PRIORITY OF ACCESS TOOL TRAINING FOR WMR LOCAL GOVERNMENT HACC SERVICES

FINAL REPORT

National Ageing Research Institute

June 2003

This project has been funded by the Western Metropolitan Region's Department of Human Services

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Background

Increased demand for HACC services has lead to the development of various targeting strategies employed by Local Government service providers in the Western Metropolitan Region of Victoria (NARI, 2001). One of these strategies is to allocate priority levels to people trying to access services according to indicators related to need and risk. To address this issue and to ensure that equity is achieved across the region, Local Governments in the Western Metropolitan Region of Victoria (WMR) decided to develop and implement a tool that measures priority of access (POA).

Primary Care Partnerships and Service Coordination

The introduction of a POA tool needs to complement broader policy developments in HACC and the primary care system in general. Primary Care Partnerships have reviewed assessment and referral practices and processes across the Victorian primary care system over recent years. One of the developments that took place as a part of this review was the introduction of a suite of tools referred to as Service Coordination Tool Templates and Guidelines (SCOT). These tools have been designed to:

- Support consistent service coordination practice
- Collect core consumer information
- Determine risk and consumer needs
- Support appropriate referral and assessment

(DHS, 2002)

Developing the POA tool

The SCOT templates cover a broad range of indicators of need relevant to priority of access for HACC services. The SCOT templates, however, do not aim to provide a process for service providers to determine potential clients' priority for service relative to other potential clients. In 2002, the National Ageing Research Institute (NARI) in consultation with Local Government HACC services in the Western Metropolitan Region of Victoria (WMR) developed a POA tool for determining whether potential and existing clients were high, medium or low priority for accessing HACC services (NARI, 2002). This project was funded through a HACC service development grant through the WMR Department of Human Services (DHS). The POA tool that was developed is closely linked to the SCOT tools and provides a process of using information obtained through completing the SCOT tools to determine priority levels.

Piloting the POA tool

During the development of the POA tool, three Local Governments in the WMR piloted the tool leading to its modification. At the completion of this project, it was recognised that the POA tool was in its early stages of development and future use and review of the tool would be required to ensure it was achieving what it was intended to. In the final report recommendations were made for training assessment staff prior to implementing the tool

across Local Governments in the WMR. Training would facilitate consistent interpretation of the tool by assessment staff, thereby, maximising the reliability of the tool.

Training for the POA tool

In 2002, NARI received another HACC service development grant through the WMR DHS to develop and implement a training program for WMR Local Government HACC assessment staff. This report provides an evaluation of the training program and recommendations for further modifications to the POA tool.

Training Program

The training program consisted of a three-hour initial training session with a follow-up one-hour discussion session after a two month period. The two month period between the two sessions aimed to provide participants with time to use the tool in their current practice. The target audience for the initial training and follow-up session was all staff who undertook assessments for WMR Local Government HACC services.

Initial training session

The initial 3-hour training session had two key objectives for participants:

1. To understand the value of a consistent approach to assessing priority
2. To be able to confidently complete the Priority of Access tool in their work.

The training was held on three dates at three venues across the region and at different times to increase the opportunities for assessment staff to attend the training. Invitations were sent to HACC management staff to forward to assessment staff. The training programs offered were:

Session 1

Where: National Ageing Research Institute, Parkville
When: Tuesday 4th March 9.00am-12.00pm

Session 2

Where: Wyndham City Council Community Services building
When: Wednesday 5th March 2.00pm-5.00pm

Session 3

Where: Maribrynong City Council, Footscray
When: Thursday 13th March 9.00am-12.00pm

Table 1 provides an outline of the training program.

Table 1: POA Training Program

Program Content	Minutes
Welcome • Introductions • Session overview • Contents of Resource Kit	15
Introduction: Why a Tool for determining priority? • Priority of Access and defining need • International Classification of Functioning Disability and Health • Benefits of using a measurement tool	15
Developing the POA tool • Requirements of a POA tool • What a POA tool does not do • Literature evidence • Anderson framework • Current Practice • Core elements	10
Reviewing the tool • POA tool overview • Who it is used for • Review of questions • Scoring • Overview of tool pilot and findings • Recommendations for further testing • Recommendations for implementing the tool • Issue of weighting	50
Morning/Afternoon Tea	15
Case Studies • Karen and Jason • Mrs B	50
Questions and discussion	15
Implementing the tool • Benefits of the tool • Summary	5
Evaluation sheets	5

In the first component of the training program participants were asked to introduce themselves and where they worked. An overview of the session was provided and the contents of the resource kit were explained. The resource kit contained the following:

- The training program outline as shown in Table 1;
- A print out of the powerpoint slide presentation;
- A bound copy of the POA tool guidelines;
- Four copies of the POA tool;
- A copy of the Service Coordination tools;

- Two case studies with completed Service coordination tools attached;
- An evaluation form;
- Some pages to write notes.

The following section, 'development of the POA tool', provided an overview of the literature evidence and introduced the Anderson framework for considering predisposing, enabling and need factors for determining use of community services. The process for the development of the tool was also explained as well as an overview of the current approaches used by Local Government HACC services in the WMR. Requirements of the POA tool were outlined.

The 'reviewing the tool' section examined the specific details of completing the tool. All questions were discussed as well as scoring and who the tool should be used for. Findings from the pilot of the tool during the developmental project were also provided to highlight the finding that the tool is quick to use and generally matches up with assessors own clinical judgement. Recommendations about implementing the tool were presented. The concept of weighting and the difficulty associated with choosing which items need additional weighting and determining the extent of the weighting was also introduced.

