Western Australia (WA) Home and Community Care Program

Assessment Framework – Service Redesign

*Implementation Plan – Phase 1*

December 2009
Background

Reform of the Community Care sector to improve eligibility screening, assessment, coordination and service delivery processes has been underway for a number of years. This reform has been guided by a number of Western Australian (WA) and national policy initiatives and projects including:

- the National HACC Framework for Assessment (1995);
- the WA Community Care Classification Project including the development of the WACCC-PAF (1997);
- the WA HACC Assessment Strategy including the development of the WA HACC Needs Identification (HNI) instrument (2003);
- the release of the report entitled *A New Strategy for Community Care – The Way Forward* (2004);
- the implementation of the Wellness Approach incorporating the key strategy of face to face wellness focused assessment (2006); and
- the *Model of Care for the Older Person in Western Australia* developed by the Aged Care Network (2007).

Building on the reform work undertaken over the past few years the WA HACC Program developed a WA HACC Program “Assessment Framework – Service Redesign” document that was used as the basis for discussion on the future direction of HACC assessment in WA.

The WA HACC Program “Assessment Framework: Service Redesign” document provided a broad outline for the proposed redesign of HACC services to support the move to an approach where eligibility screening, assessment, coordination and service delivery processes:

- are client-centred, in terms of
  - the involvement of the client and/or carer in all stages of the assessment process and ongoing service delivery,
  - the outcome for the client, and
  - the empowerment of both the client and their carer;
- enable consistency in assessment practices and outcomes;
- are outcome centred, i.e. all assessment information translates into appropriate and effective support plans and support;
- build formal linkages between all key community care service providers to effectively manage client/carer pathways;
- provide appropriately targeted service responses; and
- refocus service delivery towards an approach that supports the implementation of Wellness to maintain and improve client/carer wellbeing and independence wherever possible.

Since the release of the Assessment Framework position paper a series of forums have been held across the metropolitan area during July/August of 2009 with an additional forum held in Bunbury in August 2009.

Work has continued in the Goldfields and the Kimberley to progress the development of an implementation plan for the rollout of the Access
demonstration projects as part of a broader strategy linked to the Assessment Framework.

Consultations have also been held with peak bodies.

A WA HACC Program bulletin was distributed to the sector in September 2009 to provide a:

1. Summary of Metropolitan Forums and HACC Program Response to Issues Raised; and

The summary contained the WA HACC Program responses to issues raised at the forums and identified areas where further consultation and deliberations are required.

The bulletin also invited feedback on the draft qualitative criteria for assessment and client care coordination services. The qualitative criteria are finalised and have been circulated to the sector in November 2009.

**Proposed Access, Assessment and Client Support Model**

The Assessment Framework comprises three distinct but interrelated elements (or stages) to support and guide the client/carer journey.

1. Access Points – information, eligibility screening and referral;
2. Assessment and Client Care Coordination – face to face wellness capacity building assessment, referral -support planning and coordinating access as required for clients/carers to a range of appropriate support services; and
3. Client Support and Monitoring – delivery of wellness focused/capacity building support to client/carers and monitoring to meet the needs of the client/carer.

Progress through the stages will not be linear or sequential for all clients/carers. The model will enable alternative pathways, in situations where this is needed and based on client/carer circumstances. For example in the cases of a genuine crisis it may not be possible or necessary that the face to face Assessment is conducted prior to commencing a temporary service response. Rather services can commence and the assessment can be conducted at an appropriate point in time to identify the long term support needs of the individual.

It is envisaged that the functions of Access and Assessment/Client Care Coordination will be undertaken in the metropolitan area by separately contracted regional organisations following appropriate procurement processes. In non-metropolitan locations it is likely that some service providers will continue to conduct the range of functions across the service system with back up and support from a larger regional agency.
Key elements of the Assessment Framework

Access Points
The WA HACC Program will establish Access Points within the current Carelinks. The client/carer’s eligibility and need for assessment will be identified by the Access Point and when appropriate a referral will be made to a HACC Assessment and Client Care Coordination service for assessment. Access Points will also identify when specialist or comprehensive assessments may be warranted and make appropriate referrals to support services outside of the HACC Program.

