 2000 evaluation is a very positive outcome for the sector. The result indicates that the sector as a whole is implementing processes and organisational practices aimed at enhancing and developing the collaborative relationship between PGATS and the aged care sector. In addition, the average global rating increase from 67 to 82 over the previous year (adjusted to take account of lesser number of indicators on the 2000 instrument) shows that the improvement was across the system. All teams showed an improvement from the previous year. Particular areas of improvement occurred in PGATS' collaborative activity with the community sector and ACAS.

PART THREE: INDIVIDUAL INDICATOR OUTCOMES

This section of the report describes the ratings pattern across the state for each of the seventeen indicators, noting changes from the 1999 evaluation and highlighting areas of activity where there is potential for improvement in PGATS responsiveness to the needs of consumers of aged care services.

The generic five point scale used in the evaluation tool is as follows:

Rating 1: No action taken and no documented plan for addressing this indicator

Rating 2. No action taken but a plan is in place for addressing the indicator

Rating 3. A plan is in place and activities have occurred but not in a systematic way

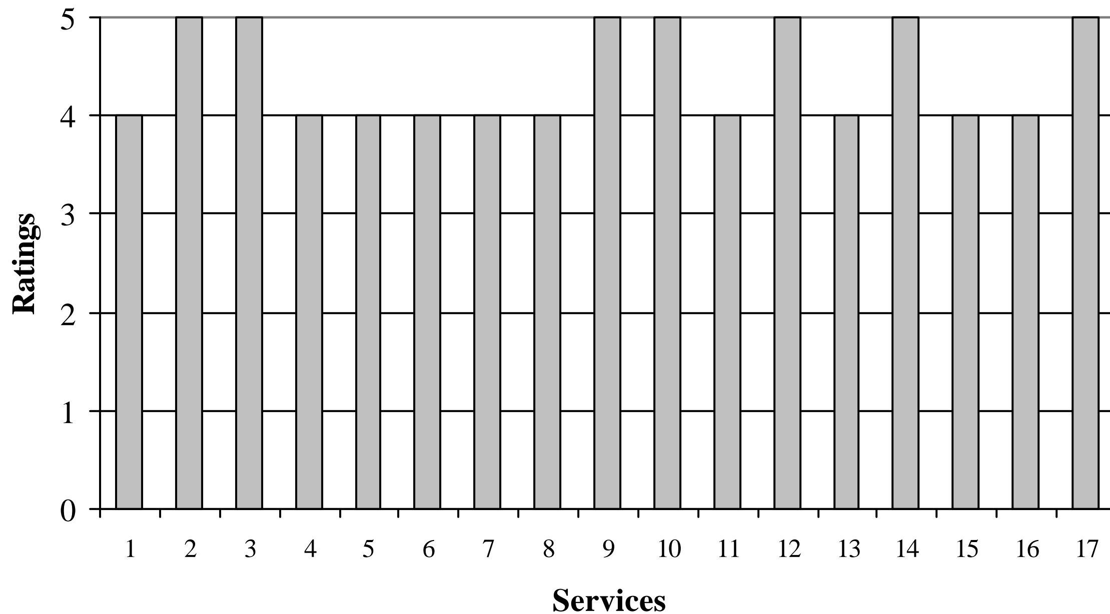
Rating 4. Systematic action taken to address the indicator but limited in scope

Rating 5. Action taken to address the indicator which is comprehensive

DOMAIN ONE: SERVICE PLANNING AND MANAGEMENT

Indicator 1.1: The service has a strategic plan for developing and improving cooperative and collaborative links between PGATS and the aged care sector

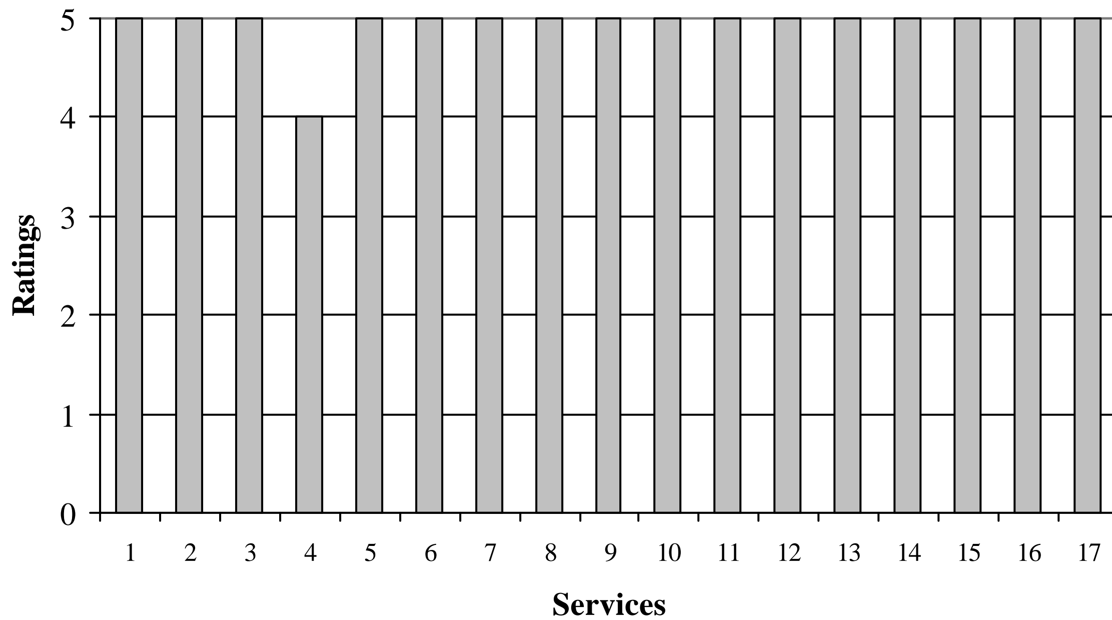
Figure 3: Ratings by Service for Indicator 1.1



The average rating for this indicator was 4.4. As shown in Figure 3, seven teams rated a '5' indicating a comprehensive strategic plan was in place. The remaining teams had taken systematic action to develop plans but these were still limited in scope. This represents much more consistent action across the state compared to last year and shows that the sector is performing well in this area.

Indicator 1.2: Participation in service management and planning meetings with ACAS, residential and community aged care providers.

Figure 4: Ratings by Service for Indicator 1.2

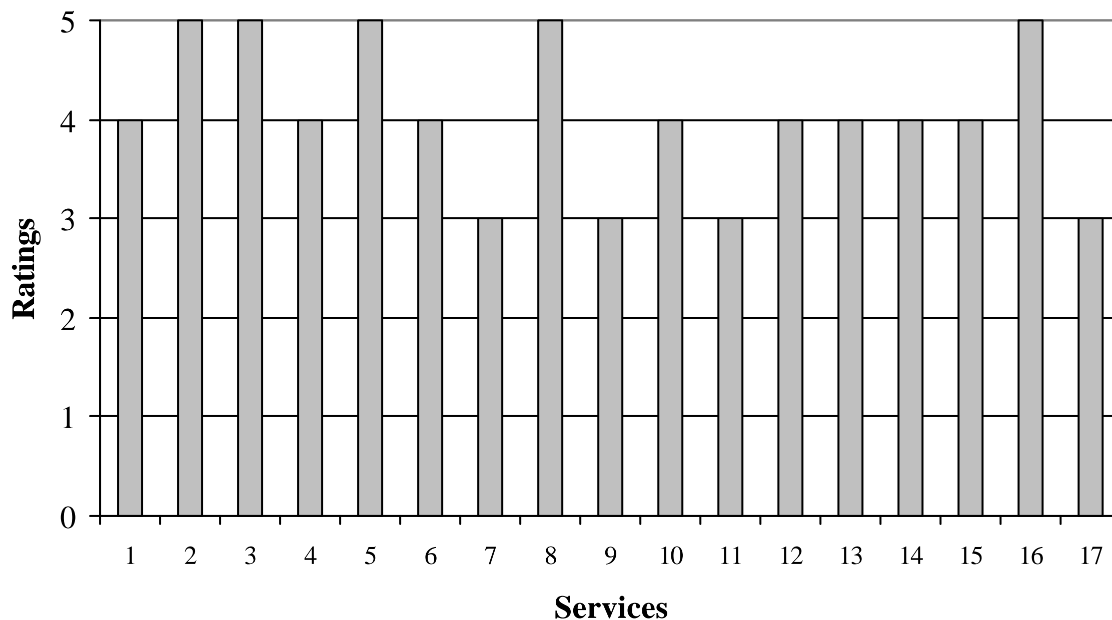


The average rating for this indicator was 4.9, the highest rating indicator overall. As shown in Figure 4, sixteen teams scored a '5' indicating comprehensive action across the state. This is an example of the sector performing consistently well across all services.

DOMAIN TWO: SERVICE ACCESS

Indicator 2.1: The service has clearly identified and communicated the PGATS target group.

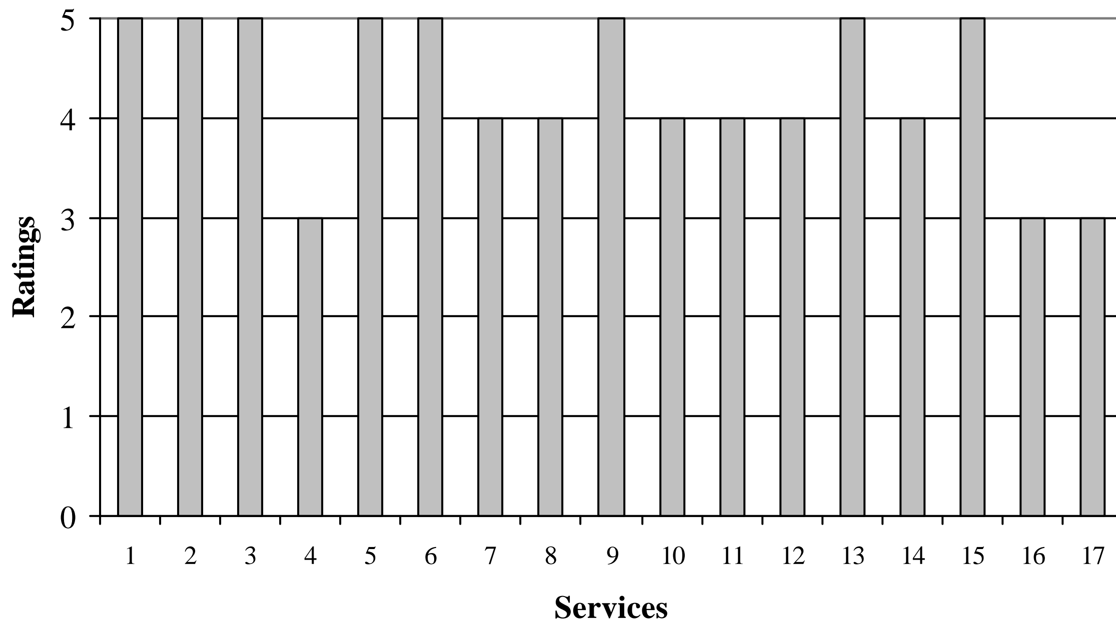
Figure 5: Ratings by Service for Indicator 2.1



The average rating on this indicator was 4.1, representing no change from the previous year. The results shown in Figure 5 demonstrate a similar spread of scores to the previous year with the majority rating a '4' or a '5'. Reasons for the lack of improvement on this indicator relate partly to the emphasis in the 2000 evaluation on evidencing the negotiation of positive outcomes for clients who are referred to PGATS but not accepted on to the service.

Indicator 2.2: PGATS provide a timely, appropriate and consistent response to referrals.

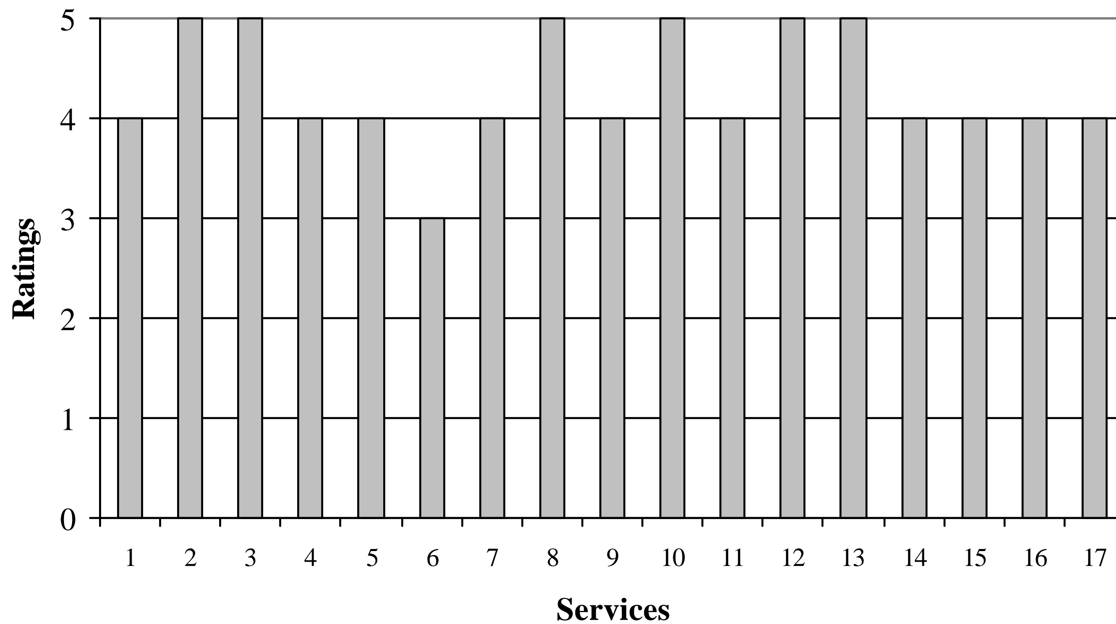
Figure 6: Ratings by Service for Indicator 2.2



The average rating for this indicator was 4.3 representing a slight increase from the previous year. Figure 6 shows fourteen teams rated a '4' or a '5' representing much more consistent action across the state compared to last year. There is some capacity for improvement in this area, particularly in the monitoring of response times and building this into quality improvement activities.

