Western Australian (WA) Home and Community Care (HACC) Program Assessment Framework

Service Redesign

April 2009
Executive Summary
The Western Australian (WA) Home and Community Care (HACC) Program “Assessment Framework - Service Redesign” document is intended to initiate the debate on the future growth and direction of client assessment in the WA HACC Program.

The need for the “Framework” has become more evident with the ongoing implementation of the Wellness Approach and the outcomes of the National Evaluation of the WA Access Network Demonstration Projects.

The “Framework” advocates the need for service redesign within HACC to facilitate the emerging thinking and trends in access and assessment in community care. It also recognises and reinforces reforms underway in the WA Department of Health (DOH) and at a national level targeted at improving the clients journey and streamline access throughout the health and community care system.

An Aged Care Network has been established to progress the reforms outlined in the WA Health Clinical Services Framework 2005 – 2015 in relation to the health needs of older people in Western Australia. An overarching policy document, “Models of Care for the Older Person in Western Australia (“Model”) outlines the three phases of ageing; entering old age, the transitional phase and the frail aged stage.

The “Model” outlines the care needs of a person who is ageing and focuses on the spectrum of services provided by the health care sector along the continuum of care as a person moves through each of these phases. The “Model” also places focus on the links to the primary and community care sectors that are integral to the care and support of older people to be able to live independently in the community.

A tenet of the “Model of Care for the Older Person in Western Australia” is service redesign, aimed at developing a service system that provides clients with a smooth and coordinated pathway to a range of care.

Work at the National level in the HACC Program mirrors the philosophy outlined in the “Model of Care for the Older Person in Western Australia” and resulted in the WA Access Network demonstration projects in Esperance, Derby/Broome and the local Government catchment area of Swan. These demonstration projects were developed to trial a revised approach to the provision of information, eligibility screening and referral into the community care system.

Accessing and transitioning service while an important part of service delivery are but one element of the induction to service. Another key element is that of assessment of needs to develop customised service responses for the client.
A great deal of work has been and will continue to be done in this area. This “Framework” is not the first step in this journey but rather reflects a progression of thinking which builds on previous work and ongoing developments in community care.

As part of this journey the WA HACC Program in March 2006 adopted the concept of a Wellness Approach as its policy position for future growth and development in service delivery for all HACC clients.

The Wellness Approach represents an important philosophical change in the thinking behind and delivery of HACC services in WA. Through a Wellness Approach, the WA HACC service sector will be supported to develop and implement service models that build capacity by actively working with the client to:

- prevent loss of independence by focussing on the retention of existing skills and
- where appropriate, focussing on regaining of skills and a subsequent increased level of independence and well-being.

This service model is more conducive to the emerging trends in health care and consumer advocacy and is in contrast to a service model focussed on continuing or increasing dependence on services.

The Wellness Approach is based on the principles that “people want to retain autonomy and build capacity, which in turn has a positive impact on their self esteem and ability to manage day to day life” and “where ‘Independence’ is not limited to physical functioning but extends to social and psychological functioning.

The “Assessment Framework - Service Redesign” is presented as a response to all of the above plus other trends confronting the community care sector, such as:

- anticipated increase in an ageing population,
- declining workforce as a result of projected demographic shifts, and the
- growing demand for more responsive and appropriate health and community care services.

In implementing this Assessment Framework, the challenge for the WA HACC Program will be to ensure the model develops in a way that allows for the diverse settings, service providers and populations catered for by the HACC program in a manner which builds cooperation and collaboration. It is anticipated that the Assessment Framework implemented in the metropolitan area will be more centralised, in contrast to many small rural and remote locations.
Introduction

The HACC Program

The HACC Program is a key provider of community care services to frail aged people, younger people with a disability and their carers. The overall objective of the HACC Program is to assist people to enhance their independence and optimise their capacity to remain living independently in the community.

Developments in Assessment

Thinking and practice in the area of community care assessment continues to evolve. A chronological overview of the significant policy thinking in the development of assessment is presented to allow the reader to view the “Assessment Framework – Service Redesign” in light of and as part of this ongoing evolution.