After a break, case studies were presented with attached completed SCOT tools. The attached SCOT tools were already completed as it was assumed that participants who were attending the POA training had already completed the SCOT training and therefore difficulties in completing the SCOT tools would not impede discussion of the POA tool. Participants broke up into small groups to work through the two case studies and to complete the POA tool. A whole group discussion followed allowing different interpretations to be revealed and discussed. This became a general discussion about the POA tool and participant's questions were addressed.

The session was completed by reviewing the potential benefits of the POA tool for assessors, their organisation, the WMR more broadly and HACC clients. Staff were asked to complete the evaluation form prior to leaving the session.

Follow-up session

Staff were invited to attend a follow-up session two months after the initial training was completed. It was intended that during the two month interval staff would have an opportunity to use the tool in the field. Two one-hour sessions were held across the region. A third session was available but not required. The key purpose of the follow-up session was to ensure all staff were interpreting the tool in the same way and to address any issues that may have arisen whilst using the tool in practice. A secondary purpose of the session was to obtain feedback from assessors about the validity of the tool and what improvements could be made to the tool. The sessions were unstructured and interactive to allow all staff to discuss their experiences.

Sessions were provided at the following times and places:

Session 1

Where: City of Brimbank, Function Centre, Sunshine
When: Thursday 1st May 9.00am-10.00am

Session 2

Where: Wyndham City Council, Civic Centre (functions area), Werribee
When: Tuesday 6th May 2.00pm-3.00pm

Evaluation of Training

The POA training program was evaluated through examining program reach in relation to the target audience, and through completion of evaluation forms by attendees at the completion of the initial training and follow-up session.

Training Reach

The training was attended by assessment staff from the seven Local Governments in the WMR indicating interest in implementing the tool by all Local Governments in the WMR. Invitations were sent to managers of each HACC service to distribute to relevant assessment staff in their service. The number of assessment staff at each Local Government varies, however previous work completed in the region indicated that Local Governments in the region employed between 3-7 assessment staff each (NARI, 2001). Table 2 indicates that between 3-7 assessment staff attended the training from each LGA suggesting that the training program was completed by most of the target audience.

Table 2: Number of attendees by Local Government

Local Government	Training	Follow-up sessions
Brimbank	3	3
Hobson's Bay	7	0
Maribyrnong	4	7
Melbourne	3	1
Melton	3	2
Moonee Valley	6	0
Wyndham	4	4
Total WMR	30	17

Fewer staff attended the follow-up training sessions. This could in part be due to some staff having piloted the tool during its development and had already provided feedback. Some of these pilot staff indicated that after completing the initial 3 hour training session they felt they were confident using the tool and didn't require the follow-up session which aimed to clarify any further issues and seek feedback. A small number of staff who attended the follow-up session had not attended the initial training session.

Feedback about the training session

Closed responses

At the completion of the initial 3 hour training session, staff were given time to complete a one page evaluation form regarding different aspects of the training program. Twenty-nine staff of the 30 who attended completed these forms. Table 3 provides the responses to the closed questions.

Table 3: Percentage of responses regarding aspects of the training session

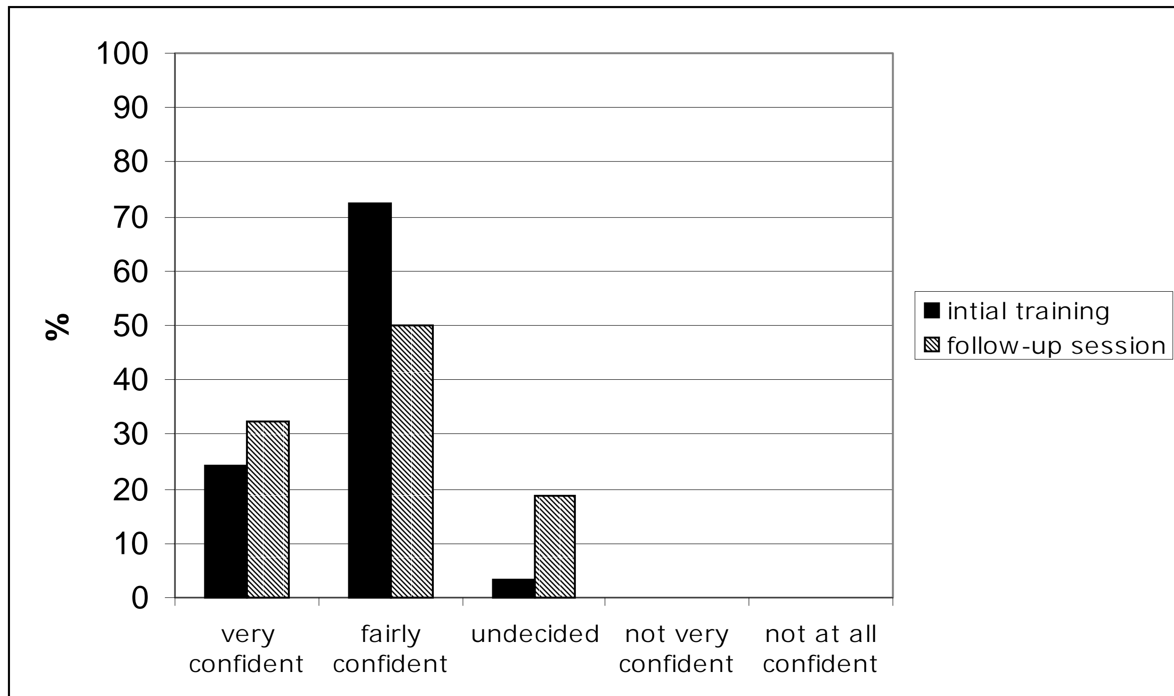
	% Poor	% Fair	% Good	% Excellent
Introduction: Why a tool?	0	7	64	29
Development of the tool	0	7	72	21
Reviewing the questions	0	10	55	35
Case Studies	0	4	50	46
Presenter	4	7	54	36
Slide presentation	0	10	59	31
Resource Kit	0	4	55	41
Venue and catering	7	14	55	24

