

# Southern Metropolitan Region

HACC/ACAS and  
PACKAGED CARE

MEMORANDUM  
OF  
UNDERSTANDING

2011

# CONTENTS

Introduction and Purpose .....	2
Part A Definitions .....	3
Part B Pre-Referral Process – Indicators for Referral .....	5
Part C Referral Process .....	6
Part D ACAS Assessment .....	7
Part E Interim Management .....	9
Part F Other processes .....	10
Part G Grievance Process .....	11
Signatory Page.....	12

## **Introduction and Purpose**

This document includes a Memorandum of Understanding (MOU) and Practice Protocols developed by the Home and Community Care (HACC) / Aged Care Assessment Services (ACAS) / Packaged Care (includes Commonwealth packaged care providers and Linkages Services) Management Group, Southern Metropolitan Region (SMR).

All relevant organizations working together in the SMR are invited to sign the MOU and follow the protocols. Through enhanced program and organizational practices it is expected that organizations and service users will benefit.

This memorandum of understanding with associated processes is to provide guidelines to ensure clear pathways and better outcomes for recipients.

Practice protocols may be used by Local Interface Networks (LINs- see below) to address issues in relation to:

- Part B – Pre referral – indicators for referral
- Part C – Referral
- Part D – ACAS assessment
- Part E – Interim Management
- Part F – Other processes
- Part G – Grievance

### **Objectives**

- To provide a set of indicators that may prompt a referral for case management and packaged care.
- To describe processes to share ideas, knowledge and resources to negotiate better outcomes for clients with multiple, complex needs.
- To streamline the existing referral processes.
- To develop clear appeal pathways for services.

### **MOU and Practice**

Signatories to this memorandum agree to adhere to the following protocols.

## Part A Definitions

**Case Management** is “a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost effective outcomes” (Case Management Society of Australia National Standards, 2004).

**Care Coordination** is “an action that results in the sequencing and delivery of services and resources in a timely and appropriate manner” (Case Management Society of Australia National Standards, 2004).

Care Coordination as defined for HACC Assessment Services:  
“All HACC Assessment services will play a role in care coordination”

Care Coordination may include the following tasks:

- facilitating inter agency care planning due to multi agency involvement in service delivery.
- facilitating development and review of care coordination plan.

(Strengthening Assessment and Care Planning: A guide for HACC assessment services in Victoria (2010) p.169).

Care coordination is also a function of ACAS and defined as an activity by ACAS which is intended to be relatively short-term. It is meant to bridge the time between when the assessment finishes and when responsibility for the client is taken on by a carer or another service provider, or until the client enters residential care (ACAS Training Manual, 2010).

**Case manager/ care coordinator/ care manager:** these terms refer to the professional worker who practices case management. The terms used will vary according to the preferences of individual case management service providers.

**Packaged Care/ Care Packages:** includes Extended Aged Care at Home (EACH), Extended Aged Care at Home/ Dementia (EACHD), Community Aged Care Packages (CACPs) & Linkages packages. Packages of care are individually planned to meet the needs of people who are aged and/or who have disabilities living in the community. Packages of care usually provide a range of specified services which require coordination. Case management is a component of packaged care funding.

**Local Interface Networks:** involves services in local areas within the Southern Metropolitan Region working on improving delivery of services through the use of these protocols as a guide to practice. This may involve meetings between ACAS, HACC and Package Care providers, developing strategies to address gaps in services, or identifying processes for improvement. These networks need to involve staff at the service delivery level as well as management level.

**Electronic waitlist system:** is a web based secure data and referral system provided by Infoxchange. ACAS and Packaged Care providers contribute a license fee to access and utilize the system. There is a central Steering group made up of representatives from ACAS and Providers that manage and oversee the program, and recommend enhancements.

## Part B Pre-Referral Process – Indicators for Referral

### Purpose

To achieve consistent decision-making regarding the need for assessment for packaged care.

### Scope

This applies to all HACC service providers including direct care workers, assessment officers, nurses and any other staff who have direct contact with clients.

### Process

**1. Early Intervention:** Direct Care Workers will provide feedback to their line managers / assessment officers on the following indicators:

- Difficulty organizing and paying bills
- Absent for Service Provider appointments
- Decrease in hygiene levels
- Increase in personal /body odours
- Decreased mobility
- Increased falls
- Increased bruising
- Medication issues
- Change of living circumstances or supports
- Frequent calls for clarification
- Nutrition issues such as weight decrease/increase, inappropriate foods, fridge full/empty
- Carer stress
- Lack of informal supports
- Isolation – unusual/uncharacteristic
- Mood changes
- Frequent or increased hospitalization

Reports of these issues may prompt further investigation or assessment.