Indicator 2.3: Referral processes between ACAS and PGATS avoid duplication

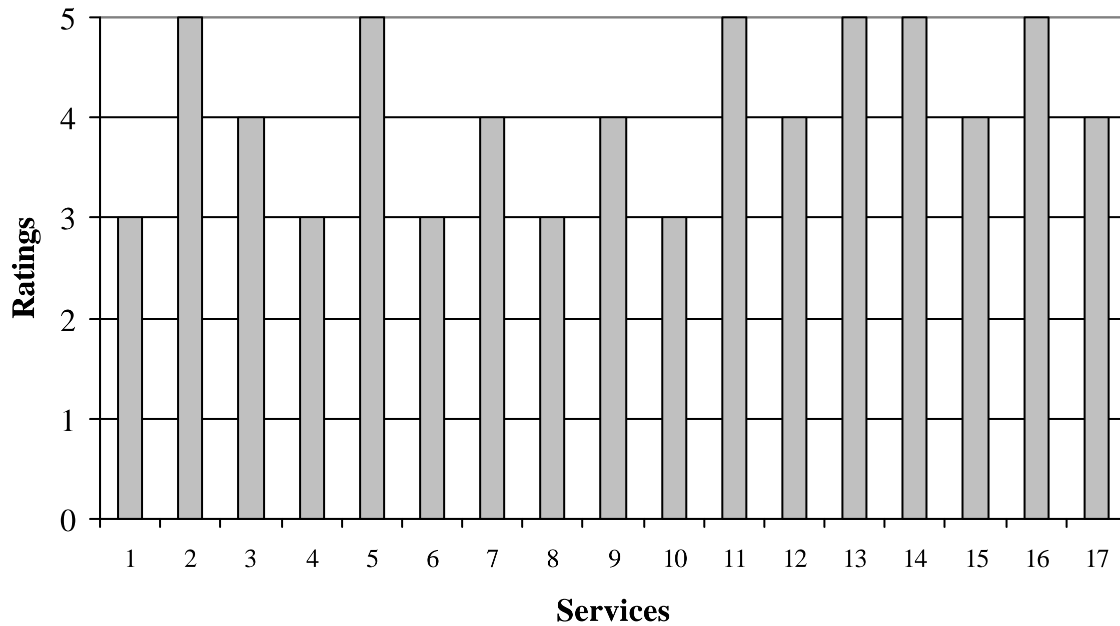
Figure 7: Ratings by Service for Indicator 2.3



The average rating for this indicator was 4.3, a substantial improvement from the previous year. Figure 7 shows that six teams rated a '5' indicating comprehensive action is occurring to minimise duplication. All but one of the remaining teams rated a '4', evidencing systematic action to address this area. This represents more consistent action and a higher level of performance across the state compared to last year; an extremely positive outcome for both PGATS and ACAS.

Indicator 2.4: PGATS provide secondary consultation

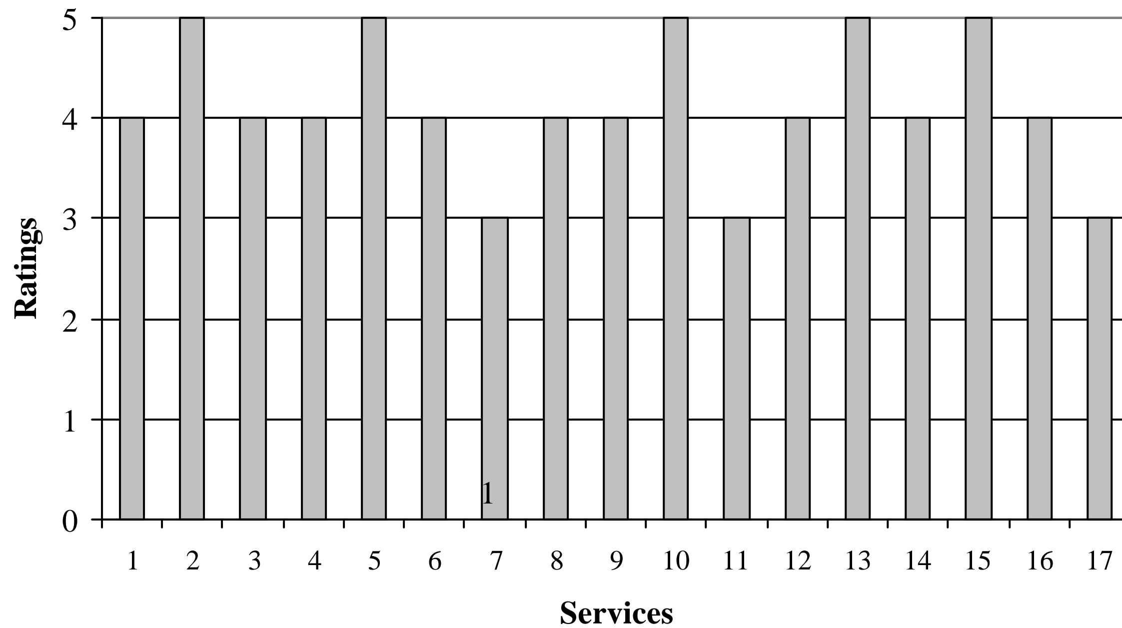
Figure 8: Ratings by Service for Indicator 2.4



The average rating for this indicator was 4.1 again demonstrating significant improvement compared to the previous year. Figure 8 shows six teams rated a ‘5’ indicating comprehensive activity, and a further six teams rated a ‘4’ showing systematic activity had occurred in this area. However five teams still scored a ‘3’ evidencing only piecemeal or one-off activity. Whilst the overall result shows a higher level of performance across the state there is still room for improvement in this area of responsiveness.

Indicator 2.5: Quality improvement activities monitor service access

Figure 9: Ratings by Service for Indicator 2.5

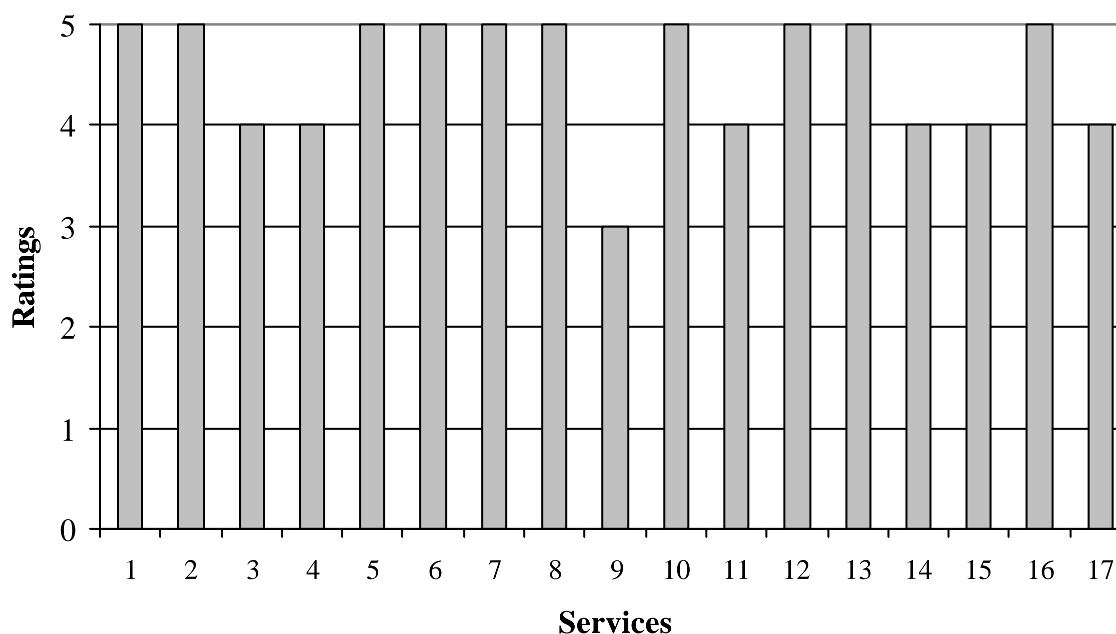


The average rating for this indicator was 4.1 showing little improvement compared to the previous year. The spread of scores remained the same with only five teams scoring a '5' and three teams evidencing one-off activities, as shown in Figure 9. Lack of improvement is attributable to the requirement to evidence monitoring of client characteristics such as clients living arrangements as well as response times and provision of secondary consultations. Despite the lack of improvement this is still quite a good result for the sector overall.

DOMAIN THREE: CASE COORDINATION AND MANAGEMENT

Indicator 3.1: Collaboration and shared processes occur with clients who are clients of the ACAS.

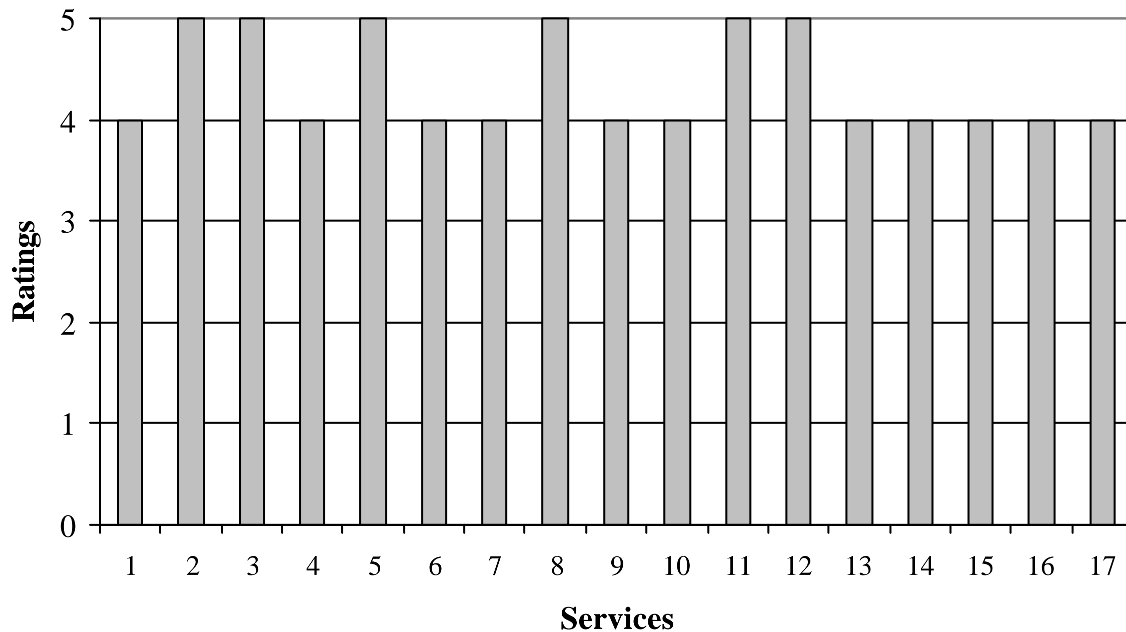
Figure 10: Ratings by Service for Indicator 3.1



Indicator 3.1 was a high scoring indicator with an average rating of 4.5. This is a significant improvement compared to the previous year. Figure 10 shows ten teams rated a '5' indicating comprehensive action was evidenced and all but one of the remaining teams rated a '4'. This represents much more consistent action and an overall higher level of performance across the state. The results mirrors the result on the ACAS indicator in domain two confirming that collaboration and communication between the two program areas is occurring in a systematic way. This is a very good result for the sector overall.

Indicator 3.2: Collaboration and shared processes occur with clients who are also clients of community care services.

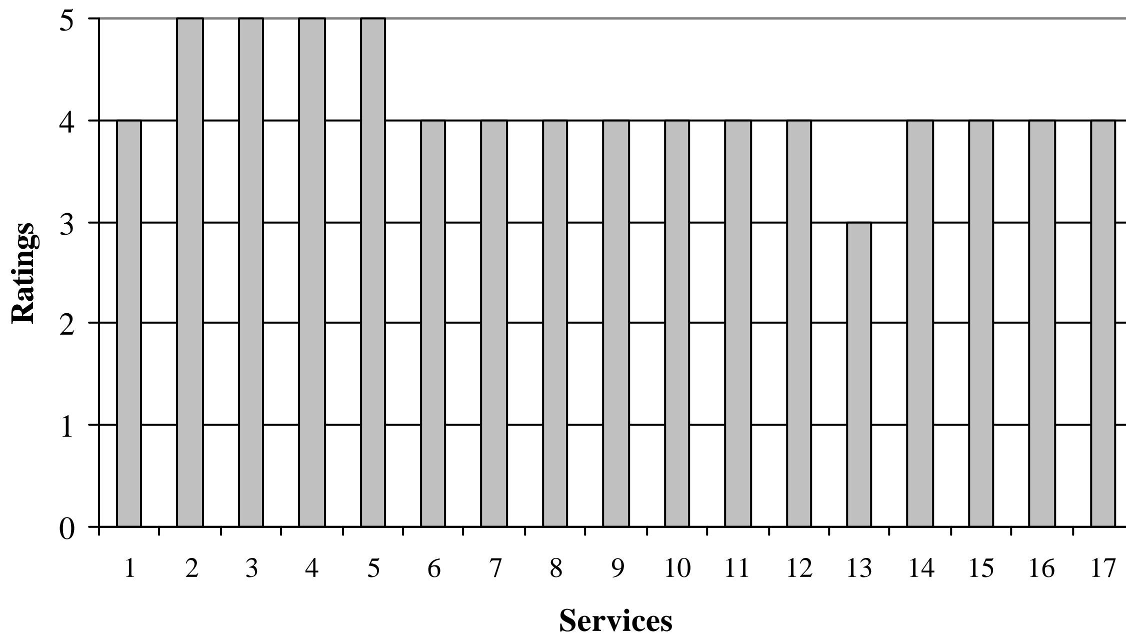
Figure 11: Ratings by Service for Indicator 3.2



Indicator 3.2 was another high scoring indicator with an average rating of 4.4. This is again a significant improvement compared to the previous year. However Figure 11 shows that only six teams rated a '5' indicating that comprehensive action was evidenced. All remaining teams rated a '4' which is not as good a performance as on the ACAS indicator, indicator 3.1. The result does however represent more consistent action by PGATS in their collaborative work with community aged care agencies compared to last year and overall, demonstrates a relatively high level of performance across the state.

