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**Initial Needs Assessment in  
Primary Care:  
Current practice in the  
Grampians Region of Victoria**

**Final Report**

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**Produced for Primary Care  
Partnerships:**

Central Highlands  
Central Grampians  
Wimmera

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## Background and Introduction

Primary health and community support services are the first point of call for most people with a physical, mental health, social or environmental problem seeking assistance to maintain their quality of life. The Primary Care Partnership (PCP) strategy, adopted by the Victorian State Government, aims to create a primary care service system that assists providers and professionals to coordinate their work for clients they have, or may have, in common. Pivotal to the integration of primary care services is the need for a common framework for assessment and care planning (Department of Human Services, 2000a; Department of Human Services, 2000c)

The three Primary Care Partnerships of the Grampians Region (Central Grampians, Central Highlands, Wimmera) recognised that an audit of assessment practice was necessary for the effective development of their primary care service systems. The aim of the research project was therefore to develop a detailed understanding of processes involved in initial needs assessments (including intake, needs assessment and referral) undertaken by organisations involved in PCPs. Whilst the main aim was to obtain a "snapshot" of initial needs assessment practice, the project also aimed to provide advice for PCPs for future development of initial needs assessment practices, with reference to best practice principles for assessment.

The methodology adopted for the project, conducted by the National Ageing Research Institute, included the use of a survey sent to all relevant organisations, a small number of in-depth interviews and a series of focus groups with assessors in each PCP. This threefold approach aimed to ensure that there was adequate depth and breadth to the data collected. The organisations that returned surveys were categorised into one of eight agency sub-groups to enable a more meaningful analysis of the data collected about initial needs assessment practices:

1. Victims of crime/sexual assault
2. Aged and disability/local government services
3. District nursing
4. Health and medical services (including ACAS)
5. Child, youth and family services
6. Psychiatric services
7. Drug and alcohol services
8. Community health services

The project findings are presented in the following sections of the project report.

## Initial contact and initial needs assessment: definitions and themes of best practice

Four clear themes of best practice were developed from the more extensive list of principles of better access developed by the Department of Human Services (Department of Human Services, 2000a). Definitions of initial contact and initial needs assessment are also provided. Although not mutually exclusive, the best practice themes are important considerations for PCP consortia considering service system or organisational reforms:

1. Client centred practice
2. Inclusive and preventative targeting strategies
3. Structural/systemic integration

#### 4. Needs led and flexible assessment practice

Recommendations for further development of initial needs assessment practices are linked with these best practice themes.

### **The practice of intake and initial needs assessment**

#### **Development and use of protocols in assessment**

A protocol generally refers to a written agreement reached by one or more parties to clarify their position or role in a particular circumstance or set of occurrences, but can sometimes be used to refer to informal arrangements. Protocols are useful in clarifying the role and expectations of, and on, the full range of service providers involved in assessment and service delivery who are required to work together or coordinate their involvement with individual clients and target groups. In the Grampians Region, 60.5% and 68.4% of agencies reported having protocols for staff to follow at initial contact and initial needs assessment respectively, but no particular pattern was evident across the different agency sub-groups. A mechanism for monitoring the implementation of protocols is recommended.

#### **The practice of referral**

Referral describes the practice of putting people in touch with other agencies or services that may be appropriate for their particular needs. A wide variety of approaches to referral in the Grampians Region was practised reflecting the diversity of the referring agencies. 26.3% of agencies indicated that they had neither proformas nor guidelines to guide referral practices. Only 50% of all organisations acknowledged receipt of referrals, and only 15.8% acknowledged receipt of referrals within a stipulated time frame. The use of a system to feedback assessment outcomes was found in 52.6% of services across the region, with no particular patterns across the agency sub-groups evident.

There is a clear demand for a more fully integrated and confidential feedback loop between different service providers. Particular issues in relation to referral of post hospital discharge clients were identified, and the adoption of strategies that ensure adequate communication between the respective organisations involved with post hospital discharge clients are recommended.

#### **Client/carer involvement**

In the Grampians Region, assessors were generally found to operate from a client centred perspective and their practice emphasised to a certain extent client and carer involvement in assessment; they routinely involved carers and other significant others in information gathering, and they aimed to ensure that actions are not forced on clients. Where clients were unable to clearly define their needs, or to make well informed decisions about their care arrangements, assessors placed a great deal of emphasis on client 'context' to obtain the broadest picture possible of the client's situation. The limited practice of "client directed" or "client or carer self managed" care in the Region is likely to be due to structural factors such as funding and service delivery arrangements which tend to limit the possibilities for client self management, rather than the approaches of individual assessors and care managers.

#### **Time frames in initial needs assessment**

The draft policy framework acknowledges that client needs can change over time, however, the document emphasises that clients will benefit if their needs are identified as completely as possible, early in their contact with the service system (Department of Human Services, 2000a). In the Grampians Region, some assessments placed heavy emphasis on gathering information at initial contact, while others regard subsequent contacts with clients as more likely to elicit the required information. It was a common view that information may need to be collected about clients' circumstances over a number of visits and contacts particularly for

assessment staff from “community health centres” and “child, youth and family services”. It was more common for “aged and disability/local government” assessors to visit once only to undertake an assessment, with this being even more likely in more outlying areas of the Region. The ability of assessment staff in the Grampians Region to commit generous and flexible amounts of time according to the specific needs of clients, in line with the client centred practice, is highly dependent on the level of funding for assessment received by the organisation. Many staff reported inadequate levels of funding for assessment by most programs.

### **Strengths and capabilities versus deficit approaches to assessment**

The draft policy framework encourages assessors to identify consumers’ needs as well as their capabilities and potential, generally reflecting a “strengths and capabilities” approach to assessment (Department of Human Services, 2000a). The majority of assessments in the Grampians Region appear to be conducted from a “strengths and capabilities” approach, however it was also apparent that some approached assessments from the perspective of considering client ‘deficits’. A balanced approach to assessing, where both deficits and capabilities have equal emphasis was also a current practice.

### **Domains of assessment**

In relation to assessment, domains refer to the scope or field of investigation. Domains of assessment vary according to the client target group and the professional background of assessors, and depend to some extent on the types of services offered. In the Grampians Region, assessment domains were found to be identified in agency assessment tools as well as on a less structured basis by the professional expertise of the assessor. There was also variation between assessors in how assessment is undertaken within similar domains.

Opportunities for commonality in assessment domains are likely to exist between like agencies and between assessors from similar professional backgrounds and this is where effort to improve service access and reduce duplication in assessment should be concentrated in the first instance. Attempting to extend the commonality of assessment domains to a greater range of organisations and assessment staff, beyond the collection and recording of common client data, would have significant training and workforce planning implications.

### **Defining and prioritising client need**

Need is often defined according to the domains of the assessment relevant to the service, the specific expertise of the assessing officer, the service type and its availability. Significant variation was found in the Grampians Region in how need was defined, with a reliance on the experience and/or professional expertise of the assessor to define client need rather than agency targeting policies.

Prioritisation is a process that assists in the coordination of service provision by guiding (or evaluating) the assessment findings in such a way that service providers can decide fairly and accurately, how much service a person should be allocated relative to the needs of other clients. In the Grampians Region the criteria considered important for assigning priority for services, like defining client need, varied according to the provider. The central issue is that the criteria that are required to prioritise clients appear to relate closely to the service/program type, and target group. Some assessors used standard assessment tools to prioritise client need but the prioritising of service provision across the Region was highly variable, and is more of an issue for those ‘high demand’ services and programs. The opportunities for common approaches to service prioritisation exist mainly between like organisations and those with the same program funding source.

### **Reassessment and review**

A review is a periodic mechanism for reassessment. The review of clients was an important part of assessment procedures for PCP organisations in the Grampians Region, with 92.1% of services in the sample having some form of reassessment process in place. While the proportion of organisations undertaking reassessment is very high, the figures do not indicate the quality of the practice. The limited availability of time (and funding) is a serious issue for service providers in the Grampians Region in relation to reassessment. The very high proportion of organisations with reassessment procedures in place in the Grampians Region indicates that this is an area that could be successfully redeveloped in line with the themes of best practice with the aim of achieving greater consistency within (and between, where appropriate) agency sub-groups. The development of protocols to increase the efficiency of reassessment practices is recommended.

### **Health promotion at the time of initial needs assessment**

The PCP strategy emphasises health promotion at initial needs assessment. One role of health promotion in the context of this strategy will be to assist in preventing ill health and disability for individuals and target groups, and to consistently capture unmet need and provide information to facilitate service planning and allocation. A range of interpretations of the practice of health promotion was reported, suggesting that a commonly accepted understanding of health promotion needs to be adopted and a range of accepted and realistic strategies need to be developed to fit with this common understanding.

## **Assessment staff**

### **Staff responsible for initial contact and initial needs identification**

A broad range of staff was reported to be responsible for initial contact and initial needs identification/assessment. The expertise of those staff usually reflected either the characteristics of the service or the organisation. Staff responsible for undertaking initial needs assessment may be different to those responsible for initial contact. The differences (less administrative staff undertaking initial needs assessments, and more emphasis on professional staff such as allied health or nursing) reflect the higher level of expertise and professional training generally expected of staff undertaking needs assessment.

