

# HOME & COMMUNITY CARE (HACC) ASSESSMENT PROTOCOLS IN WHITTLESEA



**City of Whittlesea**



**Plenty Valley  
Community  
Health**

 **Northern Health**



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# CONTENTS

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<b>CONTENTS.....</b>	<b>2</b>
<b>1. Introduction .....</b>	<b>4</b>
1.1 What is the purpose of this document? .....	4
1.2 Who is the document for?.....	4
1.3 Why has this document been prepared? .....	4
1.4 How does it relate to the Victorian Service Coordination Practice Manual? .....	4
1.5 What is service coordination? .....	5
<b>2. HACC Assessment Framework .....</b>	<b>5</b>
2.1 WHAT IS HACC? .....	5
2.2 What is the Assessment Framework? .....	5
2.3 What are the expected outcomes of the Assessment Framework? .....	6
2.4 how does the Assessment Framework relate to the active service model? .....	6
<b>3. The Whittlesea HACC Assessment Partnering Agreement.....</b>	<b>6</b>
3.1 What is the Partnering Agreement? .....	6
3.2 Who are parties to the Agreement?.....	7
3.3 what is the DURATION of the agreement? .....	7
3.4 Where can I find a copy of the Partnering Agreement? .....	7
<b>4. HACC in Whittlesea.....</b>	<b>7</b>
4.1 Which partners provide HACC services in Whittlesea? .....	7
4.2 What HACC services do these agencies provide? .....	7
4.3 Who are the designated assessment agencies? .....	8
4.4 Which HACC services are provided by each agency?.....	8
4.5 What are the Pathways to HACC services in Whittlesea? .....	9
<b>5. Assessment Types .....</b>	<b>10</b>
5.1 Living at Home Assessment (LAHA) .....	10
5.2 Comprehensive Assessment .....	10
5.3 Service Specific Assessment .....	10
5.4 Agency Specific Assessment .....	11
5.5 Who does these assessments? .....	11
5.6 Tools for assessment .....	11
5.7 Where are assessments undertaken? .....	11
<b>6. Client Pathways to a LAHA.....</b>	<b>12</b>
6.1 Intake to A LAHA .....	12
6.1.1 Initial contact .....	12
6.1.2 Initial needs identification to a LAHA.....	13
6.2 Specific Service Assessment to a LAHA.....	13
6.3 Service Delivery to a LAHA .....	13
<b>7. Referral .....</b>	<b>14</b>
7.1 Referral for a LAHA.....	14

7.2	Tools for referral.....	14
7.3	Protocols for Referral .....	14
7.3.1	agency sending a referral.....	14
7.3.2	agency receiving a referral.....	14
7.3.3	All Agencies referring .....	14
7.3.4	client self Referral .....	15
<b>8.</b>	<b>What Happens after Completion of a LAHA.....</b>	<b>15</b>
8.1	Development of a care plan .....	15
8.2	Inter agency care planning.....	15
8.3	Service Coordination Plan.....	15
8.4	Service specific plan .....	16
8.5	Client Care coordination .....	16
8.6	Referral Action Plan .....	16
8.7	Service initiation.....	16
<b>9.</b>	<b>Client rights .....</b>	<b>16</b>
9.1	Client rights .....	16
9.2	Sharing of client information.....	17

# 1. INTRODUCTION

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## 1.1 WHAT IS THE PURPOSE OF THIS DOCUMENT?

The purpose of the Assessment Protocols is to define policies, processes, practices and systems which support Home and Community Care (HACC) in the Whittlesea area and specifically to:

- Document clear expectations for agencies and practitioners
- Guide the implementation of HACC assessment at the local level
- Guide referral and service coordination at an agency level
- Provide a resource for managers and practitioners involved in service coordination
- Provide the basis for monitoring and continuous improvement of HACC Services in Whittlesea.

## 1.2 WHO IS THE DOCUMENT FOR?

These Assessment Protocols are designed as a reference guide for managers responsible for leading and managing HACC services and for practitioners involved in the implementation of services.

These Protocols complement a range of statewide resources including the:

- *Framework for Assessment in the Home and Community Care Program in Victoria*
- *Better Access to Services: A Policy and Operational Framework*

These resources can be found at [www.health.vic.gov.au/HACC](http://www.health.vic.gov.au/HACC) and [www.health.vic.gov.au/PCP](http://www.health.vic.gov.au/PCP).