Indicator 3.3: Collaboration and shared processes occur with clients who are also clients of residential aged care providers.

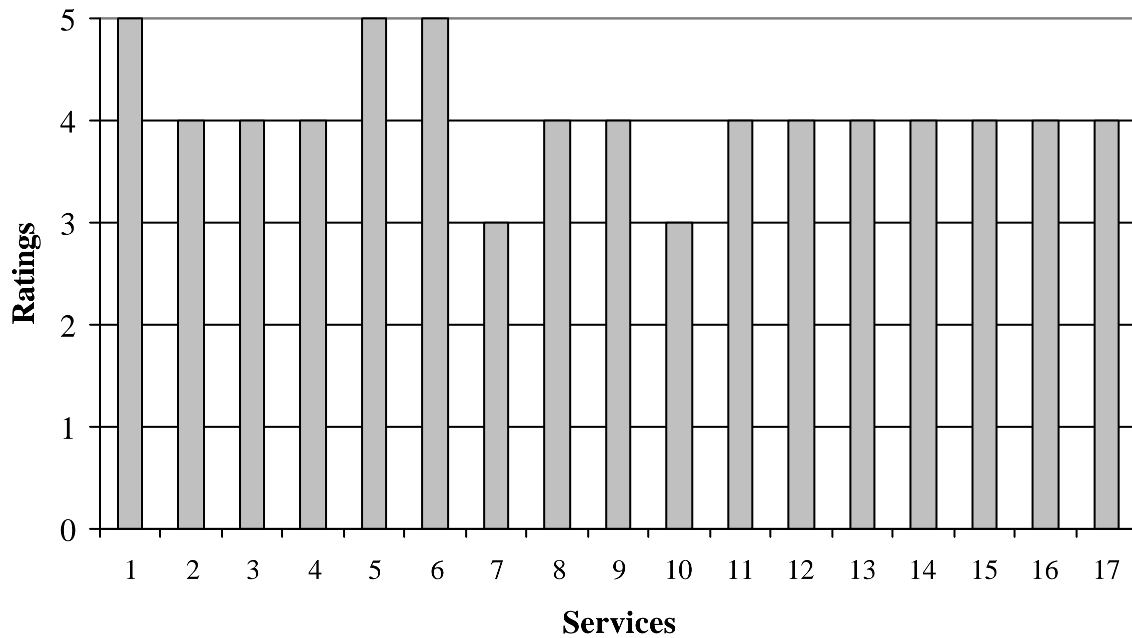
Figure 12: Ratings by Service for Indicator 3.3



Indicator 3.3 had an average rating of 4.2, slightly lower than the ratings for collaboration with ACAS and community care providers. This is an improvement compared to the previous year but not as significant an improvement as shown on the two previous indicators. Figure 12 shows that only four teams rated a '5' . This result shows a high level of performance across the state which is a good result for the sector overall.

Indicator 3.4: Strategies and processes are in place for the provision of crisis management.

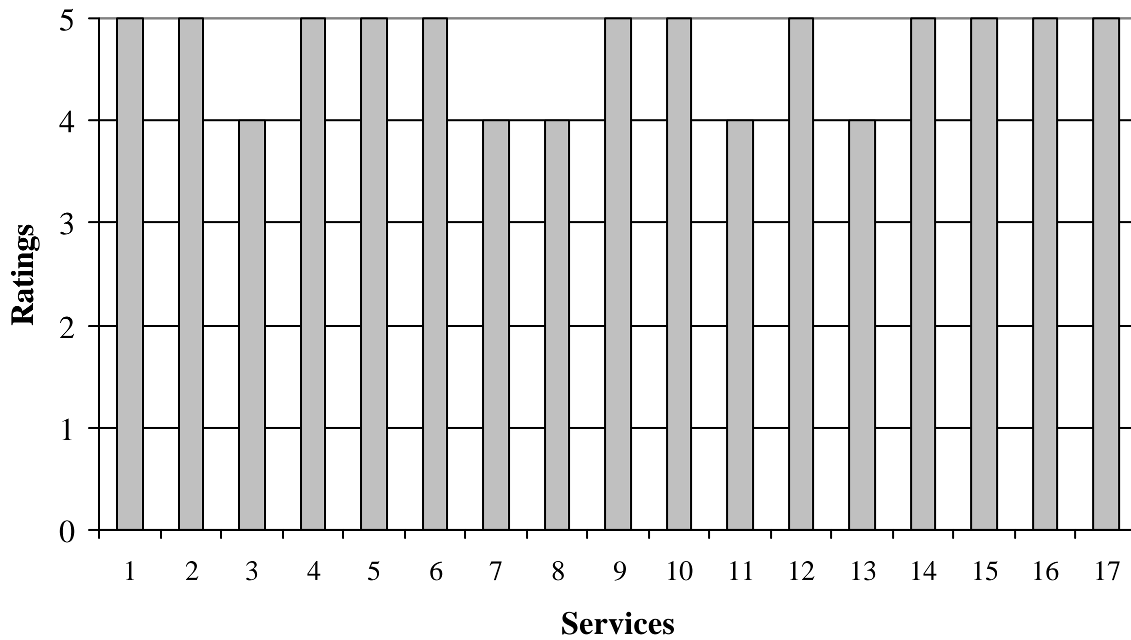
Figure 13: Ratings by Service for Indicator 3.4



Whilst indicator 3.4 scored slightly below the state average with a rating of 4.1 this is an improvement compared to the previous year. Figure 13 shows that whilst only three teams rated a ‘5’ indicating that comprehensive action was evidenced, many more teams rated a ‘4’ compared to the previous year. This represents much more consistent action and an overall higher level of performance across the state compared to the previous year.

Indicator 3.5: Strategies and processes are in place for the resolution of complaints

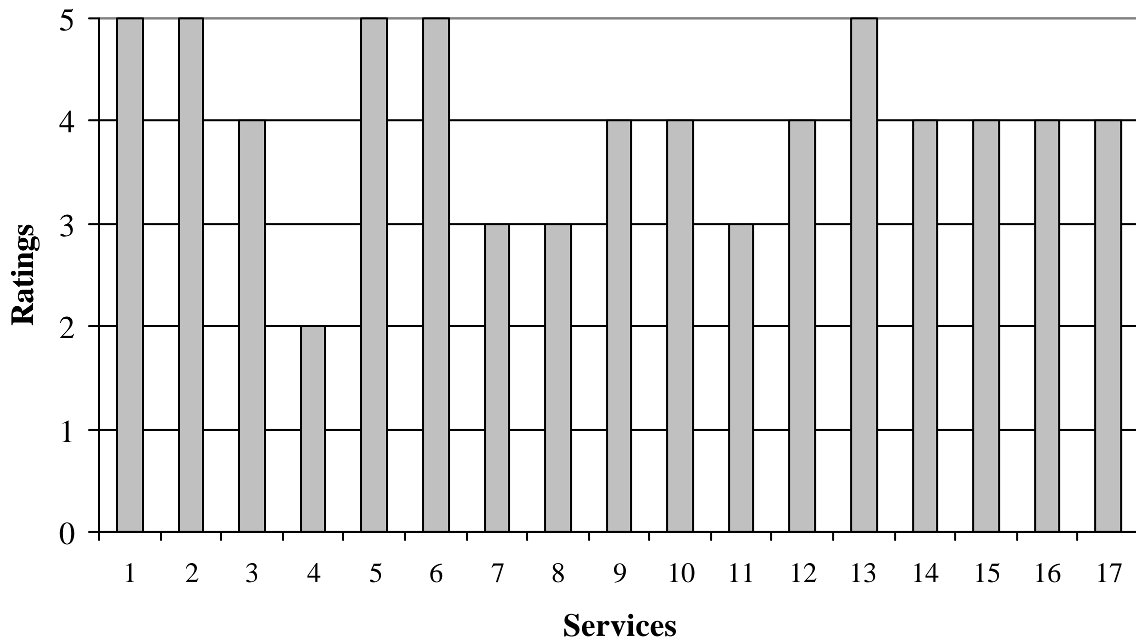
Figure 14: Ratings by Service for Indicator 3.5



The state average score for this indicator was 4.7, one of the highest scoring indicators overall and a significant improvement compared to the previous year. Figure 14 shows that twelve teams rated a '5' indicating comprehensive action was evidenced and the remaining teams rated a '4'. This represents consistent action and a very high level of performance across the state.

Indicator 3.6: Quality improvement activities monitor collaborative processes in case coordination and case management.

Figure 15: Ratings by Service for Indicator 3.6

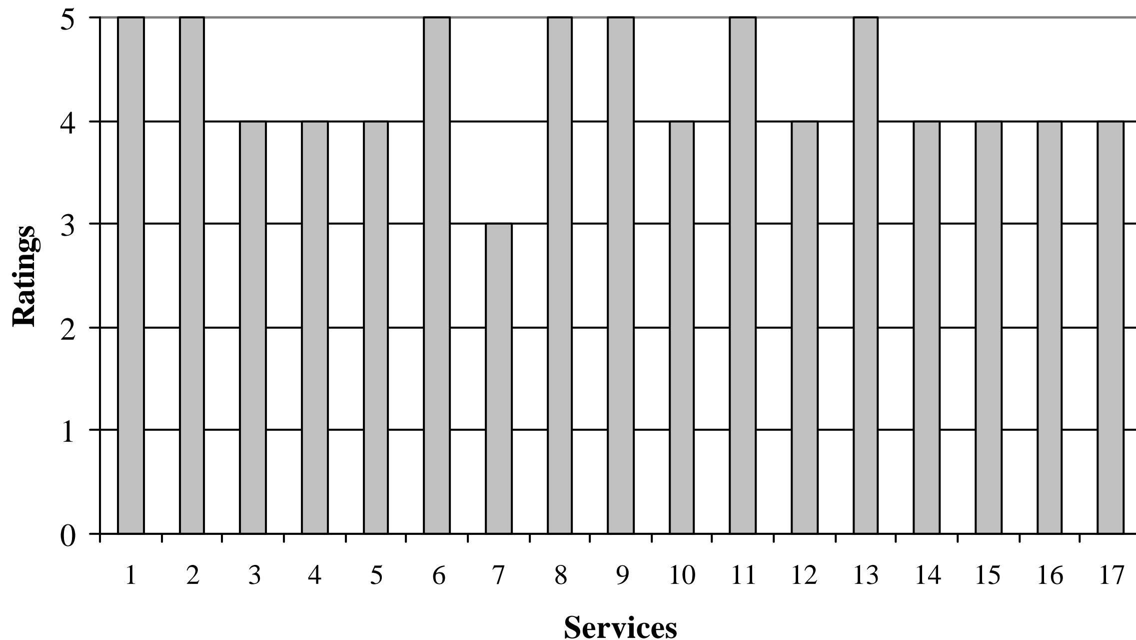


The state average score for this indicator was 4.0, slightly below average. However compared to the previous year this is a substantial improvement. Figure 15 shows five teams achieved a '5' in the 2000 evaluation whereas no teams rated a '5' last year. All but one of the remaining teams rated a '4'. This represents consistent improvement across the state.

DOMAIN FOUR: EDUCATION AND TRAINING

Indicator 4.1: Staff participate in continuing education and training on social and medical aspects of ageing and are kept up to date with local services availability in aged care

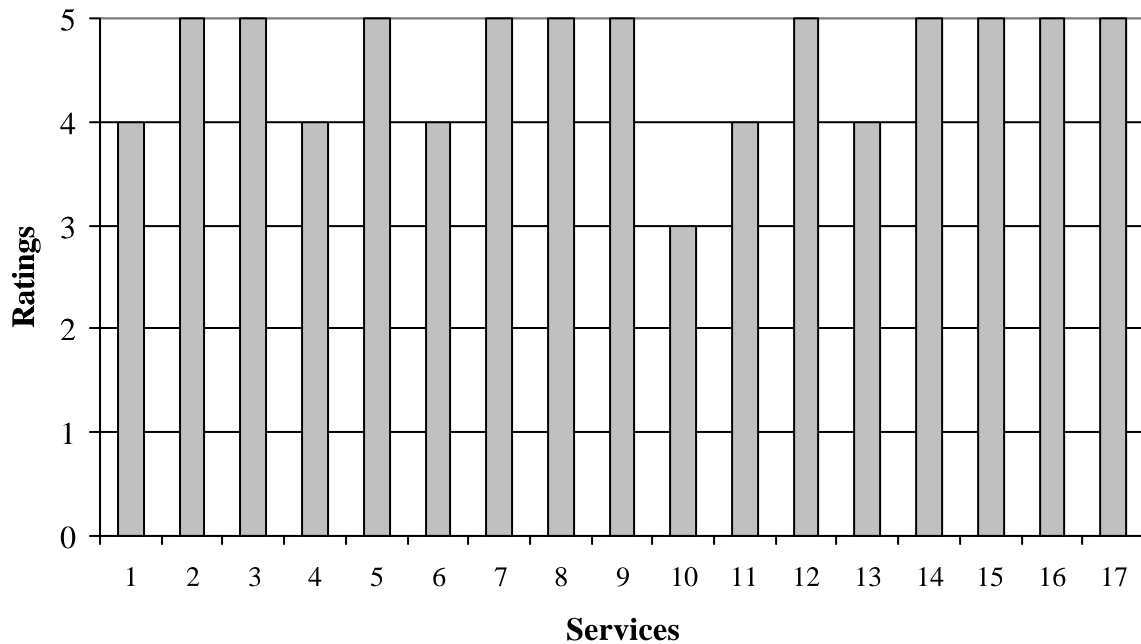
Figure 16: Ratings by Service for Indicator 4.1



The state average score for this indicator was 4.4. The rating cannot be compared to the previous year due to the change in content of the indicator. Figure 16 shows that seven teams rated a '5' indicating comprehensive action was evidenced and all but one of the remaining teams rated a '4'. This is a good result representing systematic activity across the state.