Table 3 indicates that for all of the aspects of the training investigated, the majority of participants reported they were good or excellent. The most popular aspects were the case studies where 46% of participants indicated they were excellent and 50% reported they were good. The resource kit was also regarded highly.

Confidence using the tool

After completion of the initial training all except one person was very or fairly confident in completing the tool (97%, see Figure 1). One person was undecided.

Figure 1: Confidence using the tool after initial training and follow-up sessions (%)



What would help improve your confidence?

Twenty staff who completed the evaluation forms provided responses to this question after the initial training. The most common response (14 participants) was simply to use the POA tool in their everyday practice; "Nothing other than practice with the tool in the field". Some indicated that being more familiar with the INI tools would also improve their confidence in using the POA tool. Some Local Governments had only implemented the INI tools in the same month as training for the POA tool. A number of participants also indicated the importance of discussing their experiences of using the tool with colleagues to ensure that interpretations were consistent. One participant indicated the value of the follow-up session after using the tool for the purpose of comparing interpretations. Another participant reported that ongoing review of the tool was required.

Table 4 indicates the confidence in using the tool after the follow-up session cross-tabulated with number of times using the tool. Although the numbers are small it appears that those who have used the tool on more than 5 occasions are more confident than those who have used it fewer than 5 occasions. The three participants who were undecided about their confidence in using the tool had either not used it or had used it fewer than 5 times. Some participants who attended the follow-up session had not been to the initial training and, therefore, their confidence may be lower.

Table 4: Confidence at follow-up session by experience using the tool (n=16)

Have used the tool?	Very confident	Fairly confident	Undecided	Not very Confident/not at all confident
Yes (more than 5 times)	4	5		
Yes (5 or fewer times)	1	3	1	
Not at all			2	

Are there any things you would like to change about the tool?

On the evaluation sheet for the follow-up sessions, participants were asked to indicate whether there were any things they would like to change about the POA tool. Fourteen participants provided responses with three of these indicating that no changes were required; "No. It marries really well to INI. Found it useful when reassessing "border line" clients". One client raised the issue of the suitability of the tool for younger people with disabilities; "Not relevant for respite for young families. A separate tool could be created. I have felt a client is high needs but falls into medium". Most staff wanted to see changes to the weighting of certain items on the tool;

> "Yes, I think it often still gives a result that is not truly reflective of the situation. Weight of indicators may need some balancing."

> "Scoring system – clients that are needing a service tend to score in the low, when they are eligible for service. Change to some of the categories eg ADLs give more weight or change scoring."

> "Difficulty when you see client is eligible but does not score well. Tend to use own judgement and compare/discuss with other assessment officers."

> "To change domestic ADLs score taking physical disability into more consideration."

The indicators that needed weighting that were discussed in the sessions included cognitive impairment, behaviour issues, domestic and self-care ADLs, nutrition, carer availability and carer status. One participant pointed out that the indicators that relied on self-report were less likely to be a reflection of need for services. For example, when asked to rate their health most people just said "good" regardless of the severity of existing health conditions. Participants also indicated that they didn't feel that clients accurately reported the number of falls they had had in the past 6 months. It was generally regarded that clients underestimate their level of need and therefore disadvantage themselves by not reporting difficulties they are having.

Changes to specific questions were also suggested. One participant indicated that for the self-care ADLs question the word 'calculate' should be replaced with 'add' to make it clearer. It was also suggested that for domestic ADLs the high priority box should include clients who are independent in one item. An example was given where a client had severe physical disabilities, was in a wheelchair and could not get out to complete domestic ADLs,

however, because they could manage their finances they ended up with a medium score for this item. Participants also indicated that incontinence issues were a significant factor that impacted on priority but was not included as an indicator.

Participants indicated that the environmental hazards question needed to incorporate degree of risk not simply how quickly the hazard can be resolved. If a major hazard can't be resolved this will score the same as a small hazard that also can't be resolved even though it may not pose much risk to the client. Participants also indicated that the majority of houses they went to had some environmental hazard with rugs being a common one. It was also reiterated in the sessions that the item was not about occupational health and safety issues for staff.

Changes to the 'social outings' items were suggested to make it more meaningful to different client situations. It was argued that some people may not need or want to go out of the house on a regular basis for social interaction. Some people may have adequate social interaction in their own homes and some people don't want much social interaction. For some people with cognitive impairment going on outings on their own may actually pose a risk to their wellbeing. It was suggested that the question may be more useful if it asked about whether the client was satisfied with their level of social interaction.