## 1.3 WHY HAS THIS DOCUMENT BEEN PREPARED?

These Assessment Protocols have been developed in response to the changes outlined in the *Framework for Assessment in the Home and Community Care Program in Victoria 2007*. The municipality has been funded for a pilot project to formalise the partnering arrangements between HACC service providers. The document establishes protocols for practitioners involved in the program and details agreed referral pathways between intake [initial contact and initial needs identification (INI)], assessment and service delivery; it also outlines decision criteria, tools used and services available.

## 1.4 HOW DOES IT RELATE TO THE VICTORIAN SERVICE COORDINATION PRACTICE MANUAL?

These Assessment Protocols aim to ensure best practice service coordination standards for intake (initial contact and INI), assessment and care planning for HACC clients in the municipality. These Assessment Protocols draw on the content of the Victorian Service Coordination Practice Manual (VSCPM) and are consistent with the principles and practices described therein. The VSCPM outlines:

- An agreed minimum standard across the State for how agencies work together to improve consumer care
- Common concepts and language to ensure improved Service Coordination across sectors
- An improved approach that enables organisations to be fully engaged in the principles behind Service Coordination
- An agreed statewide platform that will make possible further development of the *Better Access to Services* resource

Two other resources support service coordination:

- *Good Practice Guide for Practitioners*, and
- *Continuous Improvement Framework*.

## 1.5 WHAT IS SERVICE COORDINATION?

Service Coordination is a statewide vision to align practices, processes, protocols and systems through functional integration. Achieving functional integration enables agencies to remain independent of each other as entities and still work in a cohesive and coordinated way so that consumers experience a seamless and integrated response. Service Coordination places consumers at the centre of service delivery to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes.

Service Coordination is underpinned by the following principles:

- A central focus on consumers
- Partnerships and collaboration
- The social model of health
- Competent staff
- A duty of care
- Protection of consumer information
- Engagement of other sectors.

## 2. HACC ASSESSMENT FRAMEWORK

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### 2.1 WHAT IS HACC?

The Home and Community Care (HACC) Program provides funding for services which support frail older people, younger people with disabilities and their carers. These services provide basic support and maintenance to people living at home whose capacity for independent living is at risk or who are at risk of premature or inappropriate admission to long-term residential care.

Assessment is a critical factor in managing client pathways in and out of HACC services as well as the broader health and community care system.

The HACC program is funded jointly by the Australian and Victorian governments under the HACC Amending Agreement of 1998. In Victoria, the program provides funding to approximately 500 agencies to support over 220,000 frail older people and people with disabilities.

### 2.2 WHAT IS THE ASSESSMENT FRAMEWORK?

The Victorian Government's *Framework for Assessment in the Home and Community Care Program in Victoria* 2007 sets out program policy for Assessment as a HACC funded activity. It describes in detail the requirements for the delivery of a Living at Home Assessment (LAHA) which includes a home-based holistic assessment of need, an occupational health and safety assessment and service-specific assessments as key components.

Assessment also plays a critical role in recognising if a client's declining abilities and increasing need for service requires the client to transition from the HACC Program to a more suitable care option.

The Framework also describes related processes such as Client Care Coordination and Supported Access. Both of these processes are critical adjuncts to Assessment for specific client groups.

The Framework focuses on:

- Building on each person's strengths
- Improving the client's functional capacity and social participation wherever possible
- Delivering services or supports based on what is most important to the client and carer.

As part of this Framework, the Department of Human Services (DHS) introduced designated HACC Assessment Service Providers within all local government areas.

### **2.3 WHAT ARE THE EXPECTED OUTCOMES OF THE ASSESSMENT FRAMEWORK?**

This new Assessment Framework requires a partnership approach. Specific outcomes expected are:

- Partnerships, alliances and inter agency protocols will ensure that the assessment process is coordinated around client and carer need, drawing on specific expertise as required
- Alliances will be developed between HACC Assessment Services and other relevant organisations within a defined geographic area preferably the PCP catchment
- Alliances will build trust between organisations, reduce duplication and facilitate more timely completion and coordination of assessment, care planning and service delivery.

In addition to the partnership outcomes expected, it is anticipated that service-specific providers will be able to streamline their current processes and focus on service delivery and not the broader assessment role.

### **2.4 HOW DOES THE ASSESSMENT FRAMEWORK RELATE TO THE ACTIVE SERVICE MODEL?**

The Framework also facilitates the implementation of the Active Service Model which seeks to better assess the capabilities of people in the HACC target group and, through more flexible funding and service approaches, help clients better manage their own needs and improve their independence wherever possible.