Indicator 4.2: PGATS provide clinical education sessions to residential care providers

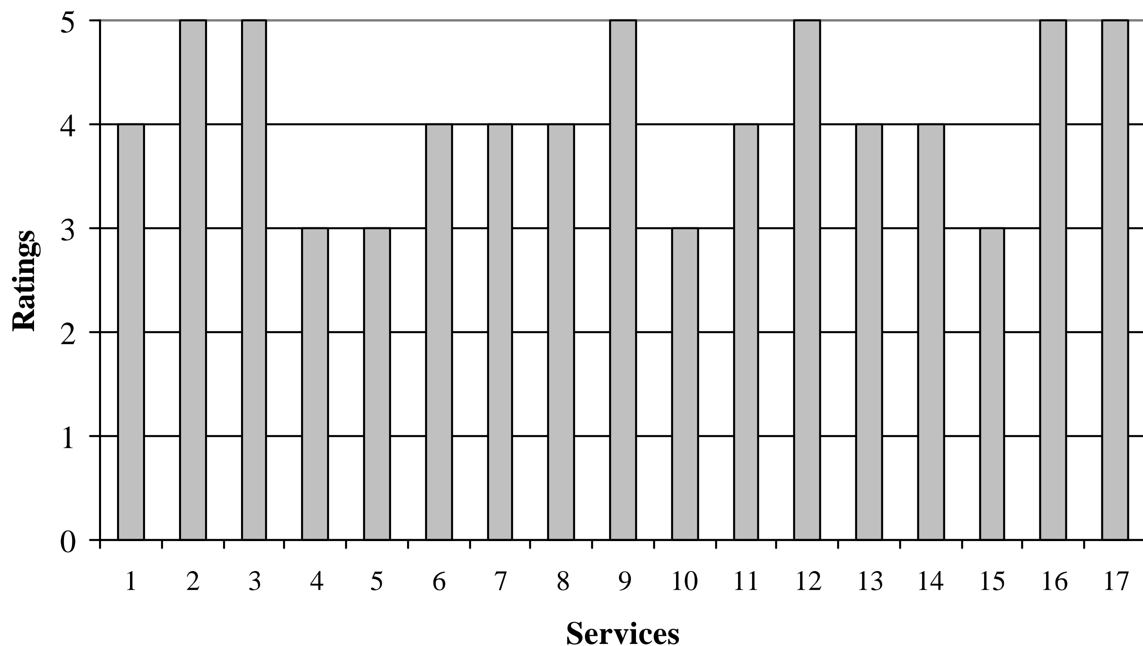
Figure 17: Ratings by Service for Indicator 4.2



The state average score for this indicator was 4.6, one of the highest scoring indicators overall and one which showed a significant improvement compared to the previous year. Figure 17 shows that eleven teams rated a '5' indicating comprehensive action was evidenced and all but one of the remaining teams rated a '4'. This result represents evidence of improved levels of activity and a high level of performance across the state.

Indicator 4.3: PGATS provide clinical education sessions to community care providers

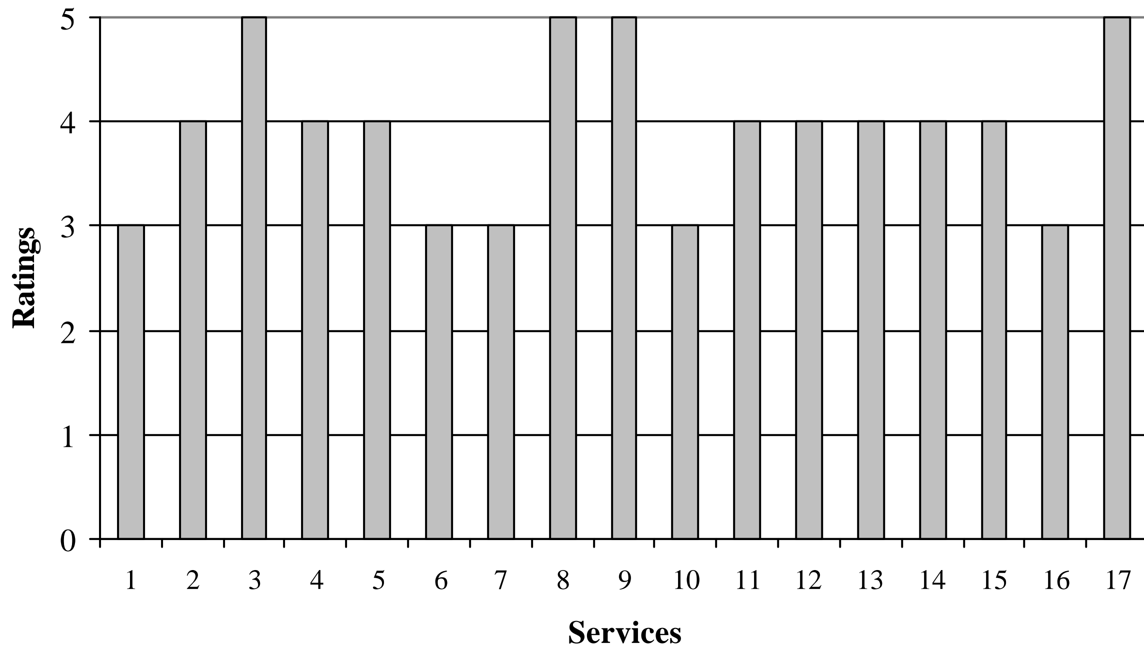
Figure 18: Ratings by Service for Indicator 4.3



The state average score for this indicator was 4.1, slightly below the overall state average. Again improvement was demonstrated across all teams compared to the previous year. Figure 18 shows that whilst six teams rated a '5' indicating comprehensive action was evidenced, four teams still rated a '3' evidencing one-off activity only. This result represents an improvement overall however there is potential for more systematic activity by certain teams.

Indicator 4.4: PGATS include ACAS in clinical education sessions organised within their auspice.

Figure 19: Ratings by service for Indicator 4.4



The state average score for this indicator was 3.9, the lowest indicator rating in the evaluation. Again improvement was shown over the year, but Figure 19 shows that there are still five teams that scored a '3', evidencing one-off activity only. This result represents evidence of improved levels of activity but there is still room for improvement for most teams across the state.

PART FOUR: REVIEW AND RECOMMENDATIONS

THE EVALUATION METHODOLOGY

Adequacy of indicators used in the evaluation

Responses from PGATS and other stakeholders obtained throughout the process of development and implementation of the evaluation over the two years suggest that the evaluation instrument developed for this project has good content validity. That is, it does adequately address the range of relevant activities and processes of intersectoral collaboration which underpin the responsiveness of the PGATS to the needs of consumers who are also clients of the generic aged care sector.

Following the first round evaluation in 1999, the evaluation tool was reviewed and feedback sought from all teams and other stakeholders. This review resulted in minor modifications to the tool for the 2000 evaluation. These changes included changing wording of some indicators to make meaning more explicit, dropping of two indicators which had been identified of lesser relevance to responsiveness, and changes to the guide to the tool in order to make it more useful.

The seventeen indicators on the latest version of the self-evaluation instrument (see Appendix 1) provide an established framework for future quality improvement activities that has been well received by the field.

Self-ratings and objective evidence

The methodology utilised in these evaluations emphasised objective evidence in the form of documented guidelines or protocols. Although the consultants acknowledge that good practice can occur in the absence of documented protocols, and that the presence of the latter does not guarantee good practice, we believe that this emphasis is justified and should be retained as part of future quality improvement activities. In any evaluation where one of the key outcomes is a comparison of performance on common activities across organisations, a reliance on objective evidence is likely to result in a more transparent and fairer process than one that relies on subjective information. Moreover, ongoing service quality improvement across the sector is likely to be best maintained by appropriate organisational policies and procedures that support and guide quality service delivery rather than reliance on less formal interpersonal relationships.

Qualitative data from the aged care sector

Descriptive information on key indicators of intersectoral collaboration was collected from generic residential aged care facilities, community provider organisations and ACAS in each of the Service catchment areas. This information when compared to the moderated self-ratings provides some support for the empirical validity of the evaluation tool used in these evaluations. In the main, the qualitative data has been consistent with the documentary based self-rating. The most noticeable discrepancies occurred in two of the lower ranking teams where feedback from the qualitative survey indicated that the team's responsiveness to aged care providers 'on the ground' was effective despite the lack of documented evidence and protocols to back up their practice. These two teams happened to be among the smallest teams in terms of EFT and this finding may reflect resource constraints.

The return rates for completed questionnaires of the generic aged care sector were reasonable for surveys of this nature (60% in 1999 and 64% in the 2000 evaluation) suggesting that this was an acceptable process for the sector.

Benefits of including qualitative feedback in the evaluation process:

- The survey data provides a broad external reference point to assist in the interpretation of the outcomes of the self-evaluation process. We believe this was particularly useful for teams who scored low on the first round of the evaluation where the survey data provided a clear focus for quality improvement activities.
- The survey increased provider awareness of what services they could expect from PGATS e.g. secondary consultations with clients who are not registered PGATS' clients, formalised protocols and guidelines for processes such as crisis management and complaints handling, clinical education tailored to agencies' needs.
- Overall the survey opened up opportunities for discussion and clearer definition of certain processes

SUMMARY AND RECOMMENDATIONS

Summary

The average global score on the evaluation tool for the 2000 evaluation was 73.0 out of a possible 85 with an average indicator score of 4.3. This is a positive outcome which indicates that overall the sector has developed protocols and procedures that reflect and support the type of collaborative activities which underpin PGATS' capacity to be responsive to the needs of clients who are also clients of residential and community aged care services.

This very positive result is in the main supported by the feedback received from ACAS, community and residential agencies regarding the PGATS' performance on the key responsiveness indicators.

The services have made significant improvements in responsiveness over the two evaluation periods. The average global rating increased by approximately 14 points and the average indicator score increased from 3.5 in 1999 to the 4.3 observed in 2000. Moreover this improvement has been across the system: all teams showed improvement over the evaluation period.

These results show that there is now greater consistency in teams' approach to responsiveness across the different domains or areas of responsiveness. In addition, the overall level of performance in the areas of responsiveness has improved to the point where action is now more likely to be occurring on a systematic basis as opposed to the previous year where much activity was one-off or piecemeal.

Two key areas where improvement occurred were case management and coordination, and clinical education. In the area of case management, for example, improvement in collaborative involvement with community care providers and ACAS showed substantial efforts by PGATS to evidence and improve their work in this area. Likewise the gains in the provision of clinical education occurred more in these two areas than with residential care providers, again demonstrating successful efforts by PGATS' to improve their responsiveness to these two sectors.

Evidence provided to the Panel as well as feedback from ACAS and the other generic aged care agencies suggest that these improvements reflect actual changes in practices.

Notwithstanding overall improvements, comments from teams and generic agencies suggest that the capacity of many teams for improvement in responsiveness is limited by resources available to the team. The relative rankings of the teams, particularly the low ranking of the smallest teams at least in part reflects this factor.

Recommendations

We believe that the two rounds of the evaluation have been effective in focussing attention on those processes which are likely to facilitate service responsiveness to the needs of PGATS clients who are also consumers of generic aged care services. Moreover the emphasis of the evaluation process on the provision of documentary evidence of activities which support a responsive service has resulted in the development or refinement of protocols and processes in all of the Services which took part in the evaluation.

The evaluation has thus provided a major stimulus to the establishment and implementation of quality improvement activities in this area of service responsiveness. In order to maintain and further improve service quality in this core area of the PGATS functioning, we would recommend that internally driven quality improvement activities which address some or all of the key responsiveness indicators used in the evaluation be put in place in each of the services.

Development of a quality improvement framework

Specifically, we would recommend the development of a quality improvement framework which addresses PGATS' ongoing responsiveness to the needs of consumers of generic aged care services.

The quality improvement framework could include the following elements:

- key processes for achieving a more responsive service including organisational commitment, vision and planning, and, participation by key consumer groups e.g. aged care agencies, GPs and client/carer at a variety of levels.
- indicators or areas of responsiveness.
- monitoring of responsiveness.
- evidence of service improvement as a result of monitoring and QI activities.
- reporting/accountability procedures.

Aged care agency and client/carer participation in service development

This evaluation process has been to some extent been a reactive one – i.e. PGATS evidenced policies, procedures and events that had occurred around identified areas of responsiveness. In the future a more pro-active or partnership approach should be adopted. That is, PGATS like any other service providers should be encouraged to involve consumers, including clients/carers, aged care providers and GPs, in strategic planning and service development and have to account for the extent to which these groups have been involved in these activities.

Quality improvement activities should incorporate qualitative feedback from all PGATS consumers as noted above. The Mental Health Branch has conducted annual client/carer satisfaction surveys which address a range of client/carer issues. Our experience with this evaluation project suggests the feedback from agencies has been one of the most useful influences on service development and delivery. Moreover the process of obtaining such feedback had the additional advantage of informing the agencies about the role of the PGATS and clarifying their understanding of what services they could or should be expecting from the PGATS.

We would therefore strongly recommend that mechanisms that result in regular feedback from consumer groups be an integral part of quality improvement processes and that the Department should have some input into areas or issues that are canvassed in this process. In future however APMHS should choose their own methods for collecting consumer feedback eg. forums, focus

groups or one- to- one discussions. Feedback mechanisms should not be limited to the processes used in this evaluation project.