### **Skills of assessment staff**

Both the literature and assessment officer interviews highlighted the need for a certain level of training and careful attention to effectively engaging the client at both initial contact and initial assessment. The most commonly recurring themes from interviews were that assessors needed:

- Communication skills
- Decision making skills
- Public relations skills
- The ability to understand client options

The importance of having the skills that enabled a reflective approach to assessment was also evident. Specific skills are needed within agency sub-groups plus generic skills common across all. The value of interdisciplinary training, particularly in relation to improving interagency communication is highlighted, and training for administrative or reception staff involved in assessment at initial contact is recommended.

## **Local considerations relevant to initial needs assessment**

### **Challenges presented by a rural location**

The Grampians Region has characteristics which impact on assessors' ability to work according to the themes of best practice, particularly in their ability to be flexible and truly needs led in their approach to needs assessment and care planning:

- Difficulty in meeting client needs at weekends
- Inability to always suitably match clients with direct care workers
- Limited service availability and access

The most commonly articulated local issue was transport difficulties, both for clients accessing services, and for service providers in being able to provide flexible, quality services. Other significant characteristics impacting on the quality of assessments include high staff turnover due to the difficulty in attracting and retaining professional staff.

### **Cultural issues**

Whilst assessors in the Grampians Region regarded clients' perceptions of their needs and attitudes to the care required as an important influence to how they assessed need, cultural factors were generally not emphasised. More information about culturally appropriate assessment of Koori clients and protocols for working with the Koori community is required and could be developed collaboratively between Koori organisations and PCPs.

## **General Practitioners and initial needs assessment**

### **The current role of GPs in initial assessments in the Grampians**

A range of data is presented that describe in very broad terms the degree of involvement between GPs and other primary care providers. Overall, there is currently a proportion of about 10% of agencies working closely with GPs with no particular patterns across agency sub-groups evident. Information collected in the focus groups strongly indicated that service provider relationships with GPs were not reliant on formal protocols. Rather, it was commonly articulated that the degree of involvement of GPs in assessment and referral depends largely on personal relationships and informal networks established between GPs and local service providers. Further, it would appear that the service providers in the more outlying areas of the Region may experience greater connection with the local GPs than service providers closer to, or in, larger centres.

### **The future role of GPs in assessment**

The main themes arising about GP engagement with improving access to primary care services related to improved communication and collaboration. The issue of client consent needs to be addressed in all cases:

- Better collaboration between GPs and other service providers especially for discharge and care planning;
- Participating in processes for two-way feedback about client needs within the wider service system;
- GPs providing brief inventories to other service providers in their PCP of completed health assessments and/or care planning for the Commonwealth Government Enhanced Primary Care strategy.

Further developmental work in Primary Care Partnerships involving considering the place of GPs in relation to service access to the broader service system, should begin with ensuring a mutual understanding of the different nature of GP services relative to other primary care providers.

## **Client data collection**

### **Data collection instruments in use in the Grampians Region**

The vast majority of service providers have some identifiable mechanism or form for recording assessment information, and whilst there is a degree of commonality between the individual items contained on these instruments, they were designed very differently. There was varying degrees of emphasis on use of defined domains and 'free text' space. Where service providers assess clients using parallel domains, there is some commonality in the descriptive information agencies collect, although the information may be collected and used for different purposes. The group with the highest degree of commonality was the "aged and disability/local government" agency sub-group.

### **The practice of data sharing (confidentiality and privacy considerations)**

The implementation of policies by service providers to protect client confidentiality at initial contact (and initial needs identification) is reasonably well developed across services in the Grampians Region. 58% of agencies reported the use of a consent or release of information form in order to share client data (Table 9); 90% reported having either a release form or protocols to ensure client confidentiality (Table 3). Client information collected at initial contact and used for referral (connection) to other service providers is likely to be much less detailed than client information collected in a more detailed initial needs assessment. The client consent issues are therefore likely to be different at each stage.

### **Potential for using a common client data form**

Despite the variability in domains and definitions found amongst assessment and client data forms in the Grampians Region, there is potential to develop a set of common data fields which could easily be adapted to a common referral form which records information collected at 'initial contact' at the very least. The use of the CIARR amongst HACC organisations provides some hints at both the benefits and difficulties associated with adopting a common client data form for a group of service providers with common clients. One of the most significant issues contributing to variable take up of the CIARR appears to be that it was designed specifically for HACC services, despite the frequent involvement of services from other program areas in assessment and service delivery for the HACC target group. The CIARR was used by 32.5% of agencies surveyed in the Grampians Region, with the bulk of these from the "aged and disability/local government" agency sub-group (mainly HACC organisations), and not surprisingly, this was the group with the greatest degree of "within-group" commonality.

Rather than focussing on the use of a specific form, it is more useful to analyse the data items commonly collected. Only 10 items were commonly collected by the majority (75%) of organisations. However, these items are significant in that they represent the platform from which to develop the core of a common referral form between all PCP service providers. Additional forms outlining specific agency sub-group needs could be developed as attachments to this basic form if required by those service types that had more specialised information needs. 80% of organisations surveyed used service specific assessment tools or forms.

## **Conclusion: future development of initial needs assessment**

The PCPs are comprised of a diverse range of service providers so it is not unexpected that a degree of variation in approaches to assessment was found. Potential to achieve greater commonality in approach to initial contact and initial assessment lies initially with client data collection and referral between PCP agencies. These, and a number of other areas for future development of initial needs

assessment practices, are proposed for consideration by the Grampians Region PCPs. The recommendations for reform are summarised against the themes of best practice (below):

#### **Client centred practice**

- Develop two tiered training program for assessment staff (i.e. initial contact and initial needs assessment staff)

#### **Inclusive and preventative targeting strategies**

- Develop system wide protocols for assessing Koori clients
- Staff training on culturally appropriate assessment
- Develop agreed definition and strategies for health promotion at initial assessment, including a training program for assessment staff.

#### **Structural/systemic integration**

- Rationalise initial contact and referral forms for all agencies
- Rationalise initial needs assessment and referral forms (as attachments to initial contact forms) for agency sub-groups
- Develop mechanisms for communication/networking for assessment staff, and for monitoring protocol implementation
- Develop IT systems to enable electronic communication, ensuring adequate training and infrastructure
- Consider protocols and system for streamlining reassessments (potentially a 'lead agency' model)
- Establish working group to consider appropriate assessment models in each PCP and Region wide
- Ensure that PCP reform processes in areas of interaction with other service providers (e.g. disability services and acute hospitals) are undertaken collaboratively and effective partnerships are developed.

#### **Needs led and flexible assessment practice**

- Offer training for reception/administrative staff involved in initial contact
- Ensure assessments contribute to broad service planning data by highlighting gaps between assessed need and service availability (needs led).

# 1. Background and introduction

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Primary health and community support services are the first point of call for most people with a physical, mental health, social or environmental problem seeking assistance to maintain their quality of life. There is growing awareness that primary care services can play a vital role in preventing ill health and disability (Raysmith, 1999). There is also growing awareness that service users would prefer and benefit from a more integrated primary health and community services system. Benefits noted include a reduction in unnecessary duplication of assessment and a more holistic approach to treatment (Gaudet, 1996). There are also acknowledged benefits to service providers and purchasers of primary care services arising from integration. Advantages include:

- efficiencies from reducing duplication of services and administration;
- ease of cross-referral between services; and
- substitution of low cost preventative services for high cost services (Sach and Clark, 2000).

In Victoria these advances in the integration of primary care services has seen the development of the Primary Care Partnership (PCP) model in 32 consortia sites across the state.

The PCP strategy, adopted by the Victorian State government, aims to create a primary care service system that assists providers and professionals to coordinate their work for clients they have, or may have, in common. The main goals of the reform are to improve the experience and outcomes for people who use primary care services; and to reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support (Department of Human Services, 2000b).

Pivotal to the integration of primary care services is the need for a common framework for assessment and care planning. As one initiative of the PCP strategy, the "Better Access to Services" (BATS) document was disseminated by the State government as a draft policy framework for discussion in July 2000. This initiative aims to develop and implement service system models that facilitate better access and care outcomes for consumers with the expectation that PCPs will improve:

- practices within and interface between current assessment processes; and
- processes for entry, needs identification and system navigation.

One of the cornerstones for the development and implementation of these systems is the successful integration of a range of primary care services. In addition to focusing on the streamlining of the practice of assessment, the success of this integration is dependent on the design and workability of information management systems and on a transparent, generative and confidential interface between service providers (Department of Human Services, 2000a; Department of Human Services, 2000c).

The combined Primary Care Partnerships of the Grampians Region recognised that an audit of assessment practice was necessary for the effective development of their primary care service system. It was anticipated that such an audit would contribute to developing an understanding about the range of assessment activities and approaches used by services in the 3 PCPs, and related organisations in the Region. A project brief was developed by representatives of these groups to engage a researcher to undertake an audit. The project brief developed by the group emphasised the processes involved in the initial needs assessment, described as "an initial assessment where the consumer's needs and health promotion opportunities are identified and where consumers are subsequently informed about the range of appropriate service options and available service to meet their needs" (Department of

Human Services, 2000a). Importantly, the project encompassed intake, needs assessment and referral, and included an analysis of appropriate client data collection tools such as the HACC CIARR.