Some of the expected outcomes from an Active Service Model approach will be:

- Increased referral to a range of allied health professionals in order to improve capacity to undertake domestic and personal care activities. This will involve active collaboration with HACC funded allied health services in order to gain timely access to these clinical interventions to maximise functional gain
- Increased use of aids, equipment and new products/technologies as an addition and/or alternative to HACC services for low level needs clients
- Incorporation of Well for Life principles into assessment and care planning practice; that is, understanding and promoting the inter-relationship and benefits of good nutrition, physical activity and social participation for independence and healthy ageing
- Increased referrals to GPs and specialist services such as rehabilitation and ambulatory services to investigate clinical/medical issues that may be identified at assessment as having an impact on functioning
- Increased referrals to Early Intervention Chronic Disease Management services to enable improved self management for clients with chronic and complex needs
- Advocacy for client and carer involvement in local prevention, health promotion activities, social and recreational activities.

## **3. THE WHITTLESEA HACC ASSESSMENT PARTNERING AGREEMENT**

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### **3.1 WHAT IS THE PARTNERING AGREEMENT?**

The Whittlesea HACC Partnering Agreement formalises the partnership arrangements between the City of Whittlesea, Plenty Valley Community Health Inc., Royal District Nursing Service and Northern Health – Bundoora Extended Care Centre in the provision of HACC services in the municipality.

These organisations are formally committed to working together to develop and implement a viable partnership structure and centralised assessment system to ensure the integrated management and delivery of all assessment services for the HACC program.

### 3.2 WHO ARE PARTIES TO THE AGREEMENT?

**City of Whittlesea (CoW)** Aged and Disability Services is part of the Community Services Department at the Council

**Royal District Nursing Service (RDNS)** is a state-wide organisation providing a wide range of nursing services in the home. The local RDNS office is based in Diamond Creek and provides services to Banyule, Manningham and Nillumbik as well as Whittlesea

**Bundoora Extended Care Centre (BECC)** is part of Northern Health which is the key provider of public healthcare in Melbourne's northern region. The service is based in Bundoora and provides services within Nillumbik, part of Darebin, part of Banyule as well as Whittlesea. BECC has decided to work in accordance with the principles of the partnering agreement and the protocols set out in this document but will not be a signatory to the Agreement at this stage

**Plenty Valley Community Health (PVCH)** provides healthcare and support services to people of all ages with a strong focus on health promotion, treatment and the prevention of illness and injury. Its services are available within Whittlesea and some neighbouring municipalities

### 3.3 WHAT IS THE DURATION OF THE AGREEMENT?

The Partnering Agreement is a three year agreement commencing in July 2009 but it will be reviewed annually or earlier if so requested by any of the partners. It is the intention of the parties to collaborate in the provision of services to the community for the foreseeable future and renewal of the Agreement will be negotiated prior to 30 June 2012.

### 3.4 WHERE CAN I FIND A COPY OF THE PARTNERING AGREEMENT?

A copy of the Partnering Agreement is available from the City of Whittlesea. Please contact:

Coordinator Home Support

Aged & Disability Services

City of Whittlesea

Phone: (03) 9217 2407, Fax: (03) 9409 9876, TTY: (03) 9217 2420

Email: [info@whittlesea.vic.gov.au](mailto:info@whittlesea.vic.gov.au)

Web Address: [www.whittlesea.vic.gov.au](http://www.whittlesea.vic.gov.au)

Street Address: Council Offices, 25 Ferres Boulevard, South Morang 3752 (Melway 183 A10)

Postal Address: Locked Bag 1, Bundoora MDC, 3083.

## 4. HACC IN WHITTLESEA

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### 4.1 WHICH PARTNERS PROVIDE HACC SERVICES IN WHITTLESEA?

- City of Whittlesea
- Royal District Nursing Service
- Plenty Valley Community Health
- Northern Health - Bundoora Extended Care Centre.

### 4.2 WHAT HACC SERVICES DO THESE AGENCIES PROVIDE?

- Home Care – domestic assistance
- Personal Care
- Respite
- Meals – delivered meals
- Property Maintenance
- Planned Activity Groups
- Nursing Services
- Specialist Assessment & Management
- Physiotherapy
- Occupational Therapy
- Podiatry
- Dietetics
- Speech Therapy
- Other Allied Health
- Linkages
- Continence Nursing.

### 4.3 WHO ARE THE DESIGNATED ASSESSMENT AGENCIES?

**City of Whittlesea** and **Royal District Nursing Service** have been designated as the HACC assessment service providers for the municipality. Designated assessment providers are funded to facilitate higher quality assessment of potential clients by better utilising the skills and expertise of agencies in the area and streamlining the way in which assessments and referrals are handled.