### 2. Pre-referral

**2.1 HACC Line managers/ assessment officers:** review feedback and assess whether a referral to packaged care is appropriate. The following indicators or 'triggers' may prompt referral for a package of care:

- Need for case management. (This may already be attended by mental health and Community Health Centres where available).
- Level of formal / informal service cannot be maintained/multiple services involved
- Difficulty managing one or more factors / issues / care needs
- Increased or fluctuating need
- Health conditions impacting on level of independence

- Carer stress
- Risk of breakdown in carer/caree relationship

**2.2 Other HACC workers or Services:** as above. Additional or alternative referral ‘triggers’ may result from discipline-specific assessments, such as Nursing or Occupational Therapy. Consideration of the need for referral may lead to the following:

- Discussion with ACAS and / or
- Joint visit of ACAS and HACC and / or
- Consultation by HACC service with packaged care service

## Part C Referral Process

### Purpose

To improve existing referral processes by obtaining consent to share client information, working together on the client’s transition between programs and providing valuable feedback / outcomes to the referrer at the time of transition.

### Scope

This procedure applies to HACC, ACAS, & Care Package Providers. Referrals are made by Services in accordance with their organization’s practice and, where relevant, with the DH Service Coordination guidelines and standards of practice.

This procedure includes additional steps to assist communication at the time of, and following, a referral of a client.

(Refer to [www.health.vic.gov.au](http://www.health.vic.gov.au) for current guidelines).

### Additional process steps

In line with identified processes, a referral will be made when the client meets program eligibility.

#### Referral to ACAS

1. Service providers are able to telephone ACAS, prior to submitting a written referral, for secondary ACAS consultation.
2. Service providers to inform ACAS of the potential for joint visits. (i.e. Client difficult to engage / Visits coincide / Potential “risk” issues).
3. ACAS assessor seeks further details / history of client from referrer if required and provides referee with written and if appropriate, verbal feedback on the outcome.
4. ACAS identifies services, if known, for later follow up by the Package Provider.

5. Referrals to be made on the Service Coordination Template Tool (SCTT) where possible.

#### Waitlist for Care Package

1. Referrals and feedback for CACP / EACH/EACHD Packages will be made to the Electronic Wait List in line with Southern Region Protocols.
2. ACAS waitlist a person on the Infoxchange e/waitlist and should notify the relevant HACC service provider when:
  - the client has been placed on a waiting list, including their priority rating
  - the client's priority category on the e/waiting list has changed due to a change in circumstances.
3. ACAS should liaise with the relevant HACC Services throughout the transition.

## **Part D ACAS Assessment**

### **Purpose**

To describe the factors taken into account when ACAS is assessing for eligibility for packaged care.

The *Guidelines for streamlining pathways between ACAS and HACC assessment services* provide recommended referral pathways for frail older people to reduce unnecessary duplication of assessments and are managed as efficiently as possible.

This document provides guidelines on:

- indicators for referral to the most appropriate assessment services: HACC or ACAS
- expectations for communication and information sharing
- supporting the transition from HACC services to Commonwealth-funded aged care packages
- mechanisms for strengthening trust and building relationships between ACAS and HACC assessment services at the local level.

For more information refer to [www.health.vic.gov.au](http://www.health.vic.gov.au)

### **Scope**

Applies to ACAS managers and assessors and clients assessed as eligible for referral to packaged care.

#### **1. Referral and assessments**

People assessed as requiring a package of care are those who (as per Commonwealth Guidelines):

- would otherwise be eligible for
  - at least low level residential care for CACP

- at least high level residential care for EACH and EACH Dementia.
- prefer to remain in the community and have available and sustainable supports
- HACC Services are already providing a high level of input which cannot be continued and can be absorbed by a package of care
- Require a coordinated package of care including ongoing monitoring, review of care needs and case management.

(N.B. Linkages packages do not require an ACAS assessment. Referrals are made directly to the Linkages provider.)

## **2. ACAS Indicators for packaged care include:**

- Difficulty for client to access services due to health issues e.g. dementia.
- A range of services required which need co-ordination.
- Complex care needs which require monitoring, reviews and individual management by a case manager
- Limited informal supports/carer stress
- At risk of entry to residential care

In some cases a person may be determined as eligible for a package of care by the services involved, but an issue may be identified which affects the access. These issues may be identified at the time of the referral to ACAS or after the assessment has occurred.

In these cases there should be:

- Feedback to the referrer
- Feedback to the current services ( this needs to be reviewed by ACAS teams in region as to what is current practice)
- Meeting with services and package provider at clients home where appropriate
- Case conferences as per agreed protocol with ACAS, HACC and Packaged Care Providers

## **3. Post Approval**

The types of issues which can sometimes present as a barrier to access, but do not determine eligibility include:

- Client cannot maintain current HACC services and is at risk of declining a package due to the client's preference for the existing HACC direct care worker
- Cost of the package i.e. client fees charged
- Full cost recovery of services will limit access to current care needs e.g. PAG or meals on wheels

This list is not exhaustive but represents possible problems of access and consistency across localities. The issues should be addressed directly with service providers where possible but may provide triggers for case conference. There may be further system and policy issues identified.