Some issues were raised in relation to the carer items. One difficulty was that carers were not always available to speak to. Another limitation cited was that some clients were managing quite well and just needed some assistance with home care, but because they lived alone they scored high on the 'carer availability' and 'carer status' items. The scoring system of the tool, however, means that scoring high on only domestic ADLs, carer availability and carer status will only provide a low priority score.

Any other comments?

One of the open-ended questions on the evaluation form for the initial training was a request for any further comments in relation to the POA tool and training session. Responses indicated that the case studies proved valuable for understanding the POA tool and different people's interpretations; "excellent case studies raised interesting discussion questions" and "case studies were helpful to get familiar with using the tool and discussing inconsistencies". Some indicated that they regarded the tool more favourably after the training session; "I believe that the tool is rather good after looking at it in depth" and "unlike the rest of my colleagues, I had not seen/used the tool before and on first sighting it looked as if it wouldn't be exhaustive enough, but now I see it is". Other comments related to the venue and speaker and some indicated that the session was useful and enjoyable.

Recommendations for revising the POA tool

Based on the feedback from the follow-up sessions, some revisions to the POA tool were recommended. A revised version of the POA tool, revisions incorporated, and accompanied by revised guidelines, are included at the end of this report. The revised version will be referred to as POA2.

The revisions recommended are:

Add weights to some items and revise overall score cutoffs

To give additional weighting to the factors that assessors regarded as having a greater impact on need for HACC services. These factors are also supported by the three key elements relating to need for HACC services as identified during the development of the POA tool: ADLs, cognitive impairment and social support (NARI, 2002). Therefore, it is recommended that additional weighting is given to self-care and domestic ADLs, cognition and behaviour and carer availability and carer status. Nutrition was also commonly identified as a key risk factor that should be given additional weighting.

To minimise confusion, weighted items have been placed on the first page of the tool with the non-weighted items on the back.

To reflect changes in the weighted items, the cutoffs scores for priority levels were modified slightly so that a score of 0-12 was low priority, 13-18 is a medium priority and 19 and over is a high priority. These cut-offs may require further modification after the POA2 tool has been used in routine practice and a review undertaken.

Modify specific items:

The domestic ADLs item was changed to allow clients to score high for this item when they were independent in one domestic activity.

In the 'self-care' ADLs item the work 'calculate' was replaced with 'add'. Incontinence issues were also added to the 'self care' ADL. Therefore, to score high on the 'self care' ADL item the client either needed to score 0-1 on the functional screen and/or have incontinence issues.

The 'environmental hazards' item was modified to incorporate both degree of risk posed by the hazard as well as how quickly it can be resolved. The guidelines also clarified that the item did not intend to identify occupational health and safety issues for staff working in the client's home.

The social 'social outings' item was modified to ask about satisfaction with amount of social interaction and social outings rather than the number of outings undertaken.

Summary

The POA training conducted for assessment staff from Local Government HACC services in the WMR reached a broad number of the target audience. Most participants were confident about using the tool after the training although it was recognised that more experience using the POA tool and the service coordination tools would improve confidence. Feedback from the follow-up sessions indicated numerous areas for improving the tool including changing specific items and giving some items additional weighting. Although the POA tool provides a framework for determining priority levels, it does not replace the clinical judgement of assessment staff or common sense.

Revisions to the tool based on this feedback and supported by literature evidence reported in the development of the POA tool (NARI, 2002) have been incorporated into a modified 'POA2'. POA2 and accompanying guidelines are included at the end of this report. It is recommended that Local Governments in the WMR review this tool and consider replacing the original version of the POA tool with POA2. The range of items remain the same with only minor modifications to some items and changes to the way the score is calculated. These changes could be implemented with minimal handover. It is also recommended that evaluation of POA2 is undertaken after staff have used the tool in routine practice for 6-12 months. This will help to ensure that the tool is adequately identifying those who more urgently require Local Government HACC services.

References

National Ageing Research Institute. (2001). Analysis of demand for local government 'in-home' HACC services in the Western Metropolitan Region of Melbourne. Parkville: Department of Human Services.

Department of Human Services (2002) "Service Coordination Orientation: A program for service providers", Primary Care Partnerships.

NARI (2002). "Development of a priority of access tool for WMR Local Government HACC providers", Parkville: Western Metropolitan Region, Department of Human Services.

Priority of Access Tool 2 (POA2)

Client's name: ______________________________ Date: ____/____/____ Assessment Officer: ____________________

Weighted Indicators	*How to complete*	*High: Score 4 or 6*	*Medium: Score 2 or 3*	*Low: Score 0*	*Score*
Domestic ADLs	Refer to **Functional Screen** items 1-5. Count the number of '2's selected and tick appropriate box:	4 0-1 item	2 2-3 items	0 4-5 items	
Self Care ADLs & incontinence	Refer to **Functional Screen** items 6 and 7. Add score for these 2 items and tick appropriate score. If incontinence issues cause difficulty automatically tick high.	6 0-1 ***and/or*** incontinence issues	3 2-3	0 4	
Cognition	If cognitive impairment has been diagnosed previously tick high. If it hasn't refer to **Functional Screen** items 4 & 5 on page 1 and item 8 on page 2	6 -Cognitive Impairment diagnosed ***and/or*** - Scored 0 on item 8 ***and/or*** - Scored 0 on Item 4 or 5 (with no physical disabilities or problems with literacy accounting for difficulty)		0 scored 2 on item 8 ***AND*** no other indication of cognitive impairment	
Behaviour	Refer to **Functional Screen** item 9 on page 2	6 Scored 0		0 Scored 2	
Carer Availability	Is there a carer* available to meet client's personal, household and social care needs? **Carer: resident or non-resident family, friend or neighbour who provides some assistance with personal, household and/or social needs.*	4 No carer available	2 Carer available to meet some needs	0 Carer available to meet most needs	
Carer Status	How well is the carer coping? (from the carer's perspective)	4 -No available carer ***and/or*** -Able to meet needs with major impact on their wellbeing	2 Able to meet needs with impact on their wellbeing	0 Carer able to meet needs with minimal impact on their well-being	
Nutrition Status	Refer to **Health Behaviours** nutrition risk screening tool. How many items were ticked?	4 4-10 items	2 1-3 items	0 None	