### 4.4 WHICH HACC SERVICES ARE PROVIDED BY EACH AGENCY?

Services	Whittlesea Com. Care	RDNS	PVCH	Northern Health
LAHA	x	x		
Home Care	x			
Personal Care	x	x	x disability funded	
Respite	x			
Meals	x			
Property Maintenance	x			
Planned Activity Groups	x		x	x
Nursing Services		x		
Specialist Assessment & Management		x		
Social Work (unfunded) <sup>1</sup>		x	x	x

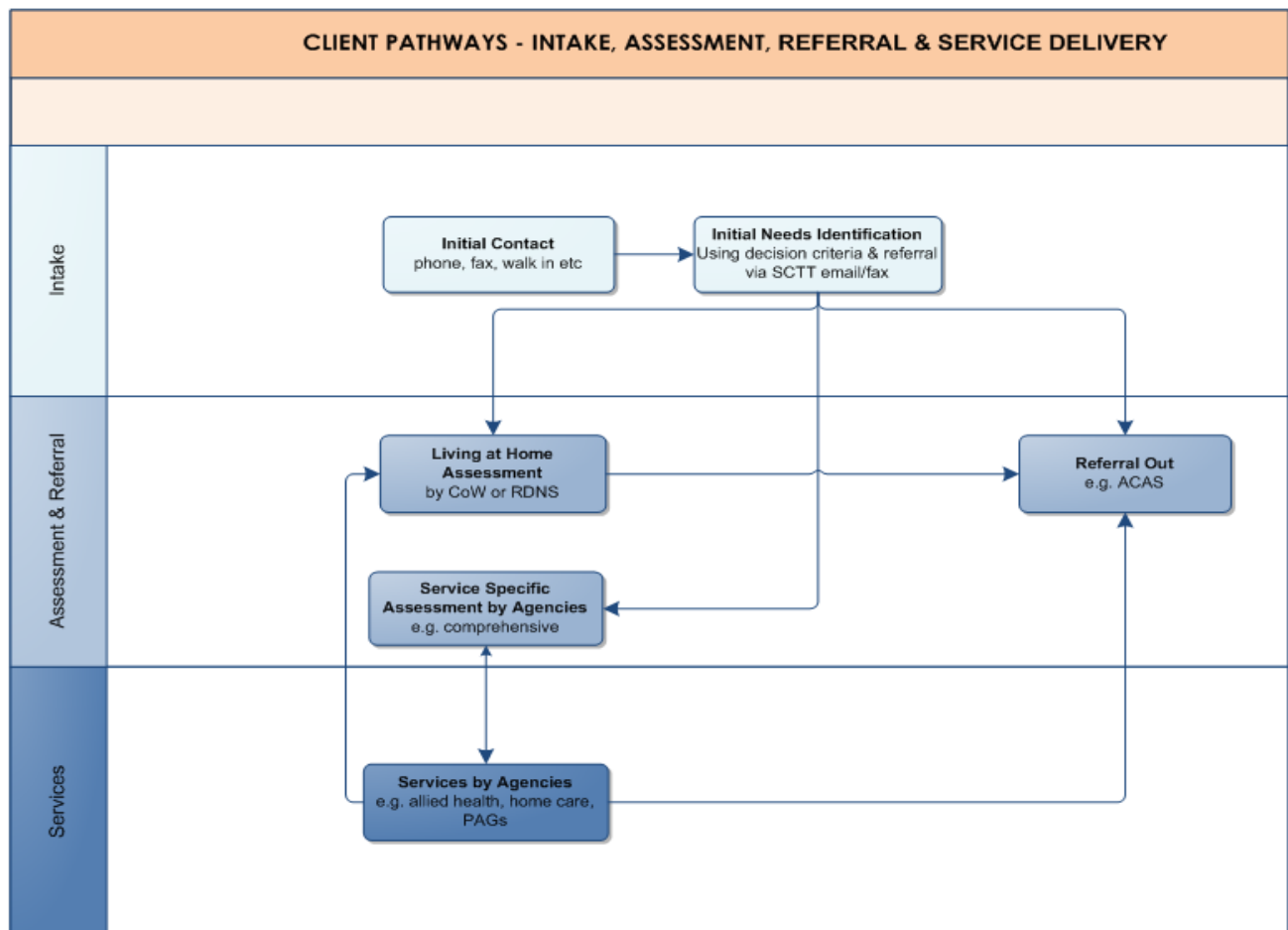
<sup>1</sup> Agencies see HACC clients in need of a social work service and use other resources to meet this need

Services	Whittlesea Com. Care	RDNS	PVCH	Northern Health
Physiotherapy <sup>2</sup>		X	X	X
Occupational Therapy			X	X
Podiatry			X	X
Dietetics			X	X
Speech Therapy				X
Other Allied Health			X	X
Linkages			X	X
Continence Nursing		X		X

**Figure 1: Showing the range of services provided across the four project partners**

#### 4.5 WHAT ARE THE PATHWAYS TO HACC SERVICES IN WHITTLESEA?

The HACC intake, referral and assessment pathways in the Whittlesea area are shown in the table below. All agencies are involved in initial contact, initial needs identification, referral, specific-service assessment and service delivery, while the LAHA assessment is only undertaken by CoW and RDNS.