In particular, feedback should be sought from clients and families themselves in relation to the effectiveness of the collaborative relationship between PGATS and generic aged care services. This is an area that was not included in this evaluation for a variety of reasons, but should in the future be central to any service evaluation as responsiveness is only desirable if it produces better outcomes for clients and carers.

Areas of responsiveness should incorporate the indicators in the 2000 Evaluation

The indicators developed for the 1999 and 2000 evaluations should be considered as the initial set of indicators around which quality improvement activities should be focussed. The indicators used in the two evaluation rounds were derived from a comprehensive review of service requirements and broad consultation; they have been generally accepted as encompassing the main elements of service responsiveness.

Information exchange between PGATS

Consideration should be given to establishing processes or structures that would facilitate discussion and sharing of ideas regarding quality improvement between the Services. Again the current evaluation demonstrated that interchange between teams was very useful in promoting good practice across the sector. Processes such a liaison group that met on regular basis, or newsletter, or website to help facilitate a consistent and shared approach to quality improvement should be considered by the Department.

CONCLUSION

In conclusion we suggest that the Evaluation Tool developed as part of the Mental Health Branch's Quality Improvement Strategy provides a good foundation for quality improvement activity in service delivery areas where consumers receive services across program areas. The focus on integration and coordination of services around individual clients is consistent with the Department's Primary Care Partnership reforms and is clearly an extremely important area for ongoing attention with regard to quality improvement aimed at achieving the best outcomes for individual clients.

Finally, we would like to thank the PGATS themselves for contributing to the development of the tool, for their feedback in revising the tool and for the substantial effort that individual's have put into developing protocols and procedures which evidence their responsiveness to the aged care sector. Preparing such high quality submissions is extremely time consuming, and the PGATS are to be congratulated for finding the time to do this amongst the many other demands placed on their time. It is hoped that in the long run this process will result in better collaborative relationships with aged care and community providers which in turn result in better outcomes for clients.

Aged Persons Mental Health Services' responsiveness to the needs of consumers of residential and community based aged care services

EVALUATION KIT

Second Round
2000

Prepared by Lincoln Gerontology Centre
La Trobe University
January 2000

CONTENTS LIST

Introduction **2**

The evaluation process **2**

Contact information **3**

The Evaluation Tool **3**
- Description and guidelines 3
- Content and scope 3
- Ratings and evidence 4
- Checklist for completion of your submission 5

Evaluation Tool:

Part A: Contextual information **6**

Part B: The Self Evaluation Instrument **9**

ATTACHMENT 1: SELF EVALUATION INSTRUMENT GUIDE **12**

Domain 1: Service planning and management 12

Domain 2: Service access 15

Domain 3: Case coordination and management 21

Domain 4: Education and training 28

Evaluation of APMHS' responsiveness to the needs of consumers of residential and community aged care services

Second Round: 2000

Introduction

Over the last several years, Victoria's public mental health services have undergone significant reform aimed at improving the provision of mental health care so that services are more effective and responsive to consumer needs.

Starting in the 1996/97 financial year the Mental Health Branch has conducted a wide ranging Quality Incentive Strategy to provide financial incentives for the provision of high quality mental health services. The Quality Incentive Strategy complements the work being undertaken on performance indicator development and consumer outcome measurement and was designed to add significantly to the range of data available to inform policy and service development. As an ongoing initiative of the Mental Health Branch, each financial year service responsiveness to specified consumer issues has been measured initially in adult mental health services and more recently in child and adolescent and aged persons' mental health services.

The measures specified for 1998/99 included an evaluation of the service responsiveness of aged persons' mental health services to the needs of consumers who are also clients of residential and community aged care services. The evaluation will be conducted over a two year period. The first round evaluation in February 1999 and the second round in February 2000.

The project aims to develop and encourage best practice in coordinating client care across the boundaries of the psychiatric and generic aged care sectors. More specifically the project aimed to

- ***Conduct a review of the seventeen Aged Persons' Mental Health Services (APMHS)[1] across the State of Victoria in order to assess their responsiveness to the needs of clients who are also clients of residential and community aged care services;***
- ***Provide a comparative analysis of the Services' performance in this area; and,***
- ***Provide information to each APMHS, which would be useful for the further development of their service quality.***

This is the second year of the evaluation of APMHS's responsiveness to the needs of consumers of residential and community services. In carrying out this project, the Lincoln Gerontology Centre developed a methodology and an evaluation tool in 1998/99 in preparation for the first round evaluation. In consultation with Mental Health Branch officers and PGATS, the evaluation tool was reviewed in November 1999 and altered slightly in response to analysis of the rating results from the first round and feedback from PGATS.

These alterations have meant that the tool is slightly shorter, now containing 17 indicators compared to 19 in the first round. Indicators 1.3: Staffing arrangements facilitate collaboration and close working relationships between PGATS and ACAS, has been

[1] *Although the project addresses the Aged Persons' Mental Health Services, the evaluation focused on the Psycho-geriatric Assessment and Treatment Service (PGATS) components of these Services as these teams operate at the interface with the generic aged care sector.*

dropped. Indicators 4.1 and 4.5 have been amalgamated into one indicator. The rating scale has been kept the same with minor changes to the definitions of rating 2 and 3. Some alterations to the Tool Guide have been made to make the type and quantity of evidence required for each rating more explicit.

The evaluation process for the Year 2000

The Evaluation process will proceed as follows

1. Evaluation Kit sent out to each PGATS in December 1999
2. Following this contact will be made by a member of the project team with the nominated PGATS liaison person to discuss if a site visit is required from a member of the project team. Site visits will occur at an agreed time in February with a member of the project team with the aim of assisting the PGATS to prepare their submission.
3. PGATS nominate the aged care service providers in their area to be surveyed by the project team. Names and addresses of providers nominated from last year will be provided. This list can be changed as seen fit by each PGATS. This survey will elicit qualitative feedback on elements of good practice and areas where further improvement would be desirable.
4. PGATS send in their completed submissions by Friday March 3, 2000.
5. Submissions are reviewed by an independent panel and moderated if necessary to ensure all PGATS employ a consistent interpretation of the relationship between evidence submitted and rating points
6. Reviewed ratings sent to PGATS for comment.
7. PGATS advised of any further amendments and finalised ratings sent to the Department.

Contact information

The key contact people for this evaluation are Peter Foreman and Heather Russell from Lincoln Gerontology Centre. If at any stage you have queries about the evaluation process you can contact either of us.

Contact details are:

Peter Foreman
Ph 94791721
Fax 94795977
E-mail: p.foreman@latrobe.edu.au

Heather Russell
Ph 94795826
Fax 94795977
e-mail: h.russell@latrobe.edu.au

The Evaluation Tool

The Evaluation Tool contains two parts:

Part A: Contextual information
Part B: Self Evaluation Instrument.

The Self Evaluation Instrument Guide (See Attachment 1) provides a guide to the rating scale for each indicator. The guide lists key processes, practices and activities, evidence of which reflected good performance on each indicator in the first round evaluation in 1999.

PART A: Contextual information

Part A of the Tool asks for a set of basic data about each PGATS to inform the consultants on the size, and local context within which your service operates. Further contextual information relevant to the nature and extent of PGATS collaboration with the aged care sector may be

provided to describe other local factors that influence PGATS capacity to meet the indicators in the tool.

Part B: The Self Evaluation Instrument

Content and scope

The Self Evaluation Instrument covers four domains of collaboration and responsiveness. Each indicator within these domains defines a key area of collaboration either with the generic aged care sector as a whole, or with specific elements of the aged care sector; namely ACAS, residential care providers and community care providers.

For the purposes of this current evaluation, services included in the community care and residential sector are:

Residential care facilities:
Nursing homes; Hostels; SRSs

Community care providers:
Local governments; RDNS; Linkages; CACPs; Day Centres

Ratings and evidence

The evaluation Instrument requires PGATS to self rate on a five point scale for each indicator. The focus of the rating will be on the availability of documented evidence to support a given rating. However it is recommended that for each indicator a written paragraph is also prepared which describes the action taken by the service to meet the indicator. The relevant documents which support this statement will need to be attached to the submission.

The list of processes, practices and activities listed under each indicator is meant as a guide to the types of activities and evidence that could be used to support your rating. As indicated in the tool, this list is not intended to be exhaustive or prescriptive but is meant as a guide to possible sources of information and documentation for each indicator.

The five point scale has been adapted from Thomas and Associates report *Evaluations of Area Mental Health Service Responsiveness to the Needs of People from Non-English Speaking backgrounds and Women:Summary report* (Thomas and Associates, 1998:65).

In order that services apply the rating scale as consistently as possible, an individual guide to the rating scale for each indicator is provided in Attachment 1.

The generic five point scale is as follows:

Rating 1: No action taken and no documented plan for addressing this indicator

No action has been taken and there is no documentation available to suggest that action is planned. A documented "plan" is not the mere statement of an intention for action to be taken but is a document in which usually there is discussion of objectives, activities and their implementation to address the indicator.

2. No action taken but a plan is in place for addressing the indicator
No action has been taken but a plan containing a discussion of objectives, activities to address the objectives and their implementation has been prepared but not yet acted upon.

3. A plan is in place and activities have occurred but not in a systematic way
A plan is in place but there is no evidence of broad scale or systematic implementation of relevant procedures or activities.

4. Systematic action taken to address the indicator but limited in scope

Objective evidence including documented policies and procedures indicates that this indicator is being met but not in all relevant cases, locations or circumstances.

5. Action taken to address the indicator which is comprehensive

Objective evidence including documented policies and procedures indicates that this indicator is being comprehensively and consistently met.

Checklist for completion of your submission

Consistent with the advice given above, your submission is expected to include the following:

1. Completion of information requested in PART A: Contextual Information pg 6-8
2. Completion of self ratings on the Self Evaluation Instrument p 9 -11.
3. Copies of documents which support your rating on each indicator.
4. A short written paragraph in support of your rating which describes action taken to meet each indicator

Guide to compiling your submission
Please attach documentation for each indicator to the written paragraph for each indicator or preferably, compile it sequentially in a ring bound folder. Please **do not** attach all your documentation as an Appendix at the back of your submission as it is very time consuming to separate out the relevant documentation and match it to the correct indicator.

Please make sure that if you are citing the same documentation in different Domains, that the **evidence is photocopied and placed into each Domain**. Reference to the same documentation **within** Domains is acceptable as long as it is clearly labelled which indicators the document it is referencing to.

Your completed submission should be sent to:

Heather Russell
Lincoln Gerontology Centre
La Trobe University
BUNDOORA 3083

Submissions must be received no later than close of business on Friday, March 3

APMHSs responsiveness to the needs of consumers of residential and community based aged care services

EVALUATION TOOL
Second Round
2000

Part A:
Contextual Information

Name of PGATS

……………………………………………………………………………………..

PGATS liaison officer and phone contact for this evaluation project

Name: Contact phone number

……………………………………………………………………………………..

Location:

……………………………………………………………………………………..

Region:

……………………………………………………………………………………..

Name of auspice:

……………………………………………………………………………………..

Team composition and size:

Please list the staff positions and equivalent EFT (eg. psychiatric nurse 2.5 , social worker 0.8)

Clinical	Management	Administrative

Part A (contin)

Est total 65+ population in your catchment:

………………………………………………………………………………………..

Number of registered clients in current case load:

Registered clients in your current case load are defined as clients registered on PRISM with more than one contact for the calendar year 1999 (this does not include unregistered client contact).

………………………………………………………………………………………..

Current living arrangements

Living arrangements	Client numbers in current case load
Nursing home	
Hostel	
SRS	
Community	
Inpatient facility	
Total	

Organisational relationship with ACAS

Which ACAS do you relate to? (If more than one, please list in order of frequency of contact)

………………………………………………………………………………………..

………………………………………………………………………………………..

Number of referrals received from ACAS in last six months, July – December 1999 (if available)

……………………………………………………………………………………….

Number of referrals from PGATS to ACAS in last six months, July – December 1999 (if available)

……………………………………………………………………………………

Do you have the same auspice as the ACAS?

…………………………………………………………………………………………..

If yes, are you physically co-located (ie. located in the same campus and same building)? How long has this arrangement been in place?

…………………………………………………………………………………………..

…………………………………………………………………………………………..

Other local contextual information
Please briefly describe any other contextual information which may bear upon your capacity to perform on the indicators included in the Self Evaluation Instrument.