Non-weighted Indicators	*How to complete*	*High: Score 2*	*Medium: Score 1*	*Low: Score 0*	*Score*
Communication	Rate the ability to communicate with others based on barriers of: • Language* • Literacy • Speech **(Refer to* ***Consumer Information****: interpreter required and preferred language)*	2 Not able to communicate needs	1 Able to communicate needs with some difficulty	0 No difficulty communicating needs	
Self rated health	Refer to **Health Conditions Profile:** In general, how would you say your health is?	2 Poor	1 Fair	0 Good ***OR*** Very good ***OR*** Excellent	
Sensory-Vision	Refer to **Health Conditions Profile.** Consider responses for reading and long distance eyesight (with glasses)	2 Both responses poor ***OR*** one poor and one fair	1 Both fair ***OR*** one fair and one good	0 Both either good ***OR*** excellent	
Sensory-Hearing	Refer to **Health Conditions Profile.** Hearing	2 Poor	1 Fair	0 Excellent/Good	
Falls Risk	Refer to **Health Conditions** profile	2 More than 1 fall in past 6 months	1 1 fall in past 6 months	0 No falls in past 6 months	
Social interactions	How satisfied is the client in the amount and quality of their social interactions/and outings?	2 Not at all satisfied	1 Partly satisfied	0 Satisfied	
Environmental Hazards	Does the environment (in and around the person's place of residence) pose a safety risk to the client or impede the client's ability to mobilise and to maintain hygiene. If an environmental hazard exists could this be resolved in the short term, the long term or is not likely to be resolved at all. Is the hazard high, medium or low risk to the client?	2 High risk, not resolvable within 4 weeks ***OR*** Medium risk, unresolvable	1 High risk, resolvable within 4 weeks ***OR*** Medium risk, resolvable within 12 months	0 low or no risk ***OR*** medium risk resolvable within four weeks	
				Sub Score:	

Other: If you have identified any other medical, social or emotional issues that are likely to increase risk (eg, psychiatric illness, depression, hospitalisations, abuse or neglect) add 2 points to the subtotal. Record the issue/s:

____ **Total Score:**______

Scoring: ❑**Low Priority=0-12** ❑**Routine/Medium Priority=13-18** ❑**Urgent/High Priority=19+**

GUIDELINES FOR THE WMR HACC PRIORITY OF ACCESS TOOL REVISED (POA2)

National Ageing Research Institute

Modified May 2003

The development of the Priority of access tool was funded by the Western Metropolitan Region's Department of Human Services for use by WMR Local Government Home and Community Care services

GUIDELINES FOR USING THE PRIORITY OF ACCESS TOOL REVISED (POA2) FOR WMR LOCAL GOVERNMENT HACC PROVIDERS

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1) WHAT IS THE PRIORITY OF ACCESS TOOL 2 (POA2)?

The revised Priority of Access tool (POA2) provides a method for HACC assessment staff to determine the priority of access level of clients/potential clients. It has been developed for use in all Local Government HACC services within the Western Metropolitan Region of Victoria. It is intended that the POA2 tool will replace priority of access tools developed by individual Local Governments. The POA2 tool increases transparency of assessment and service allocation decisions to clients and other referring agencies and helps assessment staff determine relative priority. It also aims to enable equity of access to be examined across the region for informing planning of HACC services in the future.

The need for a method of determining relative priority occurs when demand for services is greater than the amount of services available.

The introduction of the POA2 tool coincides with the introduction of the Service Coordination Tools (SCOT) introduced through the Primary Care Partnership (PCP) initiative. These tools are commonly referred to by assessment staff as Initial Needs Identification (INI) and therefore, this terminology has been used throughout these guidelines. It is recommended that use of the POA2 tool is not introduced until the INI tools are routinely used in agencies. While the INI tools consider many of the characteristics that are used to determine priority, the INI tools do not summarise the information to determine whether someone has a high, medium or low priority for access to services. The guidelines that accompany the INI tools however, suggest that the following set of codes could be used:

- Urgent - cannot wait;
- Routine – attend in date order (this may include the consumer being placed in a waiting list);
- Low – hold over during peak demand.

This terminology reflects current practice in the WMR Local Government HACC services where the categories high, medium and low are used. To be consistent with the INI guidelines and familiar with current practice in the WMR the categories; lower, routine/medium, and urgent/higher have been used.

WHAT THE TOOL DOES NOT DO

The POA2 tool is not designed to achieve any of the following:

- Specify levels or types of service provision for clients
- Provide a comprehensive assessment tool
- Replace Clinical judgement and common sense

2) DEVELOPMENT OF THE TOOL

The POA2 tool was developed by the National Ageing Research Institute (NARI) with input from a working party consisting of representation from the Department of Human Services (WMR) and each of the seven Local Government HACC services in the WMR.