The National Ageing Research Institute was engaged to undertake this research from October 2000 – January 2001. This report describes the research approach and findings, including:

- a description of initial needs assessment practices in the Region, highlighting common elements between PCP agencies (including common assessment elements for agency sub-groups);
- best practice principles for assessment practice (based on literature review and review of current practice in the Grampians Region); and
- possible areas for future development of initial needs assessment practices, including intake, needs assessment, referral, reassessment and review, and information feedback.

## **1.1 Project steering committee**

Project staff reported to a steering committee comprised of representatives from each PCP. This group met three times over the course of the project and provided guidance and support. Email contact was maintained with this group as required. The members of the steering committee were:

- Ms. Tracey Chenoweth, Dunmunkle Health Services
- Ms. Robyn Fletcher, Ballarat and District Div. of General Practice
- Dr. John Garner, Carnbrae Clinic/Div. of General Practice
- Ms. Wendy Glenister, Stawell and District Hospital
- Ms. Lynden Hayes, City of Ballarat Aged and Disability Services
- Ms. Deborah Hopwood, Central Highlands PCP
- Ms Jean Parson, Central Grampians PCP
- Dr. Adri Van der Knijff, Ballarat Health Services
- Ms. Jacinta Wainright, Child and Family Services, Ballarat

## 1.2 Project purpose, aims, scope, and research questions

Project Purpose	The purpose of this project was to develop a picture of initial needs assessment practices in the Grampians Region of Victoria. This information is important for informing further work during the Primary Care Partnership (PCP) planning and development processes.
Project Aims	The aim of the research project was to develop a detailed understanding of processes involved in initial needs assessments (including intake, needs assessment and referral) undertaken by organisations involved in PCPs. Whilst the main aim was to obtain a “snapshot” of initial needs assessment practice, the project also aimed to provide advice for PCPs for future development of initial needs assessment practices, including appropriate data collection tools.
Project Scope	<p>The project encompassed:</p> <ol style="list-style-type: none"> <li>1. An audit of initial needs assessment and related practices paying attention to: intake, assessment and referral tools; existing protocols/pathways, including referrer feedback; confidentiality, particularly in relation to the different information required by different services (e.g. GPs, district nursing).</li> <li>2. Determination of the essential elements of the initial needs identification/assessment process with reference to existing practice in the Region and the principles outlined in the DHS “Better Access to Services” document.</li> <li>3. A review of the CIARR as a possible generic tool for the initial needs identification with reference to: other available information about the implementation of the CIARR, the DHS “Information Management” document, HACC MDS and ACAS MDS.</li> <li>4. A review of best practice principles for assessment considering material developed at State, National, and International levels to inform the development of a model of initial needs assessment.</li> </ol>
Research Questions	<ol style="list-style-type: none"> <li>1. How is initial needs assessment conducted by the PCP signatories in the Grampians Region?</li> <li>2. What is the current and potential future role of General Practitioners in the initial needs assessment process?</li> <li>3. What degree of commonality exists in the initial needs assessment process between the various organisations (all agencies, and sub-groups) in relation to: <ul style="list-style-type: none"> <li>• Client data collection</li> <li>• Intake practices</li> <li>• Assessing need</li> <li>• Referral to other organisations</li> <li>• Reassessment and review</li> <li>• Information feedback</li> </ul> </li> </ol>

### **1.3 Methodology**

The methodology adopted for the project included the use of a paper based survey, in-depth interviews and a series of focus groups. This threefold approach aimed to ensure that there was adequate depth and breadth to the data collected. A review of the literature was also conducted.

#### **Literature review**

A review of the literature was undertaken for the purposes of informing the survey development, and to identify issues and principles relevant for consideration. The literature review is not presented as a separate section of this report. Rather, it is integrated throughout the report with discussion of the research findings.

#### **Survey**

An eighteen point survey was developed to collate information about the range of instruments and tools used for initial contact or needs identification in the Grampians Region, and to provide a picture of protocols set up in the region to support these instruments. The survey also collated hard copies of initial needs assessment forms currently in use in the region to record basic client assessment information.

The survey was posted to 51 service provider organisations in the Grampians Region PCPs with a return rate of 74.5% (after follow up). Some organisations returned more than one copy of the survey, but for the purposes of analysis were generally counted only once. A description of how these 'multiple returns' were handled in the analysis is included in Appendix 10.1.

All organisations that had not returned surveys by the given return date were contacted by mail, and by phone if necessary, and given extra time to complete the survey. A list of organisations that returned surveys is included as Appendix 10.1. Survey results were collated using SPSS (Statistical Package for the Social Sciences), and eight 'service type' categories or agency sub-groups:

1. Victims of crime/sexual assault
2. Aged and disability/local government services
3. District nursing
4. Health and medical services (including ACAS)
5. Child, youth and family services
6. Psychiatric services
7. Drug and alcohol services
8. Community health services

A copy of the survey is included as Appendix 10.2.

Four surveys were returned too late to be incorporated in the analysis. They were not counted in the return rate.

#### **In-depth interviews**

In-depth interviews were conducted with 3 key organisations in each PCP suggested by the PCP contacts on the steering committee (a total of 9 interviews). They provided supplementary data to those obtained through the paper based survey and enlarged the descriptions of the roles of the professionals undertaking assessments. The interviews focussed on the procedures and considerations used by assessment staff in the broad areas of data collection, decision making and quality control.

A copy of the interview questions can be found as Appendix 10.3.

## Focus groups

The focus groups aimed to amplify systemic or organisational issues that may have an impact on the implementation of assessment practices in the Grampians Region. Two generic focus groups were conducted in each PCP (a total of 6). The locations were Ballarat, Daylesford, Edenhope, Horsham, Stawell and Ararat. Again, these were conducted to obtain greater depth of information about the current practice of initial needs assessment, to explore systemic processes at the local level that may hinder or enrich assessment outcomes for consumers, and to begin to discuss ideas for future development. A list of participants in the focus groups is included as Appendix 10.4.

Particular issues discussed during the focus groups included:

- a definition of initial needs assessment, including the one included in the BATS document;
- specific local issues that may need to be considered in relation to intake, needs assessment and/or referral;
- existence and effectiveness of protocols/pathways currently in place in the local area;
- the practicality of a generic tool for recording client data at initial needs identification (such as the HACC CIARR);
- the role of General Practitioners in the initial needs assessment process (current and future); and
- future development of PCPs in relation to initial needs assessment practices, including appropriate data collection tools.

## Communication with the field

A brief "information bulletin" was developed at project commencement and distributed to key PCP representatives, steering committee members and other relevant stakeholders for dissemination to the field. This bulletin was also included with the survey that was sent to each organisation. This outlined the background to the project, including aims and scope, and described the methodology to be followed. Avenues for input into the project were described including purpose and dates of the focus groups (Appendix 10.5).

### **1.4 Primary Care Partnerships in the Grampians Region**

There are three Primary Care Partnerships in the Grampians Region:

- Central Grampians
- Central Highlands
- Wimmera

Whilst the geographical area represented by these three Primary Care Partnerships is considerable, the PCP signatories have a commitment to working together to foster commonality in assessment practice, where appropriate, across the whole Region.

Appendix 10.6 is a list of all the signatories for the three PCPs. PCP consortia are characterised by their diversity, owing to the large range of client target groups, service models and service goals. The client target groups most frequently identified by agencies (survey respondents) included frail aged (63%), adults with disabilities (55%) and children with disabilities (47%). Carers were listed as a target group for 14 agencies (37%) and families in crisis/victims of crime for nine agencies (24%). Four agencies reported that people with dementia were a target group and two agencies reported that people who were financially disadvantaged and/or unemployed were a target group. The number of new assessments conducted in

2000 by individual agencies ranged from 48 (a district nursing organisation) to 2,600 (ACAS), although not all agencies were able to supply these figures.