Functions
The functions of the Access Points are to:

- Maintain a central repository of information on community care services available to consumers, carers, service providers and health providers
- Enhance linkages and communication with broader health and community care sector.
- Process all requests for information or service re community care programs and provide relevant information about support available to stay at home, community care services and other complementary and preventative services;
- Screen out ineligible clients and advise of other potential areas of support
- Conduct broad and shallow eligibility screening for client/carer using the approved tool/s for a range of community care programs where possible/appropriate;
- Ensure approach to eligibility screening is responsive to the diversity of the HACC target group and refer for face to face assessment if more appropriate;
- Generate initial client/carer record that, with consent, will travel with client/carer;
• Identify the need for appropriate assessments including HACC Assessment, comprehensive and specialist assessments and refer appropriately;
• Refer client/carer to community support and/or health services where this is appropriate;
• Maintain register of HACC service availability to advice HACC Assessment Agencies on appropriate and available HACC services for assessed clients/carers; and
• Assign client / carer priority and urgency of need to referral to ensure high need clients are fast tracked to face to face assessment and/or service response.

**Assessment and Client Care Coordination Services**

In the Perth metropolitan area, a limited number of HACC service providers will be contracted to provide assessment and client care coordination services across a HACC region. The regional assessment and client care coordination services will operate across the following metropolitan based regions - East, North, South East and South West.

In the non metropolitan HACC regions it is expected that the assessment and client care coordination service providers will not operate across the whole region. The model will be based on local requirements.

Service providers in the metropolitan area approved to provide regional assessment and client care coordination will operate under a separate contract with the WA HACC Program for an initial two to three year period to support the implementation and evaluation of the changes.

**Functions**

The functions of the regional assessment and client care coordination services are to:

**Assessment**

• Utilise client information received from the Access Point and conduct a face to face capacity building assessment to identify factors limiting independence and identify solutions (which may or may not include a HACC support service);
• Identify the need for other appropriate assessment outside the realm of HACC where not already identified e.g. comprehensive and other specialist assessments and refer;
• Develop a wellness focused plan of support in partnership with the client/carer with recommendations as to the level of supported self care required to meet the identified needs of the client/carer;
• Coordinate access to support mechanisms outside of the HACC Program that underpin client/carer well being and independence and facilitate any broader goals the client/carer has identified as personal outcomes;
• Coordinate access to appropriate level of HACC support to meet the client’s needs;
• Liaise with Access Point to identify possible service providers who have appropriate services available to meet the identified client need;
• Work collaboratively with the appropriate service providers to support the implementation of the agreed client support plan;
• Review and reassess client/carer when referral received from service provider (agreed triggers to be developed);
• Amend or modify the goal directed support plan in consultation with the client/carers and service provider consistent with principles outlined above; and
• Support and coordinate transition to other appropriate service systems including package and/or residential care.

Client Care Coordination
• Coordinate access to appropriate level of support across a range of services to meet the client’s needs;
• Liaise and communicate with other service providers, GPs/specialists, other community supports and the client/carer to maintain support services; and
• Plan and coordinate exit/transfer to other appropriate service systems including package and/or residential care if indicated.

HACC Service Provision - Client Support and Monitoring
The provision of appropriate services to clients and carers should be the main focus of the HACC Program and the majority of service providers will continue to provide this role. The focus of service delivery will be on delivering wellness based support, monitoring attainment of client/carer goals and monitoring service quality and responsiveness to client/carer needs.

Functions
The functions of the client support and monitoring services are to:
• Work with the client/carer and their support networks to ensure that the personalised goal directed support plan is implemented;
• Monitor services to ensure that they are delivered effectively and are achieving the objectives of the support plan;
• Ensure the support provided continues to meet client/carer needs;
• Initiate contact with HACC Assessment and Coordination Agency when a change in need/circumstances has been identified, including attainment of goals (triggers to be developed); and
• Maintain ‘availability of service’ profile via Access Points.
**Impact of implementation**

The WA HACC Program acknowledges that the implementation of the Assessment Framework represents a significant shift in the way all HACC services will be delivered.