**Figure 2: Showing the HACC Intake, Referral & Assessment Pathways**

<sup>2</sup> Physiotherapy in RDNS is provided for OHS purposes but is not funded by the HACC program

## 5. ASSESSMENT TYPES

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Assessment is not a one-off event. It is a continuum - an ongoing process of building a relationship with a client and carer that begins at initial contact and continues through to service delivery, review and reassessment as circumstances change. Assessment is an interactive process between clients and providers, not a one-way communication.

The HACC Program provides a broad reach of service to a large client population. The majority of clients receive low levels of service and only a small group of clients receive medium to high levels of service.

For this reason, the assessment experience in HACC needs to be tailored to fit client need and circumstances. The provision of different types of assessments should ensure that:

- Clients with basic, one-off or short term needs are not over assessed
- Clients are assessed by staff with the appropriate expertise
- Duplication of assessment and repetitive information gathering is minimised.

In some cases, clients will receive more than one type of assessment in order to ensure they get the service that most appropriately meets their need. The aim is that different assessment types occur seamlessly without repetition of information gathering.

### 5.1 LIVING AT HOME ASSESSMENT (LAHA)

A Living at Home Assessment (LAHA) is intended to gain a broad understanding of the type and range of client and carer's needs for community based services to enable the client to remain at home. It is a broad, holistic needs-based assessment and includes:

- A service specific assessment and care plan for the range of HACC services delivered by the assessing organisation
- A referral action plan to both HACC and non-HACC services for needs that cannot be met by the assessing organisation
- An Occupational Health and Safety (OHS) assessment
- Information provision about additional services or activities for client to follow up.

A referral for a LAHA occurs when a client is identified as having unmet needs and potential to benefit from a HACC program service response.

### 5.2 COMPREHENSIVE ASSESSMENT

Comprehensive assessment is not funded by the HACC program as these assessments are carried out by the Aged Care Assessment Services (ACAS). They are an important part of the client pathway for HACC clients with high and complex needs who require more intensive levels of service.

Clients who have recently had a comprehensive assessment would not normally be referred for a LAHA as this would involve collection of information already available. A LAHA may be appropriate when a client's needs change.

### 5.3 SERVICE SPECIFIC ASSESSMENT

A Service Specific Assessment is an assessment for a particular service type, e.g. nursing or allied health, domestic assistance, planned activity group or delivered meals. The purpose is to identify the client's requirements for that service and create a service specific care plan.

Some clients will receive a service specific assessment without first having a LAHA. This may be because the client only needs the specific service or because there is an urgent need for the

service. In both cases, the service provider should consider a referral for a LAHA if the client is identified as having a broader set of unmet needs.

#### 5.4 AGENCY SPECIFIC ASSESSMENT

Agency Specific Assessments currently vary considerably depending on the range of services each agency provides. The agencies currently refer to these as a 'general' or 'comprehensive' assessment and are usually undertaken by a service specific provider (e.g. Occupational Therapist).

The service specific provider will complete the comprehensive/general assessment and their service specific assessment. The provider uses the comprehensive/general assessment information to determine eligibility for HACC and other services.

It may result in referral to other specific services (e.g. nursing, podiatry,) or other programs such as Hospital Admission Risk Program (HARP), Chronic Disease Management (CDM), and Linkages.

#### 5.5 WHO DOES THESE ASSESSMENTS?

Assessment Type	Agency	Description
Living at Home Assessment	CoW RDNS	Two designated assessment agencies to provide a LAHA, a broad, holistic needs-based assessment for people living in the area
Comprehensive Assessment	ACAS	This Assessment often identifies the need for a pathway into HACC services for clients with high and complex needs who need to transition to more intensive levels of service
Service Specific Assessments	All HACC organisations	Assessment for a specific service type such as domestic assistance, delivered meals, nursing or allied health
Agency Specific Assessment	PVCH BECC	'General/comprehensive' assessment by service specific providers to determine program eligibility and referral needs

#### 5.6 TOOLS FOR ASSESSMENT

Service Coordination Tool Templates (SCTT) were designed to assist with three out of the four service coordination elements: Initial Contact, Initial Needs Identification and Care Planning. The SCTT is not an assessment tool and there is currently no agreed or mandated tool for completing a LAHA.<sup>3</sup>

All agencies will therefore continue to use their own assessment processes while ensuring the SCTT is completed as part of the intake process and forms part of any referral process.