…………………………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

APMHSs responsiveness to the needs of consumers of residential and community based aged care services

Part B:

The Self Evaluation Instrument

Second Round Evaluation 2000

PGATS NAME:____

Rating scale:

1. No action taken and no documented plan in place
2. No action taken but a plan is in place for addressing the indicator
3. A plan is in place and activities have occurred but not in a systematic way.
4. Systematic action taken to address the indicator but limited in scope
5. Action taken to address the indicator which is comprehensive

SELF EVALUATION INSTRUMENT
JANUARY 2000

DOMAINS AND INDICATORS

	DOMAIN 1: SERVICE PLANNING AND MANAGEMENT	Rating Scale (circle appropriate score)
1.1	The service has a strategic plan for developing and improving cooperative and collaborative links between PGATS and the aged care sector	**1 2 3 4 5**
1.2	Participation in management and/or service planning and development activities via meetings with ACAS, residential and community care provider managers or via regional or sub regional aged care forums.	**1 2 3 4 5**
DOMAIN 2: SERVICE ACCESS		
2.1	The service has clearly identified and communicated the PGATS target population to the aged care sector together with written protocols for negotiating positive outcomes for clients where referrals are not accepted by the service.	**1 2 3 4 5**
2.2	Provision of a timely, appropriate and consistent response to consumers who are referred from ACAS, residential care and community care	**1 2 3 4 5**
2.3	Referral processes between ACAS and PGATS avoid duplicate procedures	**1 2 3 4 5**
2.4	Secondary consultation: PGATS provide advice or assistance to ACAS, community service providers or residential aged care providers about clients of these agencies where the clients are not registered or seen by the PGATS.	**1 2 3 4 5**
2.5	Quality Improvement: Evidence that PGATS identify the characteristics of the client target group in their catchment and monitor the effectiveness of their service access processes and procedures. Evidence that data from both these sources is used to improve responsiveness.	**1 2 3 4 5**

	DOMAIN 3 CASE COORDINATION AND MANAGEMENT	Rating Scale (circle appropriate score)				
3.1	Collaboration and shared processes occur in the assessment and care plan development of clients (including carers if applicable) where clients are also clients of the ACAS.	**1**	**2**	**3**	**4**	**5**
3.2	Collaboration and shared processes occur in the assessment, care planning and case management of clients (including carers if applicable) who are also clients of community aged care services	**1**	**2**	**3**	**4**	**5**
3.3	Collaboration and shared processes occur in the assessment, care planning and case management of clients (including carers if applicable) where clients are also residents in aged care facilities	**1**	**2**	**3**	**4**	**5**
3.4	Strategies and processes are in place for the provision of crisis management to clients living in the residential aged care sector and clients who receive services from community providers	**1**	**2**	**3**	**4**	**5**
3.5	Strategies and processes are in place for the resolution of complaints that arise out of management of clients who are also supported by aged care agencies.	**1**	**2**	**3**	**4**	**5**
3.6	Quality Improvement: Evidence that collaborative processes for case coordination and case management are monitored and data utilised to improve service responsiveness.	**1**	**2**	**3**	**4**	**5**
DOMAIN 4: EDUCATION AND TRAINING						
4.1	PGAT staff participate in continuing education and training on social and medical aspects of ageing and are kept up-to-date with developments and local service availability in the aged care sector	**1**	**2**	**3**	**4**	**5**
4.2	Provide professional clinical education sessions for residential aged care providers	**1**	**2**	**3**	**4**	**5**
4.3	Provide professional clinical education sessions for community care providers	**1**	**2**	**3**	**4**	**5**
4.4	PGATS include ACAS in professional clinical education sessions organised within their auspice.	**1**	**2**	**3**	**4**	**5**

ATTACHMENT 1:

SELF EVALUATION INSTRUMENT GUIDE

DOMAIN 1:

SERVICE PLANNING AND MANAGEMENT

The achievement of optimal care for clients who require services from both the PGATS and the aged care sector requires effective service planning and management between these two sectors.

Domain 1 covers the extent to which PGATS engage in service planning, development and management activities which focus on achieving effective integration and coordinated care for PGATS clients who are also clients of ACAS, residential or community care service providers.

INDICATOR 1.1

The service has a strategic plan for developing and improving cooperative and collaborative links between PGATS and the aged care sector

Processes, practices and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not meant to be exhaustive or prescriptive but provides examples of types of sources of information and documentation for this indicator:

-a strategic plan which describe links with ACAS, residential and community care sector, including action components and time lines.
- minutes of meetings with ACAS, residential and community care providers indicating their contribution to the development of the plan

Guide to rating scale for indicator 1.1

Rating	Description
Rating 1 No action taken and no documented plan in place	Service has no strategic plan for developing and improving cooperative and collaborative links between PGATS and the aged care sector..
Rating 2 No action taken but a plan is in place for addressing the indicator	The service has a strategy and processes in place for developing a strategic plan to improve links between the PGATS and the aged care sector. The objectives, processes and associated activities such as consultation with the aged care sector which will occur as part of development of the strategic plan are documented.
Rating 3 A plan is in place and activities have occurred but not in a systematic way.	The service has carried out one-off activities which have produced limited plans for improving links with individual aged care agencies or specific sectors such as nursing home or with ACAS but there is no strategic plan which is comprehensive across the aged care sector .
Rating 4 Systematic action taken to address the indicator but limited in scope	A strategic plan has been developed but limited in scope eg. consultation limited to one or two sectors in aged care
Rating 5 Action taken to address the indicator which is comprehensive	A strategic plan is in place which is comprehensive with specific actions described and timelines specified. Comprehensive consultation with the aged care sector occurred in the course of developing the plan.

INDICATOR 1.2

Participation in management and/or service planning and development activities via meetings with ACAS, residential and community care provider managers and/or regional or sub regional aged care forums

Processes, practice and activities:

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not meant to be exhaustive or prescriptive but provides examples of types of sources of information and documentation for this indicator:

- minutes/attendance records of PGATS staff at regional/subregional aged care forums relevant to the strategic plan identified in Indicator 1.1.

-minutes/attendance records and action plans from meetings with key community and residential care providers and ACAS.

Guide to rating scale for indicator 1.2

Rating	Description
Rating 1 No action taken and no documented plan in place	No service documentation providing evidence of the service manager or staff participate in planning or management meetings with specific aged care providers is available.
Rating 2 No action taken but a plan is in place for addressing the indicator	No service documentation providing evidence of the service manager or staff participate in planning or management meetings with specific aged care providers is available but the service has a documented plan which identifies the key regional aged care forums, key aged care providers/service in the catchment. A plan has been established to attend meetings for the purposes of planning and improving service links.
Rating 3 A plan is in place and activities have occurred but not in a systematic way.	Service documentation provides evidence that the service manager/staff participate in some aged care provider meetings for the purpose of improving planing and improving collaboration, but these attendances are not systematic.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation provides evidence that the service manager/staff regularly participate in key aged care forums and key provider meetings but this does not occur across ACAS, the residential care and community care sector.
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation provides evidence that the service manager /staff regularly participate in key aged care forums and key provider meetings across ACAS, the residential care and community care sector.

DOMAIN 2:

SERVICE ACCESS

This domain covers the way in which PGATS ensures the service target population is clearly defined, that access for consumers in that target population is equitable and that consumers receive services in a timely, consistent manner.

INDICATOR 2.1

The service has clearly identified and communicated the PGATS target population to the aged care sector together with written protocols for negotiating positive outcomes for clients where referrals are not accepted by the service.

Processes, practic e and activities:

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not meant to be exhaustive or prescriptive but provides examples of types of sources of information and documentation for this indicator:

-different types of documents which describe and communicate PGATS client population to the target audience eg. protocols, brochures
These protocols documents would include reference to:
-description of ineligible clients
-priority/targeting criteria
- protocols/guidelines for negotiating positive outcomes for clients who are not accepted by the service

Guide to rating scale for Indicator 2.1

Rating 1 No action taken and no documented plan in place	No service documentation clearly identifying and communicating the target population to the aged care sector is available. No protocols are in place for negotiating positive outcomes for clients who are not accepted by the service. The service has no plan in place for carrying out these activities.
Rating 2 No action taken but a plan is in place for addressing the indicator	The service has a plan in place for clearly identifying and communicating the target population to the aged care sector, together with a plan to develop protocols for negotiating positive outcomes for clients who are not accepted by the service.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Some service documentation is available concerning the identification and communication of the target population and protocols to certain aged care services. However this activity is piecemeal eg. only one type of documentation is available and it does not describe the target group adequately or describe the potential for a negotiated process.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation shows that the service has clearly identified and communicated the target population in a systematic way together with protocols for negotiating positive outcomes for all clients who are referred to the service. However this communication is limited in scope, aimed at one or two of the three key sectors in aged care but not all three.
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation shows that the service has clearly identified and communicated the target population in a systematic way together with protocols for negotiating positive outcomes for clients who are referred to all three key sectors in aged care (ACAS, residential care and community care providers).

INDICATOR 2.2

Provision of a timely, appropriate and consistent response to consumers who are referred from ACAS, residential care and community care

Processes, practice and activities:

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not meant to be exhaustive or prescriptive but provides examples of types of sources of information and documentation for this indicator:

-written procedures for referral processes which indicate a consistency in approach
-target response times spelled out
-referral procedures and response times are communicated to the aged care sector
-plan to ensure procedures are 'user friendly' ie. appropriate to the needs of the different providers within the aged care sector
-evidence that target response times are monitored

Guide to rating scale for Indicator 2.2

Rating 1 No documentation in place and no plan to develop documentation	No service documentation describing processes for the provision of a timely, appropriate and consistent response to consumers is available. No plan is in place to develop processes or protocols.
Rating 2 No action taken but a plan is in place for addressing the indicator	No service documentation describing processes for the provision of a timely, appropriate and consistent response to referrals is available but a documented plan to carry out such activities is in place.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Some service documentation describing PGATS procedures for responding to referrals is in place but is indicative of piecemeal rather than systematic activity eg. the documentation does not clearly spell out the referral procedures and target response times, it has not been communicated to the aged care sector and/or policies and protocols have not been updated regularly.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation describing and communicating consistent processes for responding to referrals and target response times is available but is limited in scope eg. documentation does not show a consistent and timely approach across the different elements of the aged care sector
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation describing consistent processes for responding to referrals is available and it is comprehensive eg. documentation takes into account the different needs of the three different sectors in aged care, and there is evidence that target response times are monitored.

INDICATOR 2.3

ACAS only:
Referral processes between ACAS and PGATS avoid duplicate procedures

Processes, practice and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not meant to be exhaustive or prescriptive but provides examples of types of sources of information and documentation for this indicator:

-protocols/guidelines and agreements between ACAS and PGATS describing procedures for cross referral of clients which minimise duplication
-shared or common paper work eg referral forms, common assessment forms, common client files
-shared processes such as shared intake systems
-guidelines for transfer of client information are evident and are based on client confidentiality agreements which are in line with the Mental Health Act

Guide to rating scale for Indicator 2.3

Rating	Description
Rating 1 No documented processes in place and no plan to develop documentation	No service documentation concerning the reduction of duplicate procedures and streamlining of referral processes between ACAS and PGATS is available.
Rating 2 No action taken but a plan is in place for addressing the indicator	No service documentation concerning the reduction of duplicate procedures and streamlining of referral processes between ACAS and PGATS is available . A documented plan has been developed in conjunction with the ACAS to reduce duplication.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Some service documentation concerning the reduction of duplicate procedures between ACAS and PGATS is available but these do not indicate that systematic processes are in place.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation shows evidence of action in one or two areas (eg shared intake /screening procedures, shared paperwork, common referral procedures, transfer of client information) which has resulted in systematic processes occurring between the ACAS and PGATS. Scope is limited and more action/streamlining could occur.
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation shows action has occurred in a range of areas (eg shared intake /screening procedures, shared paperwork, common referral procedures, transfer of client information) which have resulted in a comprehensive approach to minimising duplicate procedures

INDICATOR 2.4

Secondary consultation: PGATS provide advice or assistance to ACAS, community service providers or residential aged care providers about clients of these agencies where the clients are not registered or seen by the PGATS.

Processes, practice and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not meant to be exhaustive or prescriptive but provides examples of types and amount of sources of information and documentation for this indicator:

-written guidelines and procedures for the provision of secondary consultations to the aged care sector
-guidelines and procedures are communicated to the aged care sector
- evidence of the provision of secondary consultations
- evidence of monitoring the provision of secondary consultations

Guide to rating scale for Indicator 2.4

Rating	Description
Rating 1 No documented processes in place and no plan to develop documentation	Service has no available documentation describing the provision of secondary consultation to providers in the aged care sector
Rating 2 No action taken but a plan is in place for addressing the indicator	Service has no available documentation describing the provision of secondary consultation to providers in the aged care sector. However a plan is in place to develop appropriate documentation for the provision of secondary consultation.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Some service documentation describing the provision of secondary consultation is available but this does not indicate a systematic approach.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation showing systematic provision of secondary consultation is available but appears to be limited to one or two areas of the sector . Provision is not systematically monitored.
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation shows the provision and monitoring of secondary consultation across the sector is comprehensive.

INDICATOR 2.5

Quality Improvement: Evidence that PGATS identify the characteristics of the client target group in their catchment and monitor the effectiveness of their service access processes and procedures. Evidence that data from both these sources is used to improve responsiveness.

Processes, practice and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not meant to be exhaustive or prescriptive but provides examples of types of sources of information and documentation for this indicator:

- use of PRISM data or data **collected via other QA activities** to monitor
  - client characteristics
  - access issues eg. examination of the numbers of referrals and the acceptance rate of referrals of clients living in the community compared to those living in residential care; examination and regular reporting of target response times; examination and regular reporting of the level of secondary consultation activities.

- consultations with the aged care sector to review and update documentation and protocols/guidelines relevant to client access: target group definitions, processes for negotiating positive outcomes for all referred clients.
- QA activities are broad in scope, followed up to improve service responsiveness, and systematic rather than 'one-off'.

Guide to rating scale for Indicator 2.5

Rating	Description
Rating 1 No action taken and no plan in place	No service documentation is available describing QI activities for monitoring the effectiveness of service access processes and policies and no documented plan to commence such activities is in place.
Rating 2 No action taken but a plan is in place for addressing the indicator	No service documentation is available describing QI activities for monitoring the effectiveness of service access processes and policies however a documented plan to examine the effectiveness of access processes and policies has been developed.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Service documentation shows that QI activities have occurred but these are not systematic and do not feed into service improvement.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation shows that QI activities to monitor client characteristics and the effectiveness of the service response to referrals have been undertaken in a systematic way eg. data collected on response times, rate of referral from the different sectors within aged care, number and source and number of requests for secondary consultations. However this activity is limited in scope eg. not all areas have been investigated.
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation shows that QI activities to monitor the effectiveness of the service response to referrals have been undertaken in a comprehensive, systematic manner across a number of different areas eg. results from QI activities are used to improve service responsiveness, a range of areas have been investigated, further consultation to improve responsiveness has occurred with the aged care sector as a result of QI activities.