The tool was developed via consultation with the Working Party; a literature review of risk factors for HACC services and needs identification; and through investigating current tools and approaches used for determining priority for HACC services by Local Governments in the WMR.

Two tool options were developed by NARI project staff and presented to the Working Party. The option chosen by the Working Party was modified and piloted by three Local Governments in the WMR in 2002. Further modifications were made to the pilot tool after the pilot and evaluation. A training program was then developed and implemented by NARI and through this program further modifications to the tool were recommended and implemented. These guideline support the modified tool, referred to as POA2.

For further information on the pilot and feedback processes please refer to the full report: "Development of Priority of Access Tool for WMR Local Government HACC Providers" (NARI, 2002). Each LGA in the WMR received a hard copy and an electronic copy of this report. It is also available through the NARI website along with other HACC reports completed by NARI:

http://www.nari.unimelb.edu.au/divisions_health_primary.html

It is expected that implementation of the tool will lead to further refinement of the tool. To ensure that the tool is used consistently across the region it is important that any changes made are introduced by all LGAs in the WMR.

3) WHO USES THE POA2 TOOL?

The tool is to be completed by all WMR Local Government HACC service staff who conduct assessments or reviews of clients/potential clients in the client's home. The Priority of Access tool is used for all potential HACC clients including children and young adults who have a disability. Priority can be determined for any of the following Local Government HACC services:

- Home Care
- Personal Care
- Home Maintenance
- In-home Respite Care
- Meals Services
- Planned Activity Groups
- Transport

For some agencies a few of these services (e.g. home maintenance) are provided without completing an assessment and therefore completion of POA2 may not be required.

4) WHEN TO COMPLETE THE POA2 TOOL

The Priority of Access tool can be completed during the assessment with the client and/or carer or in the office after the assessment has been completed.

After the INI tools have been completed, and when assessors are familiar with POA2, completion should take **no longer than 5 minutes**.

The timing of completion may vary between HACC agencies. For some LGAs completing the form in the client's house is preferable as it shows the client how priority is determined and why they are not able to gain access if they have a lower relative priority level. For others who are able to provide some services to most clients assessed, it may not be considered necessary to complete the form in the client's home but rather complete it in the office after the assessment is completed. However, it is important that it is completed for planning purposes.

5) HOW TO COMPLETE THE POA2 TOOL

This tool is designed as a two-sided single-page instrument with fourteen indicators to be completed. The indicators have been selected based on a combination of factors including current tools used in the region, objectives for HACC services and literature regarding factors that predict service use in the community. Ten of the indicators are completed by referring to information completed on the profiles in the Initial Needs Identification (INI) suite of tools. The first four indicators are drawn from the *Profile: Functional Screen*. Completion of this profile is compulsory for all HACC services. The next 2 indicators are about carer availability and carer status and are not drawn directly from the INI but have been developed specifically for determining priority of access. The next six questions are based on information from other profiles that are not compulsory for HACC services to complete but have been determined as important for determining priority of access to HACC services. The remaining two questions are also not drawn from the INI but have been designed specifically for the POA2 tool.

Of the 14 indicators, half have been identified as having greater importance in determining priority and have therefore been given greater weighting. This means that a high or medium priority rating for a weighted item will add a higher number to the overall score than a high or medium priority for a non-weighted item. Low priority rankings for all items are scored as zero and therefore do not alter the overall score. The weighted items are on the front page and the non-weighted items are on the back.

The tool is read from left to right. There are six columns, the first column identifies the element being considered, the second contains directions for the assessor and the remaining three are labelled high, medium or low. The final column leaves room to record the score for each indicator. The 14 indicators require the assessor to circle the numbered box that reflects their interpretation of the situation/need of the client. The number in the box is then written in the far right hand column "record score". The layout of the tool is shown below for the first question on the POA2: 'Domestic ADL's'. If someone had been given a 'high' ranking for the domestic measure the 4 would be circled and the score of 4 would be recorded in the far right hand column as shown

Weighted Indicator	**How to Complete**	**High:**	**Medium:**	**Low:**	**Record Score**
Domestic ADL's	Refer to Functional Screen items 1-5. Count the number of '2's selected and tick the appropriate box:	4 0-1 item	2 2-3 items	0 4-5 items	4

The 14 indicators are described below. References to screens or profiles refer to those contained within the INI suite of tools. Please complete the INI according to the INI guidelines. Please note it is important to complete all questions on the POA2 tool for the scores and priority levels to be applied.

DOMESTIC ADLS

To complete the Domestic ADL question the assessor must refer to the INI *Profile: Functional Screen* items 1-5. These items refer to domestic activities of daily living (ADLs). The assessor counts the number of '2's (indicating independence on specific ADL tasks). If there are no '2s'- i.e. the person is unable to complete any Domestic ADLs independently or only one '2', the column under "high" is ticked and a score of 4 is placed in the far right column. If there are two or three '2s', the medium box is ticked and a score of 2 is entered in the far right column. If there are 4 or 5 "2s" the low box is ticked and a score of 0 is placed in the far right column.