It is understood that service providers will need time and support to adjust some of their practices and address the resulting workforce issues and new I.T. needs.

The existing HACC workforce will also need to be supported with clear operating policies and protocols and appropriate training to increase skills in functions relevant to their role in assessment and client care coordination services or client support and monitoring services.

**Governance**

The WA HACC Program will work in partnership with the sector to ensure a detailed implementation plan is developed for the three areas covered by the framework. The implementation of the Assessment Framework will be more effective if informed by the knowledge and experience of HACC service providers and the perspectives of HACC clients and their carers.

Implementation of the Assessment Framework will be managed by a State Steering Committee. Membership will comprise Department of Health (Aged Care Policy Directorate), Department of Health and Ageing (State Office) and the Project Manager (CommunityWest). In the metropolitan area there will be three discrete Reference Groups to inform the development and implementation of the framework.

Membership of the reference groups will comprise approximately twenty (20) representatives from the community care sector in the Perth metropolitan area and will be chosen to ensure a broad representation of stakeholders. Membership will include, but not be limited to the following:

- Access Points
- Department of Health, WA (Aged Care Policy Directorate)
- Department of Health and Ageing (WA State Office)
- CommunityWest (Project Manager)
- Selected Home And Community Care Service Providers (HACC)
- Carers WA
- Aged and Community Services WA

In order to ensure HACC service providers can allocate the required time and resources to participate fully in the work requirements of the reference group/s the WA HACC Program will ensure that funding is available to reimburse service providers for any agreed work required by the reference groups.
It is estimated that the commitment from service providers nominating for the reference groups will be equivalent to 1 or 2 days per week for a period of 3 to 6 months. This commitment may reduce to attendance of meetings only once sufficient progress is made towards implementation.

Reference Groups will consult and engage with a range of stakeholders in the Metropolitan region, including:

- Community Health
- GP Network
- Mental Health Service
- Disability Services
- Area Health Services
- Community Care providers
- Long Stay Older Patient Coordinators
- Aged Care Assessment Team

The Reference Groups may appoint new members on an ad hoc basis as issues require.

A range of other stakeholder consultation processes will be utilised to ensure all key stakeholders have an opportunity to contribute to the implementation of the assessment Framework and are informed of developments.

CommunityWest, Project Manager of WA HACC Assessment Framework will facilitate the meetings of the Steering Committee, Reference Groups and any sub groups established. Secretariat support will also be provided by CommunityWest Inc.

The operation of the Steering committee and Reference Groups will be time limited to correspond with the development and implementation of the reforms. The Steering Committee and Reference Groups will cease to exist when the WA Assessment Framework has been implemented, and members are satisfied that the approach meets the needs of WA communities.

The project management structure and process for each of the non metropolitan HACC regions will be developed based on local requirements and overseen by the State Steering Committee.

**WA Steering Committee**

The purpose of the Steering Committee is to monitor and provide guidance on the development of the WA Assessment Framework; its implementation and evaluation, including:

1. Provide guidance and feedback throughout the duration of the implementation in regards to methodology, planning, risk management and interim findings;
2. Provide direction in terms of monitoring the project ensuring timelines and key milestones are met; and
3. Provide feedback and sign off on any final reports or recommendations.
The roles and functions outlined below are ‘proposed functions’ and will be refined by the relevant Reference Group.

**WA Access Reference Group**
The WA Access Reference Group will develop the implementation plan and monitor the implementation of the Access Network Points within the metropolitan area.

**Key functions**
The Key functions of the reference group will be to:

- Establish the operational policy and guidelines necessary to implement Access Points within the Carelinks that:
  - Embed reporting mechanism to original contact(s);
  - Reinforce client/carer choice;
  - Provide for ‘fast track’ options to service where appropriate;
  - Respond to client/carer/contact diversity and special needs; and
  - Monitor and respond to feedback.

- Recommend supporting mechanisms/structures that enhance the accuracy and responsiveness of Access Point referrals i.e.
  - Availability of service; and
  - HACC Provider acceptance/rejection of referrals.