DOMAIN 3:

CASE COORDINATION AND MANAGEMENT

This Domain covers the way in which PGATS collaborate with other aged care providers involved with the PGATS client (and carer if appropriate) to:-

- ***minimise duplicate agency assessment processes***
- ***allow input from other relevant support agencies in care plan development***
- ***promote collaborative case management with relevant aged care providers***
- ***promote and conduct inter-agency case conferences***
- ***ensure continuity of the appropriate level of care***
- ***provide an appropriate crisis management service for clients and carers***
- ***manage and resolve complaints***
- ***monitor performance on the above mentioned indicators***

INDICATOR 3.1

Collaboration and shared processes occur in the assessment and care plan development of clients (including carers if applicable) where clients are also clients of the ACAS.

Processes, practices and activities**:**

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not meant to be exhaustive or prescriptive but provides examples of types of sources of information and documentation for this indicator:
- de-identified case notes evidencing collaborative processes
- guidelines/protocols describing shared/streamlined processes for assessment and care planning eg. evidence of joint or shared assessment where appropriate, common assessment tools, evidence of shared case conferences and collaboration over care plan development
- guideline/protocols for transfer of information which facilitate collaborative practices and which occur according to client confidentiality agreements which are in line with the Mental Health Act

Guide to the rating scale for Indicator 3.1

Rating	Description
Rating 1 No documentation and no plan in place	No service documentation describing collaborative processes in the management of clients who are also ACAS clients is available.
Rating 2 No action taken but a plan is in place for addressing the indicator	No service documentation describing collaborative processes in the management of clients who are also ACAS clients is available. However a plan is in place to develop documented processes.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	One or two de-identified case note examples show evidence of collaborative processes with ACAS is available or evidence of protocols for collaboration and shared processes.
Rating 4 Systematic action taken to address the indicator but limited in scope	Two or more de-identified case note examples show evidence of collaborative processes with ACAS occurring such as joint assessments or joint case conferences, **together with** evidence of protocols for joint or shared assessment processes.
Rating 5 Action taken to address the indicator which is comprehensive	De-identified case note examples show evidence of collaborative processes occurring such as joint assessments or joint case conferences, **together with** evidence of protocols for joint or shared processes of more than one type eg. shared intake, shared case conferences, shared assessment, the use of common assessment tools, guidelines for transfer of information

INDICATOR 3.2

Collaboration and shared processes occur in the assessment, care planning and case management of clients (including carers if applicable) who are also clients of community aged care services

Processes, practices and activities:

The following are examples of key processes and activities which would reflect performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:

- de-identified case notes evidencing collaborative processes
- guidelines describing shared/streamlined processes for assessment and care planning eg. evidence of joint or shared assessment where appropriate, common assessment tools, evidence of attendance at shared case conferences and collaboration over care plan development
- guidelines describing ongoing collaborative case management processes
- guidelines/protocols for transfer of information which facilitate collaborative case coordination and management and which occur according to client confidentiality agreements which are in line with the Mental Health Act eg. transfer of written documentation (forms, letters etc) following assessment, crisis events, reviews and transfers
- guidelines for the transfer/discharge of a client from an inpatient facility to a community aged care agency eg. negotiated timing of transfer and case closure
- understanding and communication of client rights

Guide to rating scale for indicator 3.2

Rating 1 No documentation and no plan in place	No service documentation describing collaborative processes in the management of clients who are also clients of community care agencies is available.
Rating 2 No action taken but a plan is in place for addressing the indicator	No service documentation describing collaborative processes in the management of clients who are also clients of community care agencies is available. However a plan is in place to develop documented processes.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	One or two de-identified case note examples show evidence of collaborative processes is available.
Rating 4 Systematic action taken to address the indicator but limited in scope	Two or more de-identified case note examples show evidence of collaborative processes occurring systematically, such as joint assessments and joint care planning, **together with** evidence of protocols/guidelines for collaborative processes of more than one type.
Rating 5 Action taken to address the indicator which is comprehensive	De-identified case note examples show evidence of collaborative processes occurring such as joint assessments or joint care-planning, **together with** evidence of protocols for joint or shared processes of more than one type right through from referral to discharge

INDICATOR 3.3

Collaboration and shared processes occur in the assessment, care planning and case management of clients (including carers if applicable) where clients are also residents in aged care facilities

Processes, practices and activities:

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:
- de-identified case notes evidencing collaborative processes
- guidelines describing shared/streamlined processes for assessment and care planning eg guidelines describing joint care plan development,
-attendance at residential facility care plan meetings if requested and appropriate
-awareness and understanding of client rights including the rights of people living in aged care facilities
-guidelines/protocols for transfer of information which facilitate collaborative case coordination and management and which occur according to client confidentiality agreements which are in line with the Mental Health Act

Where transfers to inpatient APMHS occur:
-development of a formalised processes with the aged care facility for transfers to inpatient APMHS
-protocols/ guidelines describing PGATS role following the transfer/discharge of a client from an APMHS inpatient facility to a residentia1 aged care facility

Guide to the rating scale for Indicator 3.3

Rating 1 No documentation and no plan in place	No service documentation describing collaborative processes in the management of clients who are also clients of residential care facilities is available.
Rating 2 No action taken but a plan is in place for addressing the indicator	No service documentation describing collaborative processes in the management of clients who are also clients of residential care facilities is available. However a plan is in place to develop documented processes.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	One or two de-identified case note examples show evidence of collaborative processes, or there is evidence of service guidelines/protocols for collaborative processes. However there is no evidence that these processes are systematic in their application.
Rating 4 Systematic action taken to address the indicator but limited in scope	Two or more de-identified case note examples show evidence of collaborative processes occurring systematically, such as joint assessments and joint care planning, **together with** evidence of protocols/guidelines for collaborative processes of more than one type.
Rating 5 Action taken to address the indicator which is comprehensive	De-identified case note examples show evidence of collaborative processes occurring such as joint assessments or joint care-planning, **together with** evidence of protocols for joint or shared processes right through from referral to discharge.

INDICATOR 3.4

Strategies and processes are in place for the provision of crisis management to clients living in the residential sector and clients who receive services from the community providers

Processes, practices and activities

The following are examples of key processes and activities which would reflect performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:

-guidelines for differentiating between urgent and non-urgent situations are communicated to the sector
-target response times for urgent situations are clearly articulated and monitored
- protocols are provided to aged care sector regarding PGATS role and responsibility during a crisis and their role in case management until such time as the client is placed or settled
-feedback/communication/debriefing to providers in the aged care facility after on-site crisis intervention
-evidence of written protocols/agreements with Adult Mental Health Service regarding 24 hour coverage for APMHS which reflect collaborative arrangements with the APMHS and aged care sector

Guide to rating scale for Indicator 3.4

Rating 1 No documentation and no plan in place	The service has no available documentation concerning crisis management of clients living in the residential/community aged care sector.
Rating 2 No action taken but a plan is in place for addressing the indicator	The service has no available documentation concerning crisis management of clients living in the residential/community aged care sector. However a plan is in place to develop documented processes.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Some service documentation showing evidence of processes concerning crisis management of clients living in the residential/community aged care sector is available bit it is not systematic
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation shows evidence of processes concerning crisis management of clients living in the residential/community aged care sector but this is limited in scope and does not cover each different sector in aged care
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation shows evidence of processes concerning crisis management of clients living in the residential/community aged care sector occurring in a systematic and comprehensive manner across the aged care sector and that PGATS response to these situations is monitored.

INDICATOR 3.5

Strategies & processes are in place for the resolution of complaints that arise out of management of clients who are also supported by aged care agencies.

Processes, practices and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:

-written protocols/agreements are in place which are locally developed and meet best practice standards for complaints handling
-evidence of processes for the resolution of complaints is available
-interagency meetings or other forums provide a formal agenda for discussion of issues
- clients (and carers if applicable) are provided with information on their rights, responsibilities and options regarding the making and resolution of complaints

Guide to rating scale for indicator 3.5

Rating 1 No documentation and no plan in place	The service has no available documentation concerning processes for the management and resolution of complaints
Rating 2 No action taken but a plan is in place for addressing the indicator	The service has no available documentation concerning processes for the management and resolution of complaints. However a plan is in place to develop documented processes.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Some service documentation shows evidence of processes for the management and resolution of complaints but these are not systematic across the service
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation shows evidence for the management and resolution of complaints occurring in a systematic way but this is limited in scope and does not cover each different sector in aged care
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation shows evidence for the management and resolution of complaints occurring in a systematic and comprehensive manner across the aged care sector

INDICATOR 3.6

Quality improvement: Evidence that collaborative processes for case coordination and management are monitored and data utilised to improve service responsiveness.

Processes, practices and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:

-implement quality systems which show evidence of a quality improvement cycle ie. evidence of written policies ad procedures which are systematically reviewed and improvements made following these reviews.

-monitor current performance in areas of collaborative practice specified in detail in Domain 3 eg. processes for maximising collaboration

- monitoring of complaints, crisis management

Guide to rating scale for Indicator 3.6

Rating	Description
Rating 1 No documentation and no plan in place	The service has no available documentation showing processes for collaborative case coordination and case management being monitored and data utilised to improve service responsiveness
Rating 2 No action taken but a plan is in place for addressing the indicator	The service has no available documentation showing processes for collaborative case coordination and case management being monitored and data utilised to improve service responsiveness. However a documented plan is in place to develop strategies for monitoring collaborative case coordination and case management practices.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Some service documentation shows evidence that processes for collaborative case coordination and case management are monitored and data utilised to improve service responsiveness, but activity is not systematic
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation shows that processes for collaborative case coordination and case management are monitored in a systematic, planned way but this is limited in scope eg. activities do not cover each different sector in aged care, feedback is not sought from the range of stakeholders, data not utilised to improve service responsiveness
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation shows that processes for collaborative case coordination and case management are monitored in a systematic comprehensive manner across the aged care sector, and data is utilised to improve service responsiveness

DOMAIN 4:

EDUCATION AND TRAINING

This domain seeks to identify the extent to which PGATS provide ongoing education and training opportunities to its own workers and clinical education to workers in the aged care sector.

INDICATOR 4.1

PGATS staff participate in continuing education and training on social and medical aspects of ageing and are kept up-to-date with developments and local service availability in the aged care sector

Processes, practices and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:

-PGATS have a continuing education and training policy
-a systematic plan for continuing education and a cycle of review of this plan
-resource and funding are identified for continuing education activities
-attendances at education and training activities such as seminars, courses, conferences are recorded
-feedback to all staff occurs as a result of attending these activities
-maintenance of resource files on local aged care service availability and new services (designated staff member to action this)
-attendance at aged care information sessions/forums on new programs in aged care
-invite speakers from aged care sector to PGATS staff meetings/education sessions

Guide to rating scale for Indicator 4.1

Rating 1 No action taken and no documented plan in place	No service documentation of staff attending education and training sessions. There is no documented plan to provide for this information
Rating 2 No action taken but a plan is in place for addressing the indicator	A documented plan for staff continuing education and training is in place. No service documentation concerning staff continuing education and training or how the service keep staff members updated on aged care service availability is available.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Continuing education and training is provided but not in a systematic way. The resource file is not regularly updated.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation indicates a systematic program of staff continuing education and training in place with designated resources and funding. However the range of issues addressed is limited and does not cover clinical education as well as education on aged care service availability.
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation indicates a systematic documented program of staff continuing education and training is in place with designated resources and funding. Feedback to all staff occurs as a result of attending these activities. The program is systematically evaluated.

INDICATOR 4.2

Provide professional clinical education sessions for residential aged care providers

Processes, practices and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:

- clinical training needs of local providers in residential aged care are identified and provided within an overall framework and plan
- on-site and off- site training provided
-the plan and the program is evaluated

Guide to rating scale for Indicator 4.2

Rating	Description
Rating 1 No action taken and no documented plan in place	No service documentation concerning staff providing clinical education or information sessions for staff of residential care providers is available. There is no documented plan to provide for this service.
Rating 2 No action taken but a plan is in place for addressing the indicator	A documented plan on how the service will provide clinical education sessions for residential aged care providers is in place but no action has been implemented
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Service documentation indicate that staff provide some educations sessions within the framework of an overall plan, but this is not as yet a systematic process.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation shows a systematic program of clinical education provision to residential aged care providers is in place but it is limited in scope eg. this is offered only to a limited number of providers or the range of topics is limited or the program has not been evaluated.
Rating 5 Action taken to address the indicator which is comprehensive	Service documentation shows there is a systematic documented program of professional clinical education which is planned in consultation with the residential care sector and delivered comprehensively across the sector. The program is systematically evaluated and reviewed in light of this evaluation

INDICATOR 4.3
Provide professional clinical education sessions for community care providers

Processes, practices and activities

The following are examples of key processes and activities which would reflect performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:

- clinical training needs of local providers in community aged care are identified and provided within an overall framework and plan
- on-site and off- site training provided
-the plan and the program is evaluated

Guide to rating scale for Indicator 4.3

Rating	Description
Rating 1 No action taken and no documented plan in place	No service documentation of staff concerning the provision of clinical education for staff of community care agencies is available There is no documented plan to provide for this service.
Rating 2 No action taken but a plan is in place for addressing the indicator	A documented plan on how the service provides clinical education sessions for community aged care providers is in place but no action has been implemented
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Service documentation indicate that staff provide some educations sessions, but this is not as yet a systematic process.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation shows a systematic program of clinical education provision to community aged care providers is in place but it is limited in scope eg. this is offered only to a limited number of providers or the range of topics is limited or the program has not been evaluated.
Rating 5 Action taken to address the indicator which is comprehensive	A systematic documented program of professional clinical education is in place which is planned in consultation with community care providers and delivered comprehensively across the sector. The program is systematically evaluated and reviewed in light of this evaluation

INDICATOR 4.4

PGATS include ACAS in professional clinical education sessions organised within their auspice's clinical program

Processes, practices and activities

The following are examples of key processes and activities which reflect good performance on this indicator. This list is not exhaustive but is included as a guide to sources of information and documentation for this indicator:

-clinical training needs of ACAS are identified
- ACAS are invited to sessions provided within the auspice clinical program

Guide to the rating scale for Indicator 4.4

Rating 1 No action taken and no documented plan in place	No documentation of invitations for ACAS to attend clinical education or information sessions is available. There is no documented plan to provide this service.
Rating 2 No action taken but a plan is in place for addressing the indicator	A plan identifying ACAS clinical education needs and PGATS intention to invite ACAS to clinical education sessions is in place but no action has occurred.
Rating 3 A plan is in place and activities have occurred but not in a systematic way	Service documentation indicates that PGATS invite ACAS to clinical educations sessions but the approach is not regular.
Rating 4 Systematic action taken to address the indicator but limited in scope	Service documentation indicates ACAS are invited to attend a regular, planned program of professional clinical education provided by PGATS but the program is not evaluated.
Rating 5 Action taken to address the indicator which is comprehensive	A regular program of professional clinical education is in place which is comprehensive and planned in consultation with ACAS staff, regularly evaluated and reviewed in light of this evaluation.