#### 5.7 WHERE ARE ASSESSMENTS UNDERTAKEN?

Assessment is normally conducted face-to-face in the client's home or at a service centre.

<sup>3</sup> The Victorian Government is developing a new state-wide HACC LAHA tool which will incorporate current practice, SCTT, the HACC MDS requirements and include priority of access criteria. A new LAHA tool may replace the SCTT in the future.

A LAHA is always conducted in the home environment to ensure clients are assessed broadly for functionality, need for assistance, living and caring arrangements, health behaviours and conditions, family and social networks and any other relevant information.

## 6. CLIENT PATHWAYS TO A LAHA

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When clients enter any HACC service there is a no wrong door policy. This means that a client will be guided to the right service regardless of where they present.

There are four main client pathways to a LAHA:

- Following initial contact at intake
- Following initial needs identification at intake
- Following a service specific assessment, or
- After commencement of service delivery where additional needs are identified.

In all cases, the client's information is populated into the SCTT for fax/email referral via Connecting Care.<sup>4</sup>

### 6.1 INTAKE TO A LAHA

Intake includes Initial Contact and Initial Needs Identification (INI).

#### 6.1.1 INITIAL CONTACT

Initial Contact is the first point of contact with the HACC service system. The client or another provider may make the contact by phone, fax or walk-in. The organisation registers the client's details at the time of Initial Contact and populates the client information page of the SCTT. The organisation will also normally provide accurate service information and other information where relevant or requested and obtain client consent for information sharing. Either an INI is conducted at the same time as Initial Contact or the client is referred for an INI prior to being referred for a LAHA.



All partner agencies are expected to provide access to initial contact within 1 working day of a client, their carer or their representative contacting the agency.

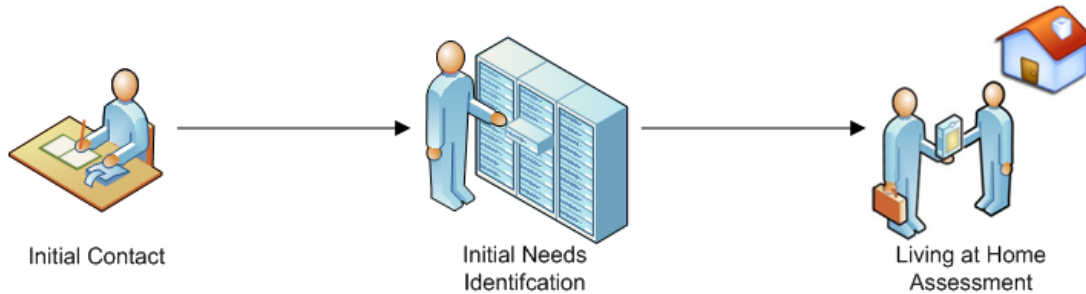
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<sup>4</sup> Connecting Care is an e-referral system to health and community services within different municipalities around Victoria. Connecting Care is used online enabling agencies the ability to make and track referrals, receive acknowledgements and view referral history and statistics.

### 6.1.2 INITIAL NEEDS IDENTIFICATION TO A LAHA

INI is an initial screening process where the underlying issues as well as presenting issues are uncovered to the extent possible. It is not a diagnostic process but aims to determine the client's risk, eligibility and priority for service and balances the client's needs with service capacity.

The additional information collected during the INI is populated into the relevant pages of the SCTT for referral to a LAHA. Client consent for information sharing and referral is also obtained.



All partner agencies are expected to commence an INI within 7 days of Initial Contact by a client.

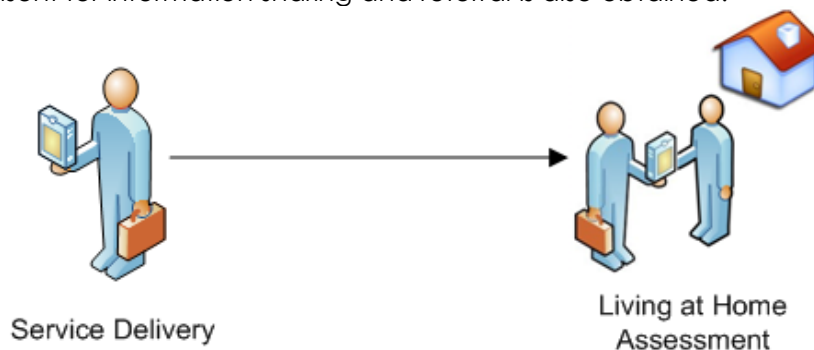
### 6.2 SPECIFIC SERVICE ASSESSMENT TO A LAHA

During the provision of a specific service assessment, the service provider may determine that the client has other needs and therefore make a referral for a LAHA. This additional client information is populated into the SCTT for referral for a LAHA. Client consent for information sharing and referral is also obtained.