- Identify and establish a knowledge management strategy to support the advice and information role of Access Points.

- Develop and recommend the stakeholder engagement plan to support the implementation of Access Points.

- Develop and recommend the marketing and promotional strategy to support the Access Points.

- Develop and recommend key performance indicators and supporting data capture mechanisms to evaluate the Access Points and enhance accountability to the HACC sector.

- Review and update the guidelines, referral protocols and policies were developed and trialled as part of the WA Access Network demonstration projects to ensure
  - Accurate information provision and referral management;
  - Identification and honouring of client choice within the process;
  - Recording and sharing of timely service availability data; and
  - Appropriate response timeframes to enquiries for assistance.

- Any other activities as decided by the group.
Assessment and Client Care Coordination Reference Group
The purpose of the Assessment and Client Care Coordination Reference Group is to develop an implementation plan for the assessment and client care coordination component of the Assessment Framework for the metropolitan area, guide the implementation process and oversee the evaluation of the approach.

Key Functions
The Key functions of the reference group will be to:
- Establish the operational guidelines and protocols necessary to successfully implement the assessment and client care coordination functions aligned to the Assessment Framework;
- Inform and develop tools and mechanisms to ensure client/carer transition from assessment to service delivery is seamless;
- Inform and pilot the development of an updated face to face capacity building assessment tool;
- Establish and implement a stakeholder engagement plan to support the implementation of the assessment and client care coordination component of the Assessment Framework;
- Develop and implement key performance indicators and support data capture mechanisms to evaluate the assessment and client care coordination component of the Assessment Framework;
- Develop referral processes for new and existing clients;
- Consider and provide input into the work of the other Reference Groups established within the Assessment Framework governance structure;
- Inform the development of assessors training and approaches to support ongoing skills development; and
- Any other activities as decided by the group.

Client Support and Monitoring Reference Group
The purpose of the Client Support and Monitoring Reference Group is to support the client support and monitoring services to transition to the implementation of the Assessment Framework and identify the key service delivery processes and functions that support a seamless journey to wellness-based service provision for assessed clients/carers.

Key functions:
The Key functions of the reference group will be to:
- Identify the potential impacts of Assessment Framework on HACC service provision and providers and where appropriate recommend strategies to support management of these impacts;
• Develop change management strategies, tools and support mechanisms required to facilitate alignment with the Assessment Framework;
• Develop guiding principles that will support service providers to successfully transition within the Assessment Framework;
• Recommend best practice engagement and relationship model(s) that support the Assessment Framework;
• Establish the framework for the review and management of client/carer support needs within the Assessment Framework;
• Identify workforce planning considerations and strategies to assist in the transition to the Assessment Framework model at agency and sector level;
• Consider and provide input into the work of the other Reference Groups established within the Assessment Framework Governance structure;
• Recommend and review training and development solutions to meet the needs of coordinators and direct support workers; and
• Any other activities as decided by the group.

Assessment Framework Key Deliverables

• Involve key stakeholders in developing and implementing the Assessment Framework.
• Develop and introduce revised tools and processes that will enable consistency of information, entry, assessment and service delivery approaches and processes across all HACC services
• Develop the access, assessment and service delivery model/s to client/carer needs in the metropolitan and non metropolitan HACC regions.
• Develop an implementation plan for roll out of the Assessment Framework initially across the metropolitan area and for each of the rural and remote HACC regions.
• Implement the Assessment Framework across WA.
• Develop and implement training, education and information material for public, community care and health service providers.
• Evaluate the implementation of the Assessment Framework across WA.
**Next steps**

Individuals available for participation in one or more of the three reference groups being established to support the implementation of the Assessment Framework can submit an Expression of Interest form by close of business Monday 8 February 2010 (form attached).

Aged and Community Services WA have been approached and have agreed to nominate six (6) representatives per reference group.

The first meeting of the metropolitan reference groups will be scheduled for March 2010.

Non metropolitan areas will be supported during 2010 to commence development of an Assessment Framework Implementation Plan appropriate to their local needs.
Delivering a Healthy WA