SELF CARE ADLS AND INCONTINENCE

The question on self-care ADLs is completed by referring to the *Profile: Functional Screen,* items 6 and 7. The scores from the two items are added together. Possible scores range between 0 (unable to independently walk or complete bath/shower) to 4 (able to independently walk, bath and shower without assistance). This score is translated into the high, medium or low categories according to scores indicated. Tick the appropriate box and then record a 6, 3 or 0 in the far left column according to which box was ticked. If the client or carer raises incontinence issues, the 'high' category will be selected for this item.

Please note: *Instructions on the Functional Screen indicate that if a client is independent on all domestic ADLs (items 1-5) it is not necessary to complete items 6 or 7 on self care ADLs as it is assumed that they will also be independent on these items. If you have recorded a "9" because the client is independent on these self-care items please consider this as a zero score for the purpose of the POA tool and select the corresponding "low" column.*

COGNITION

If a cognitive impairment such as Alzheimer's Disease or another dementia-related condition has previously been diagnosed by someone with the expertise to diagnose dementia (e.g. neurologist, physician), automatically put a tick in the high column and score 6. If no diagnosis has been made refer to Functional Screen Items 4, 5 and 8. If there is no indication of memory problems or getting confused, and the client's ability to take medicine or handle money is not influenced by confusion or memory difficulties, select 'low' and score zero. If there are some difficulties associated with memory and confusion, select the high category and score a '6'.

Completion of the *Functional Screen* alone is not able to determine whether dementia is present. If a cognitive assessment has been completed, you may need to alter the Priority of Access tool to reflect the results of the cognitive assessment.

Please note: *there is no "medium" response category for the Cognition indicator. If there is no indication of cognitive impairment the "low" category should be selected.*

BEHAVIOUR

Complete this indicator using the same process used for the cognition indicator except using item 9 (behavioural problems- aggression, wandering or agitation) instead of item 8.

Please note: *there is no "medium" response category for the Behaviour indicator. If there is no indication of behavioural issues the "low" category should be selected.*

CARER AVAILABILITY

This question is specifically about the availability of someone to provide assistance or to provide social contact for the person needing assistance. A carer may be resident or non-resident, a family member, friend or neighbour. This may refer to more than one carer. Availability includes being physically present and able to assist with tasks as well as being willing to complete tasks or provide meaningful social contact. Availability is considered in relation to the level of care required. Perhaps a client needs assistance with only one or two domestic tasks. If there is no carer available select 'high', if a carer is available to provide assistance with some of these tasks select 'medium', and if a carer

is available to complete all or most of these tasks select 'low'. If a client needs assistance with numerous tasks such as personal care, housework, gardening, shopping and transport, select high if there no carer available, medium if a carer/carers can fulfil some of these needs or low if a carer/carers can meet most of these needs.

To respond to this indicator, therefore, it is important to consider the range of tasks the client needs assistance with and the availability of someone in their informal support network to meet none, some or all of these needs.

For this indicator a high scores 4 and a medium scores 2.

Please note:

- *If there is no carer it is important to select the "high" category and score the corresponding 4 points.*

- *This question does not relate to carers provided through formal services. This has been omitted deliberately. If a client is having needs met through formal services, the assessor is to take this into consideration when deciding the type and amount of service they will be able to provide. It is important that a high, medium or low priority is determined regardless of the formal services in place.*

CARER STATUS

Carer status refers to how well the carer is managing their caring role. If there is no carer available, tick the appropriate box in the high column and move to the next item. If a carer is available consider how providing care is impacting on their physical and emotional wellbeing. Is providing care and social support having a major impact (select high), moderate impact (select medium), or minimal impact (select low). The high column would be selected if it were unlikely that the carer would be able to continue caring without some additional assistance. Consider carers own health and social support network.

For this indicator a high scores 4 and a medium scores 2.

Please note: *if there is no carer it is important to select the "high" category and score the corresponding 4 points.*

NUTRITION STATUS

This indicator refers to the number of items ticked in the nutrition risk screening tool on the *Health Behaviours Screen*. This is the last of the weighted items. A high level is scored 4 and a medium level is scored 2.

COMMUNICATION

This indicator relates to ability to communicate with others and considers issues of language, literacy and ability to produce speech. These factors are not always indicated on the INI with the exception of language where the need for an interpreter and preferred language is recorded on the second page of the *Consumer Information*.

Aspects to consider when determining level is how much communication barriers prevent people communicating their needs in everyday situations, for example, in social relationships and for purchasing goods and services. If someone speaks a language other than English and does not communicate in English they are likely to need an interpreter during assessments and to have a formal carer who speaks the same language. If they have strong networks with their ethnic community they may have many social outings with people who speak their language and be able to purchase goods in particular shops. In circumstances similar to these the assessor would select the "able to communicate needs with some difficulty (medium)". If the person was not linked with their ethnic community, lived alone and felt isolated due to language barriers, the "not able to communicate needs (high)" would be considered a more appropriate response for this indicator.

Communication issues such as ability to produce speech are also relevant for assessing this indicator. If devices such as communication boards are used the medium level is applicable. Ability to read and write English may also influence people's ability to communicate needs although if they are able to communicate verbally the assessor should select the medium level rather than the high level.

SELF-RATED HEALTH

The self-rated health question relates to the first question on the *Health Conditions Profile*: "In general, how would you say your health is?"