### 6.3 SERVICE DELIVERY TO A LAHA

At any time during the provision of a service, the provider may decide that the client's needs have changed such that a LAHA is warranted. The client's information is populated into the SCTT for referral. Client consent for information sharing and referral is also obtained.



## 7. REFERRAL FOR A LAHA

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### 7.1 REFERRAL FOR A LAHA

Referral for a LAHA involves the transmission of personal and health information, with the individual's consent, to one of the designated assessment agencies (CoW or RDNS) from another agency (e.g. BECC, PVCH)

### 7.2 TOOLS FOR REFERRAL

A LAHA referral to either CoW or RDNS should use the SCTT via fax or email on Connecting Care. The electronic referral information will then be used by CoW or RDNS to populate their client information database.

When making a referral, agencies are required, as a minimum, to complete the following tools:

- Client Information
- Summary and Referral (2 pages)
- Living and Caring Arrangements
- Supplementary form: Functional Assessment Summary (2 pages)
- Client consent (*this form is not sent with the referral*).

### 7.3 PROTOCOLS FOR REFERRAL

The following service standards apply when sending or receiving a referral for HACC services.

#### 7.3.1 PARTNER AGENCY SENDING A REFERRAL

The agency sending a referral will:

- Send 'urgent' referrals within 1 working day of obtaining client consent
- Send 'low' or 'routine' referrals within 7 working days of obtaining client consent
- Send referral information using the SCTT
- Make immediate referrals (e.g. over the telephone) when a client is in crisis and follow this up with a more detailed referral using the SCTT.

#### 7.3.2 AGENCY RECEIVING A REFERRAL

On receiving a referral, RDNS or CoW will:

- Respond to 'urgent' referrals within 2 working days of receipt
- Respond to 'low' or 'routine' referrals within 7 working days of receipt
- Record the source of referral for monitoring purposes
- Transmit a Referral Acknowledgement to the referring agency within 7 working days of receipt of the referral stating the referral has been received and the estimated date of client assessment or the reason why the referral is not proceeding
- Transmit information about the Referral Outcome to the referring agency within 14 working days of the client being assessed. Referral outcome information may include relevant assessment findings, services or interventions to be provided, care planning goals etc.

#### 7.3.3 ALL AGENCIES REFERRING

All agencies are expected to:

- Ensure clients are referred at the right time, to the right service to maximise health and wellbeing outcomes and quality of life
- Assist clients with navigating and negotiating the service system, including when a client elects to make a self referral
- Liaise and communicate with other agencies and GPs as required
- Assist clients in a seamless and timely manner by streamlining access to appropriate services through self referral or assisted referral.

### **7.3.4 CLIENT SELF REFERRAL**

When a client chooses to make a self referral, all agencies will:

- Provide the client with contact details for other agencies
- Provide the client with a copy of the completed SCTT if requested
- Document the client's decision to make self-referral.

## **8. WHAT HAPPENS AFTER COMPLETION OF A LAHA**

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### **8.1 DEVELOPMENT OF A CARE PLAN**

A LAHA leads to a care plan which includes service specific care plans and a referral action plan and is individualised and goal oriented. The aim of care planning is to maximise and enhance the client's independence and quality of life and support care relationships where relevant. Care planning recognises and supports client's strengths and abilities as well as addressing client needs.

Care planning occurs in consultation with the client and with their carers, guardians or advocates where appropriate. It takes account of the needs of the carer as well as the client and should be undertaken in a culturally sensitivity manner. The care planning process may include:

- Putting together a range of services in a manner that supports informal care arrangements such as family support and the support of friends and/or neighbours
- Devising alternative strategies to meet identified client needs when some services are not available
- Negotiating and documenting roles and responsibilities and, with the client's consent, distributing copies of the care plan to the client, carer and service providers involved. Any advocate involved should also receive a copy of the Care Plan.

### **8.2 INTER AGENCY CARE PLANNING**

Where there is multi-agency involvement in delivering services to a client, inter agency care planning will need to occur in order to coordinate the client's care. This includes the development, monitoring and review of a Service Coordination Plan.