1995 National HACC Framework for Assessment

A National HACC Assessment Working Group was established in 1995 to progress the development of a National HACC framework for assessment. The agreed assessment principles from this work included:

- A general assessment approach
- Accessible information for clients
- Flexibility of access to and provision of service
- A responsive, incremental assessment process
- A coordinated regional/local approach to assessment
- Avenues for consumer complaints
- Targeting of eligibility for service; and
- Privacy and confidentiality

It was the responsibility of the individual jurisdictions to progress the principles locally. The National Assessment Working Group was reconvened in 2003 to revisit the framework based on progress made by jurisdictions and a new national framework for assessment was developed based on a two tier system - intake assessment and comprehensive assessment.

The National HACC framework for assessment is included in the National HACC Program Guidelines July 2007 and provides the basis of all future work on the development of a consistent approach to assessment across Australia.

2003 WA HACC Assessment Strategy

In 1997 the WA HACC Program funded the WA Community Care Classification (WACCC) Project to examine the relationship between characteristics of HACC clients and the costs of community care services. The project was supported by the development of a standard instrument for assessment, the WACCC Primary Assessment Form (WACCC-PAF) that was used by all participating service providers.

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1 Calver and Lewin 2002
The WACCC Project found that:

- There was broad support for the concept of standard assessment
- The WACCC - PAF performed reliably across different modes of administration and was well accepted by assessors but client self completion of the form was not favoured by service providers
- More intensive and ongoing training was required to support assessors to maintain data consistency and quality; and
- Assessment and related activities such as data entry and information sharing involve considerable changes to administration processes for some agencies.

In 2003, as a result of the finding from the WACCC Project, the WA HACC Program in partnership with the Aged Care Assessment Program developed a single assessment process to establish a standard minimum set of assessment information that would be collected for all HACC clients. This single assessment process included the development and implementation of the WA HACC Needs Identification (HNI) instrument.

The single assessment process included a number of components:

- Eligibility and functional screen
- Generic needs identification
- Service specific needs identification
- Reassessment and review
- Coordination and support planning
- Referral
- Comprehensive assessment via an Aged Care Assessment Team

To support the implementation of the WA HACC single assessment process a training program was developed to ensure that all HACC funded service providers were in a position to complete a client assessment using the HNI prior to providing support services.

**Wellness Approach**

In 2006 WA HACC committed to refocussing it model of HACC service delivery away from a ‘dependency’ model where tasks are largely done for clients, towards a wellness model which aims to maintain and improve client independence and well being wherever possible.

A face to face wellness focussed assessment is seen as one of the key strategies to support this move.
Developments in the Client Journey

2002 National Community Care Review - The Way Forward

In 2002 a national review of the community care system was undertaken in response to industry and consumer complaints that the system was complex and confusing. Issues such as differing arrangements, inconsistent eligibility criteria and assessment processes, separate data collections, accountability processes and inconsistent user fees policies were highlighted as examples of the complexity of the sector.

The review culminated in the release of the *A New Strategy for Community Care - ‘The Way Forward’* in 2004 which identified five broad areas of action:

- address overlaps and gaps in service delivery
- provide easier access to services
- enhance service management
- streamline Australian Government programs, and
- adopt a partnership approach

*The Way Forward* outlined a range of actions to strengthen and improve community care by adopting a nationally consistent approach in key areas such as entry into the system, determining eligibility and assessing client needs.

With regard to entry to the community care system, specifically *the Way Forward* states that:

“The Australian Government will work with State and Territory Governments to identify entry (Access) points that can be easily accessed by consumers seeking community care services based on existing infrastructure”.

In line with this broader objective, the Council of Australian Governments (COAG) also agreed that by December 2007 there be more timely and consistent assessments for frail older people by *Aged Care Assessment Teams* and simplified entry and assessment processes for the *Home and Community Care Program*.