SENSORY-VISION

This indicator can be completed after completion of the corresponding questions on the *Health Conditions Profile*. The two questions on eyesight for reading and for long distance are combined for the indicator of vision, for example, two 'poors' or one 'poor' and one 'fair' would be rated a high priority. If there is a 'poor' for reading vision but a 'good' or 'excellent' for long distance vision (or vice versa) rate a 'medium' level.

SENSORY-HEARING

Refer to the Hearing question on the *Health Conditions Profile.* The hearing indicator refers to hearing with the use of a hearing aid if applicable.

FALLS RISK

The falls risk considers whether there has been no falls, one fall or more than one fall in the previous 6 months. A useful working definition of a fall is "a fall is an event which results in a person coming to rest inadvertently on the ground or other lower level, and other than as a consequence of the following: sustaining a violent blow, loss of consciousness, sudden onset of paralysis as in stroke, or an epileptic seizure" (Kellogg International Working Group on Prevention of Falls by the Elderly. 1987, p 4).

Reference:

Kellogg International Working Group on Prevention of Falls by the Elderly. (1987). "The prevention of falls in later life." Danish Medical Bulletin **34 (Supp 4)**: 1-24.

SOCIAL INTERACTIONS

The social interactions indicator does not rely on information collected on the INI forms. Being able to go out for social outings and have meaningful social interaction with others provides an indication of social and emotional support available for the person requesting services. As the preferred amount of social interaction may vary between individuals

this question asks potential clients about how satisfied they are with their current level of social interactions and outings. Dissatisfaction rates a 'high' and satisfaction rates a 'low' with "partly satisfied" indicating a medium level.

ENVIRONMENTAL HAZARDS

The environmental hazard indicator does not rely on information collected on the INI forms. This indicator requires consideration of whether the environment poses a safety risk to the client. Risk can include risk to health or ability to remain living independently in that environment. Some of the potential hazards could include obstacles in the environment; faulty or damaged appliances, furniture and fixtures; slippery floors; unsuitable bathrooms, or rooms/facilities that are used but are difficult to safely access. The indicator requires consideration of the interaction between the client and their environment- both within and directly around their place of residence. For example, an environment may be safe for someone who has good vision but not for someone with poor vision.

To complete this indicator consider two different aspects of the environmental hazard:

1. Does it pose a high, medium or low risk to the client?
2. Is the hazard unresolvable, resolvable within 12 months, or resolvable within 4 weeks

These two factors can be cross referenced in the following table to result in a high, medium or low level for the indicator:

	Not Resolvable	Resolvable within 12 months	Resolvable within 4 weeks
High risk	High	High	Medium
Medium risk	High	Medium	Low
Low risk	Low	Low	Low

A risk may pose a high risk to the client but if it can be easily resolved within 4 weeks the medium category is selected. For example, an exposed electrical wire is extremely dangerous but can be resolved quickly by an electrician*. A medium risk hazard that can be resolved within 12 months would also be allocated a medium rating on the POA2 tool.

***Please note:** *The need to refer to another service, for example an occupational therapist, an electrician, a plumber, or a home maintenance service, is an urgent task for the assessor to complete or encourage the client/family member to complete.*

The 'other' box enables an additional 2 points to be added to the Priority of Access score if other factors are influencing the client's priority level. The assessor is required to record other factors such as incontinence, psychiatric illness, depression, recent hospitalisations, possible abuse or neglect, chronic pain or other issues that are likely to increase the urgency for HACC services.

Please note: *only 2 additional points can be added, regardless of the number of additional factors reported.*

6) SCORING THE POA2 TOOL

Once all 14 indicators have been completed and the "other" category completed, a total score can be calculated using the far right column on the tool. Scores will range between 0-48 which is then used to determine a high, medium or low priority using the following score ranges:

Scores between 0-12= Low Priority
Scores between 13-18= Routine/Medium Priority
Scores between 19+= Urgent/High Priority

For service planning at the regional level, reporting of high, medium and low is sufficient. Some individual HACC agencies may choose, however, to use the scores as well. Potential uses of the score would be to determine priority within a priority level. For example, if services were only available for half of those assessed as a low priority, an agency may chose to provide services only to those who scored more than 6. Another use of the score may occur during staff leave. For example, when covering a roster for a staff member on leave, a client with a Priority of Access score of 18 may have services provided during the leave period ahead of someone who scored less than 18.

Although people assessed as a low priority may be placed on a waiting list or not offered HACC services, it should be recognised that literature suggests that some contact with a service may have benefits for the person requiring assistance. It is recommended that clients placed on a waiting list are routinely contacted to determine whether their priority level has increased.

7) Summary

POA2 provides a succinct, consistent method for determining urgent/high, routine/medium or low relative priority for people trying to access WMR Local Government HACC services. This enables the priority setting process to be transparent to clients, their families and other referring services and enables all potential clients to be treated in an equitable manner.

Although the tool has been piloted, reviewed and trialed again, the POA2 tool is in its early developmental stages. It is anticipated that further use and evaluation of the tool will lead to further modifications to make the tool as user friendly and as accurate as possible. However, it is also recognised that a tool of this nature is not able to replace clinical judgement. Although the tool may apply a consistent set of indicators to improve equity, it needs to be applied with common sense. There also needs to be a formal channel available for potential clients to dispute the outcome of POA2 tool and to have their circumstances reviewed. The POA2 tool does not intend to create rigidity in the service allocation process. It is also important that assessors consider other services outside Local Government HACC services and that referrals are made where appropriate. A review process also needs to be in place to identify changes in clients' priority level and need for services.