

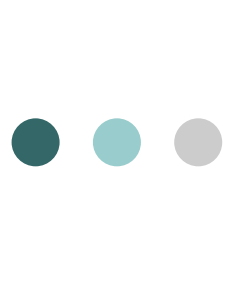


# Integrated Assessment Partnership Project

Fay Wallis OT Bendigo Health

Stacy Williams – Project Manager

March 2010



*home and community care*

A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM  
PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

## **Target Population**

- Frail older people, younger people with disabilities and their carers.

## **Aim of service Delivery**

- Provide basic support and maintenance to people living at home whose capacity for independent living is at risk,
- Prevent premature or inappropriate admission to long-term residential care.



# HACC Funded Community Services

- Allied health (physiotherapy, podiatry, O.T. etc)
- Domestic assistance
- Planned activity groups
- Personal care
- Respite services
- Property maintenance
- Linkages packages
- Nursing (community nursing, home nursing)
- Food services (meals on wheels)
- Friendly Visiting/Telelink/Respite/Transport Services provided by volunteers (Volunteer Coordination)



# Historical Perspective

## **General and Service Specific Assessment**

- Completed by HACCC assessment officers

## **Referrals to Allied Health**

- A possible outcome of this assessment

## **Service Co-ordination**

- Informal
- Inconsistent feedback to referral source
- Awareness of others roles based on personality

## **Clients**

- Expected HACCC services to do things for them
- Expected to stay on services



# Project Background

- In June 2007, DHS published the Framework for Assessment in the HACCC Program in Victoria.
- The first step in the implementation was to fund designated Assessment Services.
- The second phase of the implementation includes the development of models for partnering.



# Assessment Framework Aims

- Promote client focused assessment
- Achieve greater consistency in practice
  - Decision making and care planning
  - Recognize expertise when required
- Streamline and better coordinate assessments
- Build the foundations for the Active Service Model.



# Partnering in Assessment

- The purpose of partnering in assessment is to provide an integrated, coordinated assessment service which improves quality and comprehensiveness of Living at Home Assessments.
- Partnering makes available the full range of skills and expertise necessary to deliver Living at Home Assessments to the diverse client group.



# Loddon Mallee Region

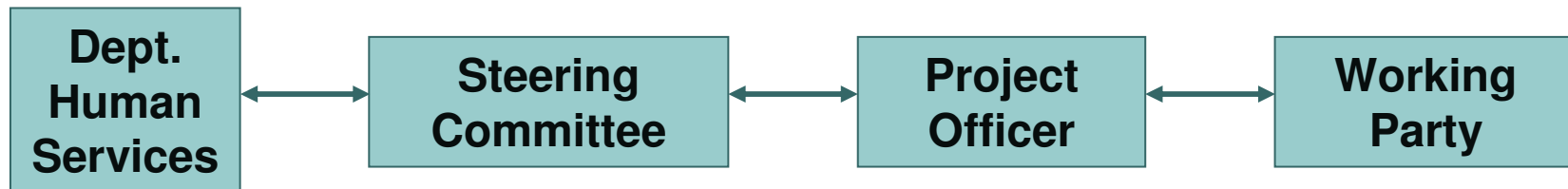
- To deliver and implement agreements and processes to support and integrated, multidisciplinary approach to delivery of L@HA.
- The partnership model will strengthen organisational arrangements between LGA, allied health and district nursing services, ACAS and Division of GPs.



# Project Objectives

- To develop formal protocols between agencies, that support partnerships and collaborative approaches, and maximise the use of a range of professional skills and expertise that work across agencies in large rural area. (Protocols)
- To develop policy and procedures inclusive of processes that identify who can provide timely assessment to best meet needs of the client. (Policy and procedures)
- To enhance a multidisciplinary team approach by developing new work practices to support the most appropriate Living at Home Assessment for the client. (Virtual Teams)
- To maximise skills and knowledge in the rural communities, by capacity building through the identification of training requirements, and the development and implementation of appropriate training packages. (training)

# Project Structure



- All stakeholders represented on either or both groups.
- Working party made up of AH Clinicians, Assessment Officers, District Nurses, etc



# Project Working Party

- Building on existing relationships
- Strengthening the partnerships
- Focus has been on outcomes for clients rather than running of a service.
- Trying to imbed process over personality



# New practice

- Two levels
  - Practitioner level
  - Organisational level
- Organisational
  - Memorandum of Understanding
- Practitioner
  - Triggers
  - Protocol



# HACC Assessment Framework (and Active Service Model)

## **Consumers**

- Increased functional capacity
- Increased involvement in tasks at home
- Maintain engagement in life



# HACC Assessment Framework (and Active Service Model)

## **Service Providers:**

- Collaboration
- Building alliances
- Involvement of Allied Health in Living at Home Assessment
- Timeliness of response
- Priority of access criteria



# New Practice

## **Protocol**

- Living at Home Assessment
- Trigger identified (during assessment)
- Call made to RHT
- Assessment details discussed
- Course of action determined
- Priority of Access determined
- Referrals made if required



## New Practice

### **Living at Home Assessment**

- A wholistic assessment completed by HACCC assessment officers to identify the need for specific services:
- Replaced the previous general assessment
- Includes identifying the need for Allied Health in the assessment
- Triggers identified



# New Practice

## Triggers:

- Are you unsure if an allied health referral is required/ necessary?
- Are you concerned about carer, client or worker safety?
- Can you identify an opportunity for client rehabilitation using an active service approach?
- Are you concerned that a client's behaviour did not match the formal assessment answers?
- Are you concerned by the clients' presentation or behaviour during Assessment?



# New Practice

## **Allied Health role in assessment**

- Rural Health Team (phone access)
- Change in priority criteria and
- Response times



# New Practice

## **Service Provision**

- Flexible service response
- Episodes of care
- Integrated with allied health intervention



# Integrated Assessment Partnership Project

## **Outcomes**

- Partnership and collaboration
- Informal processes embedded in protocol and MOU
- Acceptable to discuss assessment
- More accurate priority
- Increased responsiveness
- Better outcomes for clients



# Evaluation of the Project

- Evaluation underway
- Initial evidence suggests Training is critical to the process – training plan
- Partnerships enhanced
- Process/ practice to refined
- Final report due 30 June 2010



# Comments from the Working Group

- 'It has put us all on the same page'
- 'We have the security of continuity with staff changes.'
- 'Formalised what we have been trying to do'



More info:

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● ● ● | **Project Partners**