Appendix 2

Survey of PGATS responsiveness to the needs of clients of residential and community based aged care services

ACAS SURVEY

Could you please complete this questionnaire with reference to the PGATS

service provided by ____

Name of your ACAS: ______________________________

Contact with PGATS:

How many (approx.) referrals would you make to the PGATS in a typical six month period? _

Approximately how many of your current ACAS clients are also clients of the PGATS? ______

Please comment on the following aspects of the PGATS service

1. The service has clearly identified and communicated the PGAT target population to your ACAS. If a client you have concerns about is not accepted as a PGATS' client, the PGATS provides appropriate advice and assistance to ensure positive outcomes are still achieved for that client.

Elements/examples of good current practice:

Aspects that could be improved:

2. PGATS provide a timely, appropriate and consistent response to clients who are referred from your ACAS.

Elements of good current practice:

Aspects that could be improved:

3. Referral processes between your ACAS and PGATS seek to avoid or minimise duplicate procedures

Elements of good current practice:

Aspects that could be improved:

4. The PGATS provide secondary consultation to your ACAS ie. PGATS provide advice or assistance with clients who you are concerned about, but who are not registered with, or seen by the PGATS.

Elements/examples of good current practice:

Aspects that could be improved:

5. Collaboration and shared processes occur in the assessment and care plan development of clients (including carers where appropriate) who are also clients of the ACAS.

Elements/examples of good current practice:

Aspects that could be improved:

6. The PGATS include ACAS staff in clinical education sessions organised within their auspice.

Elements/examples of good current practice:

Aspects that could be improved:

Please add any further general comments regarding collaborative processes between PGATS and your service which have not already been covered.

Thank you for your assistance.
Please return the completed questionnaire in the envelope provided to
Heather Russell, Lincoln Gerontology Centre, La Trobe University,
BUNDOORA 3083

Appendix 2 (contin)

Survey of Psychogeriatric Assessment and Treatment Service's (PGATS)[1] responsiveness to the needs of clients of community based and residential aged care services.

Could you please complete this questionnaire with reference to the service provided by the ______________________________

Name of your organisation: ___________________________
(Only used for the purpose of identifying response rates)

Contact with PGATS:
How many (approx.) of your current clients are also clients of the PGATS?
____

Please comment on the following aspects of the PGATS service

1. The PGATS has clearly explained and communicated their target group to you. If a client you have concerns about is not accepted as a PGATS client, the PGATS provides appropriate advice and assistance to ensure positive outcomes are still achieved for that client.
Elements/examples of good current practice:

Aspects that could be improved:

2. The PGATS provides a timely, appropriate and consistent response when you refer a client to them.
Elements/examples of good current practice:

Aspects that could be improved:

3. The PGATS staff are available for secondary consultation i.e. PGATS provide advice or assistance with clients who you are concerned about, but who are not registered with, or seen by, the PGATS.
Elements/examples of good current practice:

Aspects that could be improved:

[1] The term PGATS is used interchangeably with APATT, Aged Psychiatry Assessment and Treatment Team

4. When you have a client who is also a client of the PGATS, the PGATS work collaboratively with you in the assessment, care planning and case management of the client to ensure continuity of care and to minimise duplication between the two services.
Elements/examples of good current practice

Aspects that could be improved:

5. When there is a crisis with one of your clients, the PGATS has clear strategies and processes in place for responding to the crisis.
Elements/examples of good current practice:

Aspects that could be improved:

6. If your service receives a complaint from a client or their family about the PGATS, or if your agency has a concern about the service offered by the PGATS, there are clear guidelines /strategies for addressing the complaint.
Elements/examples of good current practice:

Aspects that could be improved:

7. The PGATS provide professional clinical education sessions for community aged care providers.
Elements/examples of good current practice:

Aspects that could be improved:

Please add any further general comments regarding collaborative processes between PGATS and your services which have not already been covered.
(e.g. local factors that may bear on collaboration, plans for future activities etc)

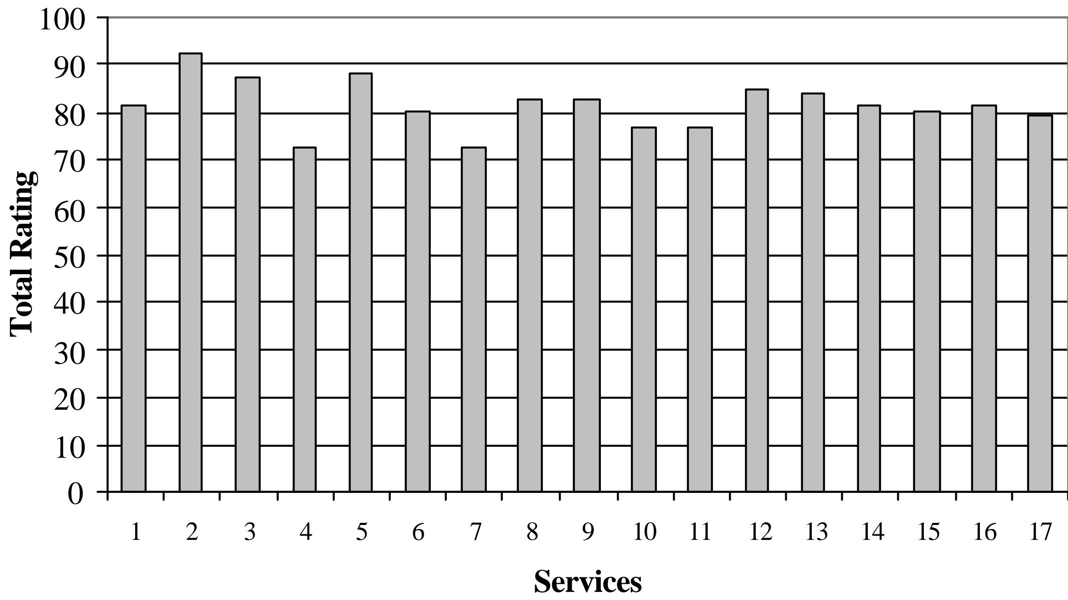
Thank you for your assistance.
Please return the completed questionnaire in the envelope provided to:
Heather Russell Lincoln Gerontology Centre, La Trobe University
BUNDOORA 3083

Any queries please contact Heather Russell or Peter Foreman 9479 3700

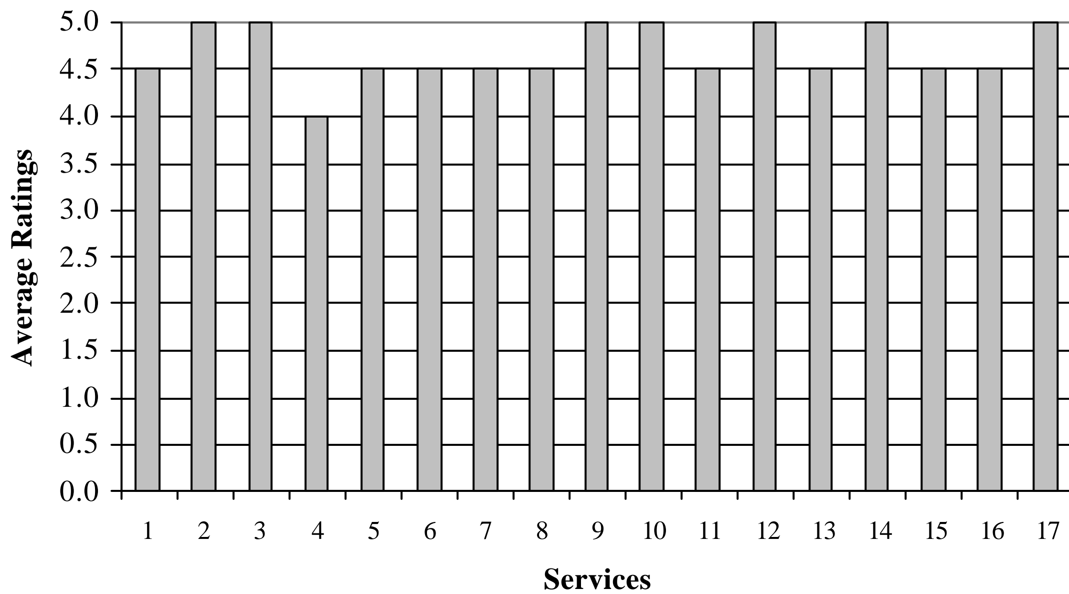
Appendix 3

GLOBAL SCORES BY SERVICE AND INDICATOR SCORES BY SERVICE

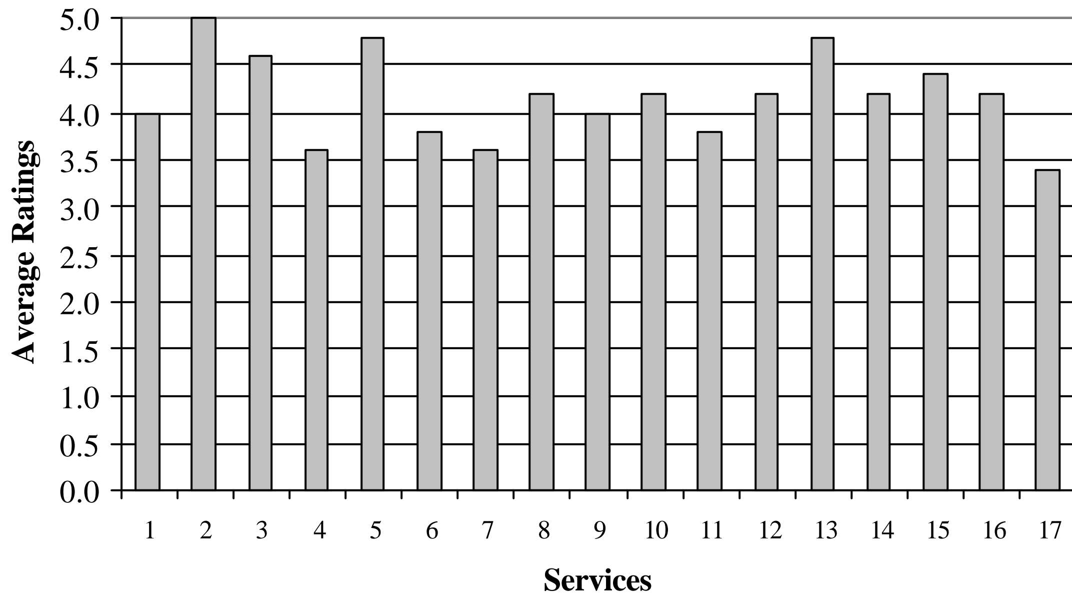
Global Index Scores



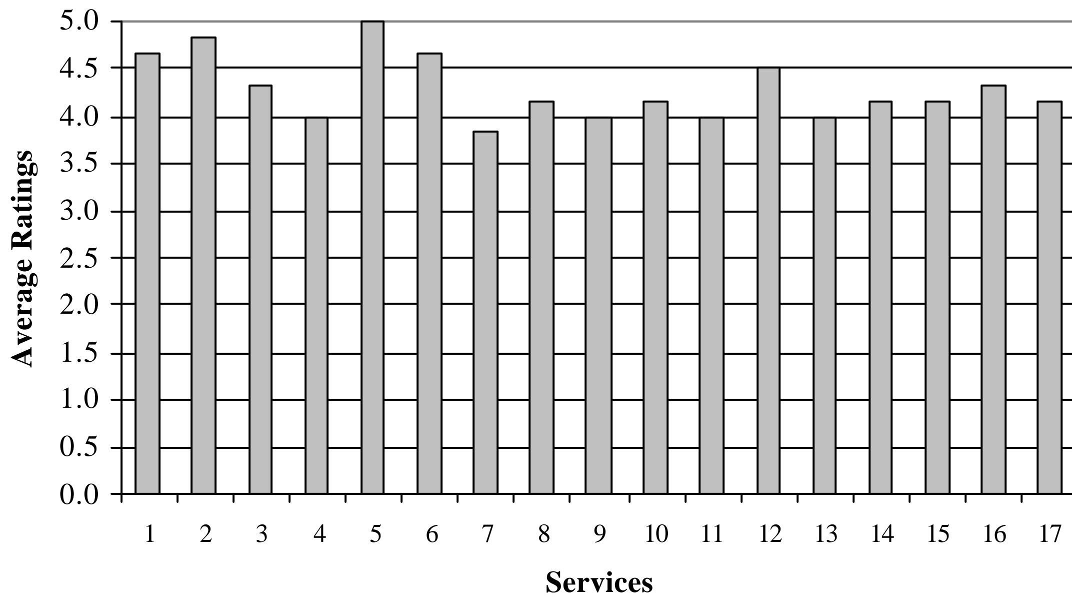
Scores on Domain One: Service Planning and Management



Scores on Domain Two: Service Access



Scores on Domain Three: Case Coordination and Management



Scores on Domain Four: Education and Training