## **Part E Interim Management**

### **Purpose**

To ensure that, following referral, individuals receive care coordination during the period between referral to ACAS or a packaged care provider and program commencement, that smooth transitioning occurs between programs and that extremely complex individuals receive a timely service.

### **Scope**

This procedure applies to all HACC, ACAS & packaged care providers who have clients with complex care needs requiring input from multiple programs.

#### **1. Interim Care Arrangements**

##### **Process**

- The existing Service will continue to maintain care coordination and that service will provide support. ACAS will provide support where there is no other service identified.
- The level of monitoring of clients on the electronic waitlist varies but issues regarding priority or increasing needs can be referred back to ACAS.
- Clients with extremely high levels of complexity can be discussed at case conferences (see below).

#### **2. Transitioning Between Programs/Providers**

##### **Process**

- Selection of a client from the waitlist involves a package provider placing them under consideration on the e/waitlist and contacting the client.
- Package Providers are encouraged to contact current service providers prior to assessment.
- Staff from the HACC service and the package provider may jointly visit to introduce the new provider to the client.
- When a client accepts an offer of a package and the packaged care provider is ready to commence services the existing services will be involved in the transition process.
- ACAS staff may be included in the transition process for complex clients.
- Up-to-date, relevant and additional information is shared between staff involved.

## **Part F Other processes**

### **1. Case Conferences**

These can occur at various points through the client journey

#### **Process**

- Any Provider can initiate a Case Conference.
- Representatives from HACC/ ACAS/ Packaged Care or other services can be involved.
- Case conferences will be documented.
- The format should include: history, issues, action plans and recommendations
- Copies of case conference notes are to be held in client files by relevant Providers
- The program initiating the referral is responsible for following up outcomes of recommendations.
- Maintaining confidentiality and privacy of information by all parties.

### **2. Response to positive changes for clients**

Occasionally, regular monitoring or feedback received about the client will indicate that their levels of available support, personal function or other circumstances have improved.

The following indicators or ‘triggers’ may prompt reporting by care staff and indicate the need for further investigation or review:

- Improved confidence and activity levels
- Improved mobility and physical status
- Change in living arrangements which increase levels of support available

(NB that this list is a guide only)

Once the situation has been reviewed, consideration should be given for a referral back to ACAS and a review of the level of care required and / or the eligibility for an existing package of care. The outcome of this may be that the client is returned to a lower level of support, if this meets ACAS assessment criteria and the client / carer consents.

In these circumstances current service providers will liaise with all relevant stakeholders to develop an agreed transition plan.

## Part G Grievance Process

### Purpose

To ensure program staff have access to a clear pathway to express a grievance, at any point of referral, assessment or transition through the HACC / ACAS / Packaged Care programs.

### Scope

This procedure applies to HACC, ACAS & Care Package Providers.

### Process

This grievance process relates to program eligibility, outcome of assessment and acceptance onto a program.

When an individual (case worker, care manager) is dissatisfied with a decision made by any of the above programs regarding the outcome of a referral, assessment or transition process the following general steps should be taken:

#### HACC (all HACC funded agencies)

Initial contact is to be made with the main member of staff involved in referral, assessment or the transition process. Alternatively the Team Leader / Program Coordinator or the manager of the specific local HACC program can be contacted.

#### Packaged Care Programs

Initial contact is to be made with the case manager. Alternatively the program Coordinator/Manager or the senior manager can be contacted.

#### ACAS

Initial contact is to be made with the ACAS clinician involved in the assessment. Alternatively the ACAS Manager can be contacted if unresolved.

ACAS has an appeal process within the Aged Care Act and if any client or person affected by the decision is not satisfied with the decision, they can write to the Secretary of the Department of Health and Ageing. They must write within 28 days of receiving this advice and give the reasons why they think the decision should be changed to:

The Secretary  
Department of Health and Ageing  
C/- State Manager  
Ageing and Aged Care Division  
GPO Box 9848  
MELBOURNE VIC 3001

**NOTE:** Each Program will have slightly different pathways, but advice will be given to the complainant of the next appropriate step in the appeals process.

**Changes to Protocols**

Any recommended changes to protocols will be referred to all signatories of the MOU for approval prior to adoption.

**Statement of Commitment**

I .....

on behalf of:.....

.....(Service)

agree to the protocols as stated in this memorandum and agree to abide by the principles stated above.

Signed.....

Date .....

Contact: Ph:.....

email:.....

1. Please complete and sign this page.
2. Photocopy this page and post copy to:

Villa Maria Community Services Southern  
 Attention: Suzanne Chamberlain  
 Unit 4, 147-151 Foster Street, Dandenong VIC 3175