**Table 1: Agency sub-group classification**

Service categories/agency sub-groups	Agencies within each category (based on survey returns)
1. Victims of crime/sexual assault	<ul style="list-style-type: none"> <li>• Ballarat CASA</li> <li>• Women's Health Grampians</li> </ul>
2. Aged, disability, and local government services	<ul style="list-style-type: none"> <li>• Carers Choice</li> <li>• Central Highlands Coordinated Community Care</li> <li>• City of Ballarat</li> <li>• Hepburn Shire Council</li> <li>• Hindmarsh Shire Council</li> <li>• Horsham Rural City Council</li> <li>• Northern Grampians Shire Council</li> <li>• Pyrenees Shire Council</li> <li>• West Wimmera Shire Council</li> <li>• Wimmera Volunteers</li> <li>• Yarriambiack Shire Council</li> </ul>
3. District nursing	<ul style="list-style-type: none"> <li>• Avoca Health Services</li> <li>• Ballan District Health Care</li> <li>• Ballarat District Nursing Society</li> <li>• Ballarat Health Services (HITH, PAC)</li> <li>• Djerriwarrh Health Services</li> <li>• Dunmunkle Health Services (Community Health Care Minyip; Medical Centre Murtoa)</li> <li>• East Grampians Health</li> <li>• Harrow Bush Nursing Centre</li> <li>• Lake Bolac Bush Nursing Centre</li> <li>• Rural Northwest Health</li> <li>• West Wimmera Health Service</li> <li>• Wimmera Health Care Group</li> </ul>
4. Health and medical (including ACAS)	<ul style="list-style-type: none"> <li>• Carn brae Clinic</li> <li>• Grampians ACAS</li> <li>• St. John of God Hospital</li> <li>• Stawell District Hospital</li> </ul>
5. Child, youth and family services	<ul style="list-style-type: none"> <li>• Centrecare, Ballarat</li> <li>• Child and Family Services, Ballarat</li> <li>• PINARC</li> <li>• Stawell Neighbourhood House</li> <li>• Wimmera Uniting Care, Stawell</li> </ul>
6. Psychiatric services	<ul style="list-style-type: none"> <li>• Grampians Psychiatric services</li> </ul>
7. Drug and alcohol services	<ul style="list-style-type: none"> <li>• Palm Lodge Centre</li> </ul>
8. Community health services	<ul style="list-style-type: none"> <li>• Ballarat Community Health Centre</li> <li>• Grampians Community Health Centre</li> </ul>

One rationale for the PCP reform is that many organisations will work with the same individual clients or client target groups so by integrating the services there is likely to be more integrated and seamless service delivery. In line with this rationale, agencies were categorised into sub-groups (Table 1), to enable a more meaningful analysis of the data collected about initial needs assessment practices. Services were classified according to the similarities in:

- program funding
- clients
- services provided (eg health/medical focus; centre based)

Whilst this categorisation is not exact, it does help to identify particular themes evident in the practice of initial needs assessment. The service categories (agency sub-groups) share similarities in client target groups and services provided. These categories were not predetermined in the survey, so were classified based on the survey returns and range of responses provided, and agreed by the project steering committee.



## **2. Initial contact and initial needs assessment: definitions and themes of best practice**

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This chapter provides definitions of the key terms used throughout the draft policy document (Department of Human Services, 2000a) to ensure a common understanding. Apart from the definitions of key terms, the principles of better access included in the draft policy document were also a point of reference for the research. The principles were grouped into four key themes and the themes used as a framework for analysing both the literature and the data collected in the Grampians Region. This chapter also briefly discusses these themes of best practice.

### **Initial contact**

Initial contact is described as “the point at which a consumer has first contact with the service system”, and may involve telephone or face to face contact. It may include the provision of service information, health promotion literature and/or a discussion about health promotion opportunities. Initial contact may also involve the recording of basic details about the client and may require interpreter services. Initial contact should facilitate direct access to initial needs identification (Department of Human Services, 2000a). The Department of Human Services is encouraging PCPs to enhance better access for consumers through building on and enhancing a range of approaches to initial contact. Importantly, the initial contact with the service system should ensure that consumers:

- have their initial needs met;
- are provided with appropriate service information;
- have basic details recorded (with due regard to privacy and confidentiality); and
- have a positive experience of their initial contact with the service system (Department of Human Services, 2000a).

The description of initial contact provided by DHS closely aligns with commonly accepted definitions of “intake” whereby clients are quickly screened or reviewed to gain a basic idea of their main presenting problems and the kinds of services for which they might be considered. This permits their case to be allocated to a suitable worker. An important element of screening will include preparation of staff and creating forms which will be used to record not only basic information but will ask for material which might identify problems requiring deeper exploration (Payne, 1995: 84).

### **Needs assessment**

Needs assessment is frequently described as a process of developing an understanding of client capabilities and needs for assistance and planning to meet those needs (Hughes, 1995; Seed & Kaye, 1994). Initial needs identification is described in the draft policy framework as an “initial assessment where the consumer’s needs and health promotion opportunities are identified and where consumers are subsequently informed about the range of appropriate service options and available services to meet their needs.... (and) is also the point at which there is a determination of the consumer’s risk, eligibility and priority for service” (Department of Human Services, 2000a: 15). Some definitions point out the importance of taking a broad view of assessment to ensure that practice is client focussed and not limited by definitions of assessment that may in practice be too rigid to enable a holistic response to clients’ needs (McVicar & Reynolds, 1995; Holten et al., 1992).

## **2.1 Principles of better access – themes to guide PCPs**

The Department of Human Services developed a list of 20 principles of better access to be taken into account by PCPs and incorporated into the models, processes and practices that PCPs develop (Department of Human Services, 2000a). For the purposes of this research project these principles were grouped to assist with developing a framework for analysing the survey and interview data.

The four clear themes evident in the principles of better access (Table 2), though not mutually exclusive, were used as a means of structuring the analysis of both the literature and data collected on current practice in the Region. As key themes for principles for best practice, these will be important considerations for PCP consortia considering service system or organisational reforms. Such reforms should always enable a client focus, and a needs led and flexible assessment practice, in addition to the more systemic issues such as targeting and structural integration.

**Table 2: 'Better Access to Services', themes and principles**

<b>Themes</b>	<b>Principles (identified in "BATS")</b>
<i>Client centred practice</i>	1. People are treated with dignity and respect.
	2. Assessment is a human interaction that takes into account the engagement and development of relationships. It is dynamic and ongoing and is an essential part of service delivery.
	3. Consumers are empowered to undertake effective self management for their illness or disability where possible.
	4. The protection of the confidentiality of consumer information and consumers' consent to their information being shared is consistently and appropriately achieved. Where a person is not competent to consent, it is obtained from their recognised representative.
	5. Consumers and referring providers are informed of the outcomes of their assessment and reasons why a publicly subsidised service is not able to be provided where this is the case.
	6. Consumers are aware of their right to a review of the assessment outcomes and have details of the review processes provided to them in culturally appropriate formats.
<i>Inclusive and preventative targeting strategies</i>	7. Early intervention strategies are employed to prevent people at risk of developing or relapsing into illness or disability from doing so.
	8. The needs of all consumers including people who are marginalised, vulnerable, or have special or urgent needs, are taken into account in developing service models.
<i>Structural/systemic integration</i>	9. Consumers do not experience unnecessary, duplicative and/or unnecessarily intrusive information collection practices.
	10. Consumers receive coordinated and planned care where needed, based upon evidence of best practice.
	11. Consumers' needs are addressed by a multidisciplinary approach where appropriate.
	12. Assessments are undertaken by staff that are appropriately skilled, qualified, experienced, supervised and supported.
	13. Assessments include a registered Division 1/Division 3 nurse or medical officer where it is identified that an individual has unstable health and/or personal care needs.
	14. People, (including those with unstable health and/or complex support needs, changes in age, need or geographic location), are able to move between services, without experiencing interruption to the provision of services.
	15. Assessment practice is guided by the practitioner's clinical and professional expertise and not by the application of specific data collection forms and assessment tools.
<i>Needs led and flexible assessment practice</i>	16. Assessments are undertaken in the environment in which services are to be delivered, for example, in the person's home, wherever possible.
	17. All of an individual's needs, including health promotion or illness prevention opportunities, are identified at the point of assessment and not just those needs that can be met by the agency undertaking the assessment.
	18. Consumers placed on a waiting list before or following an assessment are appropriately managed and have access to interim support where required.
	19. Relevant information follows the consumer when referred to other providers (with appropriate consumer consent).
	20. A flexible, problem-solving approach is used where an individual's preferences are in conflict with either the service provider or the carer/family.

## **Client centred practice**

Client centred practice, or consumer focussed service approach, is an umbrella term that refers to placing the client/family at the centre of the assessment and service delivery process. In relation to assessment specifically, attributes of this approach should include:

- understanding assessment as a process of working cooperatively to assist the consumer, and where relevant their carers/family, to identify their needs for assistance and how these can most appropriately be addressed;
- willingness to respond to needs that are unusual or difficult and require responses outside the “normal” way of doing things; and
- willingness to advocate strongly with other organisations about the needs of a consumer if this is identified as necessary (McVicar & Reynolds, 1995: 35)

## **Inclusive and preventative targeting strategies**

The term targeting is usually used to describe the strategic use of limited resources to produce the desired outcomes for clients. As a theme for the principles of best practice, targeting needs to be undertaken in the context of the needs of the local area taking into consideration particular demographic, social and economic characteristics. This broad theme can also be taken to refer to the appropriate targeting of specific interventions to individuals. For example, systematic consideration of individuals’ health promotion needs (including psycho-social factors) at the time of assessment may lead to a range of interventions and recommendations beyond those that have hitherto been commonly recommended but which have the potential to have longer term benefits for the individual (National Ageing Research Institute, 2001). For service providers that have common client target groups, having clear, explicit and consistent targeting policies is important.

## **Structural/systemic integration**

Structural or systemic integration enables clients to experience seamless service delivery regardless of the number of separate providers involved in the person’s assessment and care. This may be achieved by adopting models that allow for and encourage multidisciplinary assessment practice, the benefits of which include better communication, improved relationships, coordinated care, and holistic and effective assessments (Parry-Jones & Soulsby, 1999). Different models of assessment reflecting integration range from those that adopt a coordinated entry approach across a number of separate service providers (sometimes referred to a “single point of entry”), through to a single assessment service offering a single point of entry to a local system of care. Within any model of assessment, a range of mechanisms can contribute to integration. These include using common data fields/assessment domains across a range of relevant service providers (and ensuring appropriately trained staff and infrastructure in their correct application), and having common client consent systems when information about clients needs to be shared. The important feature of an integrated service system, however, is that the assessors and service providers regard their role as relating to a whole service system, rather than simply to their own agency.

## **Needs led and flexible assessment practice**

In a “needs led” approach to assessment, assessors start with the needs and difficulties of the client, leading to the exploration of what the most acceptable and appropriate ways of meeting those needs might be. In contrast, a “service-led” assessment begins with the assessor considering what service the client might need, or what services are provided that the client might need (Holten et al., 1992). A needs led approach to assessment emphasises a range of options for care, an opportunity for individualised and flexible planning of services, and cooperation between different agencies and disciplines in assessment and care management (Seed & Kaye, 1994). A service led approach to assessment, in contrast, is driven

more by what the agency offers and how many resources are available, rather than the individual's needs.

Assessing need is often associated with political pressure to provide services and with rationing services (Payne, 1995; Gibson, 1999). The implications of this for the practice of intake and needs assessment suggests that the pressure to provide service is sometimes less about targeting the need, and more about distributing limited resources. In addition, high demand for service can reduce flexibility (National Ageing Research Institute, 2001), so processes must be put in place that enable as much flexibility as possible for assessors within these constraints.



### **3. The practice of intake and initial needs assessment**

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Characteristics of how assessment is undertaken, such as the content themes and pace of the assessment process, is determined by the field of practice and the organisational settings that comprise them (Meyer, 1993) and by the professional background and training of the assessors (Holten et al., 1992). This section examines the practice of assessment in the Grampians Region, in particular, intake practices, initial needs assessment, referral practices, reassessment and review and information feedback. Tables 3 - 6 present in summary form, the responses to the survey questions of the 38 respondents, grouped in the eight service categories (described in chapter 2). The number of survey respondents in each category is noted in brackets:

1. Victims of crime/sexual assault (2)
2. Aged and disability/local government services (11)
3. District nursing (12)
4. Health and medical services (including ACAS) (4)
5. Child, youth and family services (5)
6. Psychiatric services (1)
7. Drug and alcohol services (1)
8. Community health services (2)

Significant features of these tables are described in the relevant sections in this chapter. Other important themes arising from the research are also presented in relevant sub-sections. Direct quotes from assessment officers interviewed appear in italics throughout this and the following chapters, identified by the agency sub-group to which their organisation belongs.

**Table 3: Overview of the use of forms and protocols at intake, assessment and referral**

	Total % N = 38	Victims of Crime N = 2	Aged & Disability/LGA N = 11	District Nursing N = 12	Health & Medical/ACAS N = 4	Child/Youth /Family N = 5	Psychiatric N = 1	Drug and Alcohol N = 1	Community Health N = 2
Service has a form to complete at initial contact	94.7%	100%	100%	92.3%	100%	80%	100%	100%	100%
Service has protocols for staff to follow at initial contact	60.5%	50%	63.6%	41.7%	100%	40%	100%	100%	100%
Service has a form to complete at needs identification	89.5%	50%	90.9%	100%	100%	80%	100%	100%	50%
Service has protocols for staff to follow at needs identification	68.4%	0	72.7%	66.7%	75%	60%	100%	100%	50%
Service has a proforma for other services to complete for referrals	47.4%	50%	45.5%	58.3%	50%	40%	0	100%	0
Service has a proforma and/ or guidelines for other services to follow for referrals	73.7%	50%	81.8%	76.9%	66.7%	80%	100%	100%	0

**Table 4: Overview of the referral systems and feedback patterns**

	Total % N = 38	Victims of Crime N = 2	Aged & Disability/LGA N = 11	District Nursing N = 12	Health & Medical/ACAS N = 4	Child/Youth /Family N = 5	Psychiatric N = 1	Drug and Alcohol N = 1	Community Health N = 2
Services acknowledge receipt of referral to referring agency	50%	100%	45.5%	33.4%	75%	60%	100%	100%	50%
Services acknowledge receipt of referral within stipulated time period	15.8%	0	18.2%	8.3%	25%	20%	100%	0	0
Services feedback assessment outcomes to referrer	52.6%	100%	45.5%	33.3%	75%	60%	100%	100%	50%

**Table 5: Overview of the systems in place to ensure client confidentiality**

	Total % N = 38	Victims of Crime N = 2	Aged & Disability/LGA N = 11	District Nursing N = 12	Health & Medical/ACAS N = 4	Child/Youth /Family N = 5	Psychiatric N = 1	Drug and Alcohol N = 1	Community Health N = 2
Services have either a release form and/or protocols to ensure confidentiality	90%	100%	91%	75%	100%	100%	100%	100%	100%

**Table 6: Overview of reassessment and review procedures**

	Total % N = 38	Victims of Crime N = 2	Aged & Disability/LGA N = 11	District Nursing N = 12	Health & Medical/ACAS N = 4	Child/Youth /Family N = 5	Psychiatric N = 1	Drug and Alcohol N = 1	Community Health N = 2
Services reassess clients routinely only	7.9%	0	9.1%	8.3%	0	20%	0	0	0
Services reassess clients in response to triggers only	15.8%	0	18.2%	8.3%	25%	40%	0	0	0
Service reassess clients routinely and in response to triggers	68.4%	50%	72.7%	75%	50%	40%	100%	100%	100%

### **3.1 Development and use of protocols in assessment**

A protocol generally refers to a written agreement reached by one or more parties to clarify their position or role in a particular circumstance or set of occurrences. The term can be used to refer to a formal agreement, which is signed by the parties for whom the agreement relates. However, sometimes the term can be used to refer to informal arrangements that have been developed over a period of time but for which there is no documentation; or procedures describing relationships between organisations that have been documented but not 'signed off'. Protocols often represent the culmination of a long process of discussion and negotiation between the parties involved.

In the primary care sector, protocols are useful in clarifying the role and expectations of, and on, the full range of service providers involved in assessment and service delivery who are required to work together or coordinate their involvement with individual clients and target groups. Formal protocols between home care organisations and district nursing agencies are relatively common and examples are provided in some of the available literature on assessment in this area (Holten et al., 1992). The development of formal protocols has been encouraged by funding bodies as a means of streamlining assessment and service delivery (Department of Human Services, 1998), and some developmental projects have specifically focused on assisting service networks to reach this level of agreement (National Ageing Research Institute, 1998). However, some caution is necessary in developing and using protocols to guide practice in assessment. There is the temptation for protocols to override other considerations in assessment with the potential to lead to inflexible practice:

... when an organisation is governed by rules and protocols and does not rely upon professional assessment to differentiate among cases, then use of office manuals, labelling procedures, and prescribed interventions predominate. This kind of practice is found .... in settings where the client's need is pressed into the mould of the available services. This kind of routine activity does not attempt to address the unique features of a case. On the other hand, aimless over reliance on inferences, to the end that no intervention takes place, leads to ineffective practice (Meyer, 1993: 69).

Being clear about the role of protocols and the extent to which they should guide practice is paramount.

The survey specifically asked providers about their use of protocols. In the Grampians Region, 60.5% and 68.4% of agencies reported having protocols for staff to follow at initial contact and initial needs assessment respectively. There was no particular pattern evident across the different agency sub-groups. However, it should be remembered that having protocols is no guarantee that they will be followed. A monitoring system, such as regular network meetings where protocols are routinely discussed and reviewed, may also need to be in place.

### **3.2 The practice of referral**

Referral describes the practice of putting people in touch with other agencies or services that may be appropriate for their particular needs. Whilst it can describe the action of a friend, family member, or the client themselves contacting a service provider, it most usually describes the action of a professional or organisation recommending contact with another professional or organisation. There is nothing implicit about the term that indicates that the referrer wants or requires information about whether the client was successful in making contact with the organisation to which they were referred, or the outcome of the referral if contact was made. These

details need to be specifically negotiated between organisations that commonly have such referral relationships and is often documented in formal protocols. *Connection* with services, rather than referral, may be a more appropriate term to use where this information flow is a required feature of the practice.

The variety of approaches to referral in the Grampians Region reflects the diversity of the referring agencies. Referrals were made through a variety of mediums - telephone, fax or formal letter. Written referrals may contain a completed proforma or alternatively comprise a simple note with the basic details of the client. Clients may self-refer, they may be referred by a family member, neighbour or complimentary service provider already attending the client, or a referral can be made by others in the community as diverse as the local school principal, postal officer or the district nurse. It was reported that referrals in the smaller communities of the Grampians Region may take place in informal settings, as in casual conversations "in the supermarket" (which raises issues of confidentiality and information exchange). Agencies receiving referrals from various sources reported that they address all modes of referral with equal regard and importance.

The survey asked whether agencies had proformas or protocols for other agencies to fill out or follow to initiate referrals. Of the 38 agencies that responded to the survey, 26.3% indicated that they had neither proformas nor guidelines. The community health category of respondents was the least likely to have protocols or proformas compared with the other service categories, but the small number of available services and the wide variation in their practice makes it difficult to identify clear trends.

Only 50% of all organisations acknowledged receipt of referrals, and only 15.8% acknowledged receipt of referrals within a stipulated time frame. The acknowledgement of referral was practised across all the agency sub-groups with the larger sub-groups showing greater within-group variation. The use of a system to feedback assessment outcomes was found in 52.6% of services across the region, with no particular patterns across the agency sub-groups evident.

Allied health practitioners may need to be better linked with the wider service system, as some evidence suggested poor pathways and systems for communicating assessment outcomes for this group of professionals:

*The data collection system (by other service providers) cannot determine the level of need (for my information) when urgency is required. Communication between providers is sometimes not thorough enough. Telephone referrals are too casual...often there is not enough criteria given to determine the level of need of the client. District nurses have different administrative burdens and don't want to spend time on detailed referrals even if it means providing the OT with an understanding of the level of urgency. Also clients may not be aware of the information that assessment officers need to make their case urgent ("Health and medical" organisation)*

There is a clear demand for a more fully integrated and confidential feedback loop between different service providers. Building a sound interagency communication framework requires input from a broad range of professionals. But to fully implement such a system there also needs to be a thorough understanding of the opportunities for clients within the service system by all the contributing professionals. The importance of protocols for a well structured referral system and/or clear channels for feeding back information to the referrer cannot be underestimated.

## Post hospital discharge

The issue of referral of post hospital discharge clients is included as a separate section because it was frequently singled out as an issue in the interviews and focus groups. It should be acknowledged that the current "Effective Discharge Project" in the Region, and the PCP "Service coordination sub-committee", aim to address many of the issues raised, and much work has already been done in this area. Further, it is unclear at which stage hospital discharge practices should be targeted by PCPs in their developmental work in initial contact and initial needs assessment. The view was expressed in the Region that community primary care providers needed to establish mechanisms for initial contact and initial needs assessment prior to involving discharge planners in developing assessment practices. In contrast, it was also said that discharge staff needed to be involved in such developmental work throughout the process.

Specific issues in the discharge procedures of the local hospitals discussed in focus groups included the need to ensure that discharge staff have a good knowledge of the community service sector in the local area, and the criteria that assessment officers need in order to provide service to clients once they arrive home from hospital. Community care providers felt that the complexity brought to service provision by post hospital discharge clients needed acknowledgement, and some practices such as discharging patients shortly before weekends or holiday periods caused additional workload and stress. Discharge staff also emphasised that it was equally important for them to have confidence in and knowledge of the relevant community care providers to ensure that best practice occurs.

The need for better assessments to be undertaken in hospital prior to discharge, which may need to involve a home visit, to avoid inappropriate services and care to be recommended for individual clients was also highlighted. The example of checking memory in hospital, where the results may be very different to those obtained from conducting the same test at a home visit, was used to highlight the different assessment outcomes in different settings.

Whilst there are many full cost recovery Post Acute Care (PAC) clients who access community services, there are also many other clients who are not eligible for PAC, but who are discharged from hospital and referred to community service providers. In these cases, it appears to be common practice for the community care providers to conduct their own assessment regardless of the level of assessment information about the client provided by the hospital staff. This is an area which could be examined more closely to determine whether there are practices that could be changed to reduce the likelihood of duplication of effort. In addition, it was reported that in some hospitals discharge staff generally reviewed high needs clients within a week of discharge, or sooner, depending on the particular circumstances of the client. This is another area that could be examined more closely to ensure that communication between the respective organisations is occurring adequately.

Reference to the wider literature reveals some principles that could be incorporated into discharge practices. For example, it is important for carers of young people and adults with disabilities (and presumably carers generally), to be included as active participants in the discharge planning process (Heaton et al., 1999). The use of family meetings in discharge planning has been suggested as an important mode of empowerment for individuals (Opie, 1998), and is an area where increased involvement of community service providers may be beneficial. A collaborative approach (between hospitals, community providers and GPs where appropriate) at the time of discharge in assessing and arranging care for these clients was emphasised by participants in the project.

However, the respective roles and responsibilities of the range of service providers involved in caring for post hospital discharge clients needs careful consideration. In relation to providing clients with information about their care arrangements and

other post discharge information it may be more appropriate to take a broader view of the responsibility for clients' information requirements. Given the highly individual nature of patients' information needs, there are difficulties for hospital staff in attempting to meet these needs comprehensively. In the context of shorter duration hospital stays and "primary care led" services, it has been suggested that rather than hospital staff continuing to be responsible for ensuring that patients are adequately informed while still in hospital, more responsibility for meeting information needs could be shouldered in the community (Worth et al., 2000). Discharge staff in the Grampians Region suggested a system of data sharing/transfer, whereby assessment information collected at discharge (and on admission) could be linked directly to the client data needs of community care providers. Such practices would require a committed partnership approach to assessment between hospital staff and key community service providers, including GPs, and would need to be dealt with initially at policy and management levels.

A priority for the Grampians Region may be to adopt strategies that ensure adequate communication between the respective organisations involved with post hospital discharge clients. In addition, a mechanism needs to be developed to ensure that the relevant organisations in local areas have adequate knowledge of the roles, practices and requirements of each other. Possible duplication of effort where community providers routinely reassess clients referred to them regardless of the information provided by the hospital discharge staff could also be examined more closely. Problems associated with hospital discharge, similar to the experiences overseas, may only be improved by resolving or preventing interagency conflict at management levels which have a tendency to 'play out' at the level of assessment practice. Issues that need to be dealt with are likely to relate to trends such as increasing demands on services and budget difficulties (Parry-Jones & Soulsby, 1999: 36).

### **3.3 Client/carer involvement**

Client and carer involvement in initial needs assessment is emphasised in the draft policy framework (Department of Human Services, 2000a) and is a generally accepted principle of best practice. However, the individual circumstances of each client play a large part in determining the extent to which this principle can be put into practice. A useful way to analyse current practice in relation to client involvement about assessment decisions (in line with the theme of client focussed practice), is to regard the level of involvement as being represented along a continuum of:

- No involvement
- Informed or told
- Consulted
- Equal say, true veto, able to negotiate
- Client directed
- Client or carer self managed (Øvretveit, cited in Payne, 1995: 104)

In the Grampians Region, direct client involvement was not emphasised by all assessors, although a direct question on this topic was not asked of them. They did, however, have an acute awareness that many of their clients were unable to clearly define their needs, or to make well informed decisions about their care arrangements. In such cases, assessors placed a great deal of emphasis on client 'context' to obtain the broadest picture possible of the client's situation and had strategies to obtain clients' views about their circumstances in a less direct way. This is illustrated in the following:

*Inquiring with the client in new ways to find out what they would really like, for example, what did you used to do that you miss out on now? ("Aged and disability/Local Government" organisation)*

*The assessment should never overlook the clients' wishes...getting the broadest picture on the context of the client should be your goal* ("Community Health Centre" organisation)

Assessors also routinely involved carers and other significant others in information gathering:

*Never overlook who is in the family... we attempt to gather views from everyone. It is especially difficult to get the views of the male partner* ("Child, youth and family services" organisation)

*The observation in the home (is vital) to get an overview of the client's social situation as well as the status of the house. Always chat with neighbours, carers and social contacts. You need to be able to identify need in a holistic framework rather than let the service drive the assessment* ("Health and medical" organisation)

Whilst service providers may require information about the outcomes of their referrals, it was clear that assessors wanted to ensure that actions should not be forced on clients, and as long as the provider's duty of care was not compromised, clients had the right of vetoing recommendations. As one assessment worker elaborated:

*Assessment is conducted in such a way as to introduce information to the client about the kinds of services that are available to them, rather than have the client be told 'what they should have...(The client should be) made aware that the referral has been made and has given permission to go in...clients also need to know who we are, where we've come from and have a clear understanding of the intention of the meeting. They need to be clear that they have the right to say 'no'* ("Community health centre" organisation)

Assessors in the Grampians Region generally operated from a client centred perspective and their practice emphasised to a certain extent client and carer involvement in assessment. Whilst the practice of "client directed" or "client or carer self managed" care was not specifically examined in this research project, it would appear to be far less common. This is more likely to be due to structural factors such as funding and service delivery arrangements which tend to limit the possibilities for client self management, rather than the approaches of individual assessors and care managers.

### **3.4 Time frames in initial needs assessment**

The draft policy framework acknowledges that client needs can change over time, however, the document emphasises that clients will benefit if their needs are identified as completely as possible, early in their contact with the service system (Department of Human Services, 2000a). Much of the literature suggests that assessment information may need to be collected over a period of time. For example, in relation to assessing individuals from culturally diverse backgrounds for counselling services, Paniagua recommends collecting data gradually across sessions rather than seeking a large amount of client information in one session (Paniagua, 1998).

It was a common view of participants in the interviews and focus groups that information may need to be collected about clients' circumstances over a number of visits and contacts. For example, one community health centre worker described the assessment function as ongoing:

*There's no end to the process of assessment because it's like shifting sand. It's a continual building and reviewing of information ("Community health centre" organisation)*

Another suggested that 3 – 5 sessions might be the optimum time to undertake a thorough assessment of a client's situation, and others indicated that the pattern can vary significantly:

*Two hours are required for a full assessment. Some assessments are one offs, others may take a couple of weeks ("Health and medical" organisation)*

Assessment staff from "community health centres" and "child, youth and family services", in particular, said that it was very common for the "real needs" of clients to emerge only after a period of time when the original presenting problem had been attended to. Some assessments placed heavy emphasis on gathering information at initial contact, while others regard subsequent contacts with clients as more likely to elicit the required information:

*Information collected at the initial assessment will not be extensive. The assessment will sometimes take two to three weeks to complete ("District nursing" organisation)*

Although some local government assessors for aged and disability services participating in the focus group interviews agreed that assessment of their clientele quite often took place over a number of sessions, it was more common for local government assessors to visit once only to undertake an assessment. In the outer areas of the Region, local government assessors are even more likely to take only one session (usually of 1.5 hours) to complete an assessment. This is because the distances are often prohibitive of more than one visit. One assessor described it as common to drive 45 minutes to a client's home, so felt it was more efficient to take a little longer on one visit than to make two or more shorter visits. The practice of separating assessment from service provision, which occurred in many local government services in Victoria as a result of Compulsory Competitive Tendering, may have limited the ability for assessment to be ongoing and responsive to changing circumstances in organisations where this occurred. The need for further research on this issue has been highlighted elsewhere (National Ageing Research Institute, 2001).

Clearly, client centred practice would involve allowing an adequate (generous) and flexible amount of time for an assessment, which may be at one session or a number, depending on the individual circumstances of the client/carer. When adequate time is made available for assessment, there is greater opportunity to develop trust between the client and the worker which increases the likelihood that the client will be ready to reveal deeper problems and difficulties if they exist:

*Time can be a burden, but that's what the job is...to assess. You shouldn't sacrifice time for good assessment ("Aged and disability/local government" organisation)*

However, the ability of assessment staff to commit generous and flexible amounts of time according to the specific needs of clients, is highly dependent on the level of funding for assessment received by the organisation. Assessment staff highlighted the inadequate levels of funding for assessment by most programs, indicating that it does not adequately take into account the time actually spent undertaking assessments.

### 3.5 Strengths and capabilities versus deficit approaches to assessment

The draft policy framework encourages assessors to identify consumers' needs as well as capabilities and potential, generally reflecting a "strengths and capabilities" approach to assessment (Department of Human Services, 2000a). In the Grampians Region there is a wide range of service providers and a range of assessment approaches, but all assessments aim at minimising risks to clients while increasing their opportunities. The way that different service providers go about this are varied and can be approached from different perspectives.

The majority of assessments in the Grampians Region appear to be conducted from a "strengths and capabilities" approach. The majority of the interview participants emphasised the importance of client strengths and capabilities in developing a thorough assessment. For example:

*Assessment may consider what may need to be in place for them when they return home...or may be to assist them when they are learning new skills after a stroke or may be in response to their improving health and their diminishing need for support...("Aged and disability/local government" organisation)*

*The criteria used to determine the level of need of the client are flexible to the extent that they are client driven. For example, if a client needs transport because she's quarrelled with her daughter, it is our job to mediate the quarrel rather than provide the transportation. Keeping the support networks alive and viable is very important in isolated communities. It keeps the client independent and helps them maintain their very vital links to the community ("Aged and disability/local government" organisation)*

The interviews highlighted that there are different approaches to assessment other than the strengths and capabilities approach discussed in the draft policy document "Better Access to Services". Two of the interviewees described the importance of assessment according to client deficits as well as strengths and capabilities. A deficit model of assessment can be compared to a medical diagnosis or a psychiatric approach to assessment. In this sense, assessment is conducted against a benchmark or 'norm', and criteria are organised according to their severity or the number of those criteria (deficits). Deficits are thereby measured or totalled to determine the degree of deviation each case may be from the norm, so that as deviation from the norm increases so too does need.

Consideration of deficits as well as strengths was found to be important for assessment in circumstances where the 'client' might be an entire family wanting to address interpersonal dynamics or potential violence. Deficits might include the poor schooling of the parents, the family's past or recent contact with illicit substances, their contact with child protection, police or correctional services.

*The Strengthening Families program is for high needs families. The assessment doesn't differentiate high or low...(but) the Strengthening Families program can be done badly if the deficits in the family are ignored ("Child, youth and family services" organisation)*

Maintaining a balance between consideration of strengths and deficits can also be seen in the procedures of organisations that use both clinical expertise to assess a client's overall functioning and supports and use of standardised tools to measure deficits. For example the Aged Care Assessment Services have a series of tools to be completed as part of their assessment process, which provide standardised information (i.e. compared with the norm) to other agencies about the physical, mental and social wellbeing of clients:

*We receive a referral with basic information like client details, the GPs or workers or hospitals involved and a summary of their problem and the reason for the*

*referral. The assessment involves the cerebral function test, the Barthel Index, the Geriatric Depression Scale, a Mini-Mental State Examination, nutritional information...* ("Health and medical" organisation)

A balanced approach to assessing, where both deficits and capabilities have equal emphasis was also a current practice:

*... to recognise the independence of the client and assess what the client can do as much as what they can't ...* ("Aged and disability/local government" organisation)

On the surface, the PCP emphasis on a strengths and capabilities approach appears to be well represented in the Grampians Region. However, it is also important to acknowledge other approaches to assessment and their particular contexts. Whether an assessment is conducted primarily to enhance client strengths or address deficits for the client, or emphasises neither one approach over the other, the threshold or baseline assessment at which the program or service begins, needs to be well documented and reflect the most complete picture of client need.

### **3.6 Domains of assessment**

In relation to assessment, domains refer to the scope or field of investigation. Domains of assessment used vary according to the client target group and the professional background of assessors. Assessment domains will also depend to some extent on the types of services offered, although the 'single point of entry' concept implies that a range of service providers will assess against a set of common domains regardless of the service their particular agency offers.

Assessment domains may be formally identified in agency assessment tools or instruments or they may be decided on a less structured basis by professional expertise or assessor experience. For example, one Grampians Region service provider, an outreach service, indicated that they did not have a form to complete at initial contact and preferred to use informal processes as much as possible to fit in with the philosophy of the outreach approach. The domains assessed also relied on the professional judgement of the assessor rather than any written guide.

There was also variation about how assessment was undertaken within each domain. Firstly, some domains such as mental capacity may have more prescribed criteria for the assessor to attend to than domains such as social isolation, which may rely on more intuitive questioning by the assessor. Secondly, different assessors, depending on their professional background and where they are placed in the service system, will approach the same domains in varying degrees of depth. For example, an occupational therapist and a local government aged and disability assessment officer might both assess for home safety/hazard issues, client mobility and falls incidents to determine the level of need of a client. For the OT, this may comprise the majority of their assessment, and the issues would be explored in considerable detail. For the local government assessor on the other hand, these issues may comprise a relatively small component of the whole assessment and therefore could not be explored in any detail.

In relation to assessment of older people, research elsewhere has indicated that assessment tools tend to focus upon the functional domains and financial aspects with consequently less attention to other areas such as mental health or the needs of carers (Stewart et al., 1999). A comprehensive, but not exhaustive, list of assessment domains/data collection items was developed in this research project to analyse the assessment and data collection forms used in the Region (see Table 7). This analysis appears later in the report, and identifies which items and domains are specifically recorded in the assessment forms of individual agencies. The analysis does not, however, take account of the ways in which other information is gathered and recorded by assessors. For example, there was the sense that clients' stories

need to be told in an open way and recorded as such. Assessment forms cannot always guide how this information is sought or recorded:

*Comprehensive case notes are required to determine need and to develop a case plan...a case plan is developed with the client's input and their ideas about their own need in the service. Case notes contain information that is essential to prioritising services (they include)...observations, reflections, expanded stories, other issues like gambling problems or poor schooling... Case notes are important to improve the picture of the assessment over time ("Child, youth and family services" organisation)*

Variation in assessment domains between agencies does not necessarily reflect bad practice, any more than commonality in assessment domains between agencies always reflects best practice. Similarly, heavy use of open ended or 'free text' space in assessment forms does not reflect bad practice any more than reliance on prescribed categories reflects best practice. More opportunities for commonality are likely to exist between like agencies and between assessors from similar professional backgrounds and this is where effort to improve service access and reduce duplication in assessment should be concentrated in the first instance. Attempting to extend the commonality of assessment domains to a greater range of organisations and assessment staff, beyond the collection and recording of common client data (discussed in Chapter 7) would have significant training and workforce planning implications.

**Table 7: Data collection and assessment domains: framework for analysis**

<p><b>1. Referral information</b>            Referral source            Reasons for the referral            Client's perception of the problem</p>	<p>Allergies            Dietary requirements            Oral health            Sleep problems/habits            Sensory – Visual            Sensory – Hearing            Continence/ bowel health            Obese/under weight            General physical appearance            Foot care</p>
<p><b>2. Demographic information</b>            Name            Address            Telephone            Age/DOB            Gender            Marital status            Ability/ disability            Key contacts            Country of birth            Ethnicity            Language spoken            Religion            Interpreter required?            No. of dependants            Living arrangements/ household composition            Accommodation type            Income type            Occupation/employment status</p>	<p><b>7. Cognition</b>            Cognitive capacity (e.g. dementia)            Intellectual disability (e.g. developmental or acquired brain injury)            General mood</p>
<p><b>3. Assessment record and/or tool used</b>            CIARR            Service specific assessment record            Risk screening tool/s</p>	<p><b>8. Psycho-social</b>            Perceived quality of life/well being            Client's perception of his/her ability to remain at home            Willingness to receive help            Leisure activities            Recreational needs            Cultural issues            Recent life events            Challenging behaviours            Client's or carer's service delivery preferences / priorities</p>
<p><b>4. Functioning</b>            Need for personal care and assistance            Fitness to drive            Independence in ADL's            Use of equipment or aids            Mobility and /or balance            Communication</p>	<p><b>9. Risk (non-psychiatric)</b>            Nutrition risk            Home hazards            Risk of abuse/ neglect</p>
<p><b>5. Social/ enviro. context</b>            Availability of the carer            Carer's ability to continue caring/ carer stress            Spouse abuse            Social support            Needs of dependants/ ability to care for dependants            Financial issues            Geographical isolation/ transport issues</p>	<p><b>10. Psychiatric</b>            Psychiatric conditions            Suicide risk            Risk of harm to others</p>
<p><b>6. Health</b>            Vital signs            Ongoing medical conditions (e.g. disease/ disorder, hypertension)            Previous operations            Medications (e.g. number, need help administering)            Medical equipment (e.g. pacemaker)            Prosthetic items (e.g. dentures, hearing aids, glasses)            Nursing care needs            Immunisations</p>	<p><b>11. Lifestyle</b>            Gambling            Substance use            Exercise</p>
	<p><b>12. Educational/ vocational</b>            Need support to find or maintain employment/ educational placement/ occupation</p>
	<p><b>13. Forensic issues</b>            Offences (incl. drink driving)</p>
	<p><b>14. Other services received</b>            Listing of other services            Informal assistance?</p>
	<p><b>15. Consent</b>            Form used to obtain consent from clients to release information</p>
	<p><b>16. Assessment outcomes</b>            Action required/ level of urgency            Action taken            Referral action            Recommendations</p>

### 3.7 Defining and prioritising client need

A needs led approach to assessment practice implies that the client/carer has a role in identifying their need in conjunction with discussion of a range of options, and that identification of need is not influenced by the type and availability of service provided by the assessor's organisation. In practice however, need is often defined according to the domains of the assessment relevant to the service, the specific expertise of the assessing officer, the service type and its availability.

Comments made by assessment officers highlighted the variations in practice for assessors reaching decisions about client need:

*Levels of need aren't used but issues like income or accommodation will be important in determining the (priority) status of the client. Post-natal depression and depression in general can be used to determine the level of need. Both are serious risk factors for environmental neglect... Information used for determining the level of need comes through observation ("Child, youth and family services" organisation)*

*The level of need is determined by the organisation's "targeting and assessment policy"...this can be influenced by the client's environment, their distance from town, whether they have a carer, family contact or support base...their temperament and whether they're outgoing or stoically independent...("Aged and disability/local government" organisation)*

*Sensitivity to the level of need comes through the home visits; through the workers' building rapport and biding their time with the clients, who might be otherwise stubborn about the acceptance of services ("Community health centre" organisation).*

Interview participants were asked to describe how assessment, and responses to assessment information, differs between a client with high and low needs. One respondent cited the agency targeting policy as the main tool, but on the whole respondents indicated that the experience and/or professional expertise of the assessor were relied upon rather than a formal targeting policy. So while high and low need may not be defined extensively by agency guidelines, the criteria developed by individual assessors or assessment teams for making decisions about need and prioritising services, are certainly clear to the people undertaking the assessments. The following interview excerpts highlight examples of the processes and criteria that are important for individual assessors to differentiate high and low need clients:

*High need is determined according to the capacity of the client and their level of independence...indications of high need might include their isolation, the client's capacity to perform activities of daily living, their family support and social life, driving skills, the client's perception of their need and finally what the service can provide... Assessment doesn't differ formally between high and low needs clients, it depends on what comes out in the conversation and through observation. You can probe a bit more to explore more detail or ask a different question of a high need client ("Aged and disability/local government" organisation)*

*The assessment is driven by the number and severity of the presenting problems. For example financial issues tend to be salient at first contact...a high needs client will have multiple presenting problems...psychological, alcohol, criminality, unemployment, poverty, lack of transport... ("Child, youth and family services" organisation)*

*High need clients might include people with disabilities of any age, or with MS, motor neurone disease or arthritis. If the client's activities of daily living are restricted in a way that affects their social wellbeing, like eating and cooking, then they are considered in high need too... High need often requires more assessment time (0.5 x more), and more research to service their needs (2 to 3 times more). ("Health and medical" organisation)*

Prioritisation is a process that assists in the coordination of service provision by guiding (or evaluating) the assessment findings in such a way that service providers can decide fairly and accurately, how much service a person should be allocated relative to the needs of other clients. Approaches to prioritisation include score based, descriptive, or broad guidelines with clinical judgement, to place individuals in a low, medium or high category (National Ageing Research Institute, 2001).

In the Grampians Region, need was defined differently according to the type of service, and the criteria considered important for assigning priority for services also varied according to the provider. Client details necessary for prioritising services included some of the following:

*...vulnerability (i.e. emotional coping capacity or grief and loss issues), their quality of life, isolation, transport and mobility, their health status..., their nutrition, the state of the home environment, the viability of the family support networks, visitors and informal support networks, medication use, access to other services and safety factors...("Community health centre" organisation)*

*...the age of the children may indicate high priority (e.g. very young toddlers and early teenage years have greater urgency than other age groups of children)...Where the family is at or the level of crisis, for example the family may need new accommodation before any of the other systemic issues can be addressed...'Readiness' by the family to engage with the agency will trigger us to move quickly...to 'seize the moment'. Referrals from DHS get a higher priority than community referrals because of how the program has been structured to serve clients from DHS ("Child, youth and family services" organisation)*

*...how often they have contact with others and how good their network is; the rapport they have with their daughter or family; whether they have a personal alarm system; commitments; physical needs; isolation, safety, frailty and the closeness of the nearest neighbour; their risk of a fall; the condition of the floors, laundry, shower etc; their coping ability and confidence in regaining new skills ("Aged and disability/local government" organisation)*

The central issue illustrated by these excerpts is that the criteria that are required to prioritise client is dependent on a very wide range of factors, but appears to relate closely to the service/program type, and target group.

Factors like resource availability, client eligibility, level of need and/or urgency are salient issues for assessment officers in the Grampians Region. However, it has been suggested elsewhere that other factors contributing to the process of prioritisation include the level of knowledge the assessing officer has of community resources and alternatives, and the level of consultation that an assessment officer is willing to pursue to fully weigh client need against the options available (Grimwade, 2000). All factors are important for accurate assessment, but the latter group of factors, associated with professional expertise, is likely to have a greater influence over the consistency and accuracy of assessments across and within client groups when standardised tools are absent. Alternatively, if a score based approach is used then issues of standardisation and internal and external validity need to be considered. Some assessors in the Grampians Region use standard assessment tools to prioritise client need but the prioritising of service provision across the Region is highly variable, and is more of an issue for those 'high demand' services and programs.

## **Opportunities for a common approach**

Variability in criteria used to determine need and priority is common in the community care sector. A preliminary examination of criteria that are commonly used to determine client need indicates that the range of criteria is very broad and that the domains of assessment specify the parameters of assessments. While the domains of assessment can provide some stepping stones toward the development of a common approach to assessment and common assessment tools, studies overseas reveal high variability, low comparability and a low capacity to generate

and standardise information (Stewart et al., 1999). Some work has been done in Victoria to develop an assessment tool relevant for a number of aged care providers (Mann, 1998). However, this was directed at aged and disability service providers (primarily HACC) and did not address the needs of the broad range of service providers such as those represented in PCPs. Options for the development of a common approach to defining need may be found in the skills and professional backgrounds of assessment staff, and like organisations defined by the service type and/or program type. More detailed research on this issue is recommended.

Prioritisation of clients is likely to occur after the initial assessment for the purposes of allocating services to clients based on their needs *relative to other clients*. Achieving commonality in prioritisation for services where demand exceeds supply is a more pressing issue as this more