**WA Access Network Model Demonstration**

During 2006 the WA HACC Program developed the WA Access Network Model to trial the nationally agreed Access Point functions. This model was developed to build on existing systems and tools available within the community care sector. Three Access Network Demonstrations have been trialled in WA, Esperance, Broome/Derby and the Swan local government catchment area.
The Access Network demonstration agencies provide an initial point of contact for people seeking information about community care services and other relevant support options; identify whether the person is within the eligible target population to receive community care services; and provide an initial needs identification screening. Access Networks facilitate referral to other appropriate services and refer individuals for face to face needs/wellness assessment and development of service response.

Access Networks also refer individuals to comprehensive assessment and other specialist assessments e.g continence, falls and memory clinics.

In addition, they aim to reduce duplication of effort for service providers and clients in the sharing of relevant client information to support transition across the continuum of care.

The choice of agencies to participate within the Access Network demonstration project was determined in relation to each agency’s commitment and capacity to:

- profile and promote itself as the initial point of contact for people requiring information and/or community support
- provide information about choices to stay at home, community support and other complementary and preventative services
- filter clients to appropriate support or assessment options based on their individual requirements and situation
- conduct broad and shallow screening against agreed protocols
- refer clients to service providers or other assessment processes
- commence the development of a client information record that, with client consent, will travel the journey with the client through the service system.

National Evaluation of WA Access Network Model

KPMG have been contracted by the Department of Health and Ageing to conduct the national evaluation. To support this evaluation KPMG developed a National Evaluation Framework that includes 18 evaluation questions based on the endorsed national functions and target outcomes for the Access Point Demonstration Projects.

The purpose of the National Evaluation is to ensure the Access Point Demonstration Projects meet the objectives of:

- providing information about community care services
- providing advice on eligibility for services
- conducting a broad and shallow assessment of a person’s needs (including the carer)
• facilitating referrals to community care service providers or to other specialised or comprehensive assessors as appropriate.

The evaluation will inform ongoing improvements and decisions regarding the wider roll-out of Access Points across Australia. The evaluation is being conducted at local, jurisdictional and national levels.

Some Key Findings from the National Evaluation of WA Access Network Model

KPMG’s Demonstration report 2 January 2009\(^2\) was based on an examination of the WA Access Network demonstration project experiences as they relate to the agreed National Evaluation Objectives.

Some of the key findings from the report identified that:

• The relevance of many of the national Access Point objectives varied according to the location of the demonstration.

• Where there are few service providers, consumers are more likely to be able to know how to access community care services, and service providers are more likely to have an informal working relationship. By contrast, where there are a large number of providers, each with differing service types and eligibility criteria, consumers are more likely to have difficulty in accessing services. Inappropriate reassessments are also more likely when there are a greater number of providers.

• Where the Access Network Points were also community care service providers, there was a perception among non access network service providers that the Access Network Points tended to self-refer, rather than refer out to other agencies.

• Access Network Point service providers did not report any major increase in their numbers of new clients, suggesting that the self-referrals tend to be part of the ‘natural pathway’ process.

• The sharing of client information via fax is an issue, and there have been some difficulties associated with obtaining acknowledgement of referral acceptances from some non access network service providers.

• Access Network Points are more likely to be needed to address issues in metropolitan areas (and large regional centres with numerous providers).

There were some aspects of the demonstration projects that were seen as positive steps in supporting client access and management within the service system including:

- The SLK register – this enabled the client’s status within the service system (new or existing client) to be determined, thereby increasing the likelihood of appropriate responses.
- The Carelink Service Directory – this provides those undertaking a Client Needs Identification (CNI) with the means to identify the relevant service provider(s) to whom clients can be referred, particularly in view of the increased accuracy of information contained within it. However actually using the directory has been problematic for some, given its internal structure.
- The Carelink service availability spreadsheet – this provides up-to-date information on service capacity, thereby increasing the timeliness with which clients can access services they need.

Several of the agencies operating as Access Network Points in the Swan demonstration project commented that, based on their early implementation experience, a single point of access would be preferable to the network model. Moreover, they identified Carelink as the potential agency to operate this single point of access for the following reasons:

- this would be a natural extension to the current Carelink role within the community care service system
- Carelink is not a service provider in its own right and therefore could not be perceived as being biased in client referral.

These agencies acknowledged that this view represented a shift from their original position regarding a more centralised client entry point into the community care system.