### **8.3 SERVICE COORDINATION PLAN**

A Service Coordination plan identifies issues/problems for a client and establishes goals as well as actions that will be taken to achieve these goals. It also identifies a primary contact to take the lead agency role and be a central communication point between the client/carer and relevant service providers. A Service Coordination Plan (using the SCTT) is only developed for clients with complex needs and/or multi-agency involvement. The objective of the Service Coordination Plan includes:

- Providing clarity of roles and communication processes
- Maximising client and carer involvement in the care planning processes and decisions

- Enhancing the sharing and updating of relevant information between organisations.

GP inclusion in inter agency care planning is an important issue to consider. For clients with chronic or complex needs consideration should be given to the client's need for a GP Management Plan or Team Care Arrangement. Team Care Arrangements initiated by GPs incur a rebate under the new Medicare chronic disease management items.

## **8.4 SERVICE SPECIFIC PLAN**

Service specific care plans detail the type and level of each specific service to be delivered such as domestic assistance, respite or nursing care.

## **8.5 CLIENT CARE COORDINATION**

All HACC Assessment Services will play a role in Client Care Coordination. Care coordination describes activities undertaken following a LAHA for a subgroup of clients with complex needs and circumstances. Client care coordination applies to clients receiving services from multiple organisations who are not receiving case management as part of a package of care.

Client Care Coordination for this client sub-group is an extension of the assessment, care planning and care plan implementation process where there is multi-agency involvement. It is important to nominate a key contact and advise the client who the key contact is. Client Care Coordination may include a range of tasks such as:

- Facilitating inter agency care planning due to multiple agency involvement in service delivery
- Facilitating development and reviews of the service coordination plan
- More frequent monitoring and review of the service-specific care plans, or
- Assistance with accessing services from a range of program areas outside the HACC Program.

## **8.6 REFERRAL ACTION PLAN**

The Referral Action Plan translates information collected about the broad range of client needs into agreed referral actions for services not provided by the assessing organisation. The Summary and Referral Template for the SCTT tools contain a template for documenting referral actions.

## **8.7 SERVICE INITIATION**

An agency receiving a referral action plan, care coordination plan or referral for other HACC services will provide the advice, services, review etc within the agreed timeframes and notify the referring agency accordingly. This includes the regular review of client waiting lists and keeping the client and referring agency informed.

# **9. CLIENT RIGHTS**

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## **9.1 CLIENT RIGHTS**

The client has the right to:

- Access to interpreter services if needed
- Use an advocate if desired
- A copy of completed relevant sections of the SCTT tool

- Explanation of service and referral options
- Referral in accordance with privacy requirements
- Information about expected waiting times

## 9.2 SHARING OF CLIENT INFORMATION

Informed consent must be obtained prior to transfer of personal information to other agencies. All clients will be referred electronically to reduce time, duplication of effort and being asked the same information at each point of contact.

## 10. GLOSSARY OF TERMS

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**Connecting Care:** An e-referral system for health and community services that protects confidentiality of client information. Connecting Care enables agencies to make and track referrals, receive acknowledgements and view the referral history and statistics.

**Home and Community Care (HACC):** HACC is a program that funds services at home and in the community for older people, people with disabilities and their carers.

**Living at Home Assessment (LAHA):** A broad, holistic needs-based assessment which occurs in the client's home. The care plan resulting from a Living at Home Assessment includes a referral action plan to both HACC and non-HACC funded services for needs that cannot be met by the assessing organisation. A Living at Home Assessment includes service-specific assessment and a service specific care plan(s) for the range of HACC services delivered by the assessing organisation.

**Primary Contact:** The nominated person who works with the client/carer and other organisations to facilitate inter agency care-planning and care coordination.

**Referral Action Plan:** The Referral Action Plan translates information collected about the broad range of client needs into agreed referral actions for services not provided by the assessing organisation. The Summary and Referral Template for the SCTT tools contains a template for documenting referral actions.

**Service Coordination Plan:** A plan which documents issues/problems for a client, goals, actions that will be taken to achieve these goals, and identifies a primary contact responsible for liaising between organisations. A Service Coordination Plan is only developed for clients with complex and/or multi-agency involvement.

**Service Specific Assessment:** An assessment for a specific service type such as domestic assistance, delivered meals, nursing or allied health.

**Service Specific Care Plan:** A care plan for a specific service type e.g. domestic assistance, personal care or nursing.

**Service Coordination Tool Templates (SCTT):** These have been designed to assist with three out of the four service coordination elements: Initial Contact, Initial Needs Identification and Care Planning.

The Service Coordination Tool Templates are not assessment tools and therefore do not replace the agency's assessment processes. Assessment builds on the information that has been collected at intake directly from the client, or information received on the SCTT tools from referring agencies.