The outcomes from the National Evaluation of the WA Access Network Point demonstration projects and in particular lessons learnt, have informed the development of this assessment framework.

2008 WA Assessment Framework - Service Redesign in HACC

The assessment framework in WA will include three components that form the overall client assessment process:

1. Access Network Points - information, eligibility screening and referral
2. Face to face assessment - with a wellness capacity building approach
3. Client care coordination - support planning and coordinating access to the range of appropriate support services as a result of planning, reviews and reassessments
One of the underlying premises of this assessment framework is that the client/carer is involved as a partner in all stages of the assessment process and ongoing service delivery.

In this context assessment can be defined as a decision making process that is orientated to maximising a client’s capacity for independent living in the community and effective provision of needed supports.

Some of the key principles underlying this assessment framework are that the assessment process should:

- Be 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

The process should also:

- Enable consistency in assessment practices and outcomes and
- Be outcome centred, i.e. all assessment information translates into appropriate and effective support plans and support.

1  **Access Network Point**

In the Perth metropolitan area and some major rural towns an access network point will be established to assist client entry into appropriate community care.

The Access Network Point will:

- Screen and filter clients for a range of community care programs
- Determine client and carer eligibility for a range of community care programs
- Conduct broad and shallow eligibility screening
- Refer for face to face assessment
- Identify need for more specialist assessment outside the realm of a HACC provider
- Set the scene in regards to establishing client expectations of HACC from a Wellness Approach to service delivery
- Commence the client record, which should represent complete and accurate information as required

The underlying premise of the framework is that at point of entry there is an obligation to identify need and eligibility to ensure that the client is referred for a face to face assessment to gain access to the most appropriate support service response.
The framework recognises that the client’s journey is not linear nor is it contained to the HACC Program; rather it reflects an interconnected network of pathways.

The framework presupposes the sharing of client details, with consent, in order to limit unnecessary and intrusive questioning and thereby support caller ‘acceptance’ of eligibility screening.

**Criteria for Access Network Point Agency**

The [draft](#) criteria for the Access Network Point can be found at Appendix One.

2 **Face to Face Assessment**

The WA HACC Program will identify and establish a network of HACC funded agencies with skills and capacity to conduct face to face assessments from a wellness, capacity building approach and develop, with the client, goal directed support plans.

The client’s eligibility and need for assessment is identified at the Access Network Point and the client is then referred to a HACC agency that is funded to conduct a face to face assessment. The Assessment process is about identifying with the client their abilities and needs, which will then require coordination to access the appropriate level of support to meet their needs. It is not about a service response to a specified request.

The face to face assessment is a critical factor in managing client pathways entering and exiting HACC services. It is the mechanism by which organisations discover in consultation with the client, carer and family what is needed in order to live as independently as possible.

The assessment is not simply a precursor to service provision. It is about understanding a client and carer’s needs, broadly defined, as opposed to interpreting needs only in relation to the services that can be provided by the assessing agency. It needs to be a problem solving exercise in which the assessor, client, and/or carer together identify where the difficulties lie, what factors are potentially limiting independence and agree on solutions to these problems (which may or may not include a HACC funded service.)

A wellness focussed assessment determines the level of a client’s ongoing functional ability and works with the client to determine the appropriate level of support and the time frame for this support.

Planning, monitoring, review and reassessment are processes that ensure that the service system is responsive to client and carer changing circumstances in the context of available resources.
Face to face assessment will require the assessors to:

- Take as a base line that all HACC clients have the capacity to maintain/improve their functioning and well being across all domains.
- Recognise that assessment is not a one off event; it is an ongoing process which needs to be adapted in a timely and flexible manner as people’s needs/circumstances change.
- Incorporate a broad based assessment of client and carer need which focuses on building on a client’s strengths and capacities. This involves problem solving and identifying opportunities for improving functional capacity and participation in social and community activities. This should incorporate advice on local, formal and informal support and service options. NB The assessment should give a clear indication of the type and amount of support required and the most appropriate person to provide it.
- Recognise when there is an opportunity for short term support to facilitate the client to get back on their feet and be transitioned off formal support services.
- Develop and implement in partnership with the client and/or carer goal orientated support plans (including potential referrals to a wide range of organisations and services) based on needs identified.
- Identify if a client’s declining abilities and increasing need for service requires alternative support and/or transitioning from the HACC Program to a more suitable care option.
- Collaborate and develop strong links between services and key health and community care organisations for clients to maximise their capacity.
- Identify clear pathways to review and reassessment (This includes review of the ongoing appropriateness of the service) as part of the support plan.

### 3 Client Care Coordination

Assessment is not independent from the support planning process. Therefore the responsibilities of those agencies designated as HACC funded assessment services include development (in partnership with the client) of a support plan and coordinating access to the range of appropriate support services as a result of that plan. The assessment service provider will also be responsible for the regular review and reassessment of the client’s needs including the documentation of ongoing changes to the support plan.

HACC service providers responsible for client care coordination will take on responsibility for:

- Formalisation of the support services in line with the support plan
- Ensuring that the support plan continues to meet the client’s needs through effective monitoring and reassessment
- Liaison and communication with other service providers and client/carer including the development and documentation of formalised communication links
- Planning and coordination exit/transfer to other appropriate service systems including packaged and/or residential care
Criteria for approval to provide HACC Assessment and Client Care Coordination Services

The draft criteria for assessment and client care coordination services providers can be found at Appendix Two.

An Opportunity to Improve Client Data Quality for Planning Purposes

This assessment framework is also seen as an opportunity to improve data quality for Planning Purposes.

Currently, all Agencies individually collect, record and report the client information which is ultimately used at the program level for planning purposes. The quality of this Minimum Data Set (MDS) information varies significantly between agencies in terms of its completeness and accuracy. Furthermore, it is common for conflicting information to be reported for the same clients from different agencies.

The identification of specialised Access and Assessor agencies, with a commitment to providing quality information about clients, has the capacity to greatly improve the completeness, accuracy and consistency of HACC data, thus providing a stronger foundation for planning processes. A commitment to sharing of that information should also reduce the administrative burden on non-Assessor agencies; those agencies would accept the information (including MDS client details) provided by the Assessor agency and maintain their own focus on providing the direct support services as outlined in the support plan.

As such, Assessors would also be required to

- Review client details recorded at the Access Network point and update client record accurately
- Share that information and promote continuation of the client record as part of the referral and service coordination processes
- Update details on the client record as part of any client review process

Conclusion

Assessment is a key function in the provision of appropriate support to HACC eligible clients and the need for an Assessment framework has become more evident with the implementation of the Wellness Approach and the three WA Access Network Demonstration Projects.
Effective assessment and support planning are critical factors in managing client pathways entering and exiting HACC services as well as the broader health and community care system. They are the mechanism by which agencies discover in consultation with the client, carer and family what is needed in order to live as independently as possible.

Assessment and provision of support that has a capacity building or wellness focus can assist a client to retain their function for as long as possible and in many instances can facilitate clients to regain their independence and well being, instead of a continuing or increasing dependence on services being provided by others.

The development of an Assessment Framework based on streamlined access, face to face wellness focused assessment and coordination roles for some HACC Agencies also creates an opportunity to improve the quality of data that is collected in relation to clients and used for program planning purposes.

This document sets out the direction for reform in assessment in the WA HACC Program. The aim of the framework is to build on existing best practice principles in assessment and attain positive outcomes for clients across the HACC sector in WA.

The challenge for the WA HACC Assessment Framework is to work with the sector to develop a commitment to change that is then translated into reality and allows for the diversity of the HACC service sector in a manner which builds cooperation and collaboration.
Draft Criteria for Access Network Point Agency

The following criteria will be used as part of an Expression of Interest to identify a community care provider to carry out the role of the Access Network Point in the Perth metropolitan area:

- More than one full time position (assessor/co-coordinator) to manage intake, eligibility and referral process as priority to other workload. This should be separate from ‘assessment’ role
- Established procedures and relationships to meet the needs of callers with special needs
- Administrative support to establish and implement integrated process and protocol for quality management of intake/screening requirement
- Provision of quality MDS data including audit/review mechanisms to ensure ongoing quality of data and process
- Provision of IT and technological supports to enhance phone based eligibility screening
- Protocol to ensure and support independence of intake/screening and referral role from service goals/targets
- Training and ongoing support of intake/screening and referral role to ensure currency of sector knowledge and service options
- Reinforce the Wellness Approach to service delivery and clearly distinguish eligibility from service delivery
- Tracking and record management protocols for intake/screening management
- Complaints management process for Access Point
- Privacy and confidentiality provisions for client information management

Competency of Intake Personnel

- Microsoft applications and computer based systems to collect and record data and generate reports
- Excellent written and verbal communication skills, advanced interviewing and engagement skills via telephone
- Highly organised, self motivated and proactive in finding solutions or problem solving
- Application of screening and assessment tools integrating professional judgment in assessing outcomes and referral options
- Relationship management with sector stakeholders

Knowledge

- Understanding of Government policies and programs in the community care sector
- HACC and other community care eligibility and assessment protocols
- Community resources to assist intake screening and referral
- Privacy and confidentiality consideration in client management
Appendix Two

_Draft Criteria for HACC Assessment and Client Care Coordination Services_

To provide face to face client assessment and client care coordination services HACC service providers will need to meet the following criteria:

- Demonstrated commitment to wellness principles
- Currently funded to deliver a broad range of HACC services
- Service delivery is provided by the service providers employees, not brokered to other third parties
- Demonstrated commitment to providing quality client information through complete and accurate MDS recording and effective reporting processes
- An organisation’s policies clearly define the assessor’s role in providing assessment in order to accurately account for this activity from a funding and reporting perspective. Processes, policies and procedures are to include:

  - Operational policy and procedure manuals and position descriptions that clearly define the assessor’s role in client assessment, and reviews, support planning, risk management and identification of Occupational Safety and Health (OSH) issues.
  - Position descriptions that clearly distinguish assessment tasks from other responsibilities. Assessment staff play a dedicated role in conducting assessments from a wellness capacity building approach
  - Agreed assessor/client ratio
  - Capacity to provide face to face assessments to determine the clients'/and or carers needs
  - Capacity to respond to the diversity of the HACC population and where appropriate develop formal protocols/Memorandum of Understanding’s (MOU’s) with Culturally and Linguistically Diverse (CALD) and Aboriginal clients/service providers
  - Capacity to develop protocols with specialist organisations if assessment requires additional skills and expertise. i.e. younger people with disabilities, people with mental health problems
  - Capacity to work in partnership with the client to develop goal orientated support plans and a referral action plan, if required to a range of other services outside of any given organisations’ that will support the clients goals
  - Capacity to coordinate access to flexible services that support a client’s independence and social capacity
  - Commitment to assess and review/reassess clients within designated time frames (Referral Protocol) or as clients circumstances change
  - Identified staffing composition, and expertise - Assessment staff with a mix of expertise to create a ‘team’ approach
o Capacity for individual support staff to be multi-skilled and work across a broad range of “service types” i.e. domestic assistance/personal care, social support/respite care
o Expertise to assess carer needs for ‘at risk’ carers
o Well developed pathways/links to other community based services i.e. ACAT, Allied Health, GP’s
o Operational infrastructure that has the capacity to provide:
  ▪ a quality assurance program to meet the National Community Care Standards
  ▪ an appropriate structure, which provides for professional supervision, mentoring and peer support
  ▪ ongoing opportunities for professional development and training in Wellness Assessments
  ▪ IT/IM systems that support efficient and effective practices in data collection and data management processes

• Commitment to being involved in a working group re competency based training for assessors
• Commitment to be engaged in multi agency collaboration and learning and development opportunities
• Development of shared protocols and processes including an agreed set of practices for agencies in managing demand when assessed needed services are not immediately available
• Development of greater transparency around assessment and agreed support
• Link with Workforce Development and Skills Framework developed by CommunityWest
• Commitment to staff development and future training needs (i.e. understanding of impact of disability and ageing on functioning)
• Maintain up to date information and knowledge of local community resources that can support a clients’ independence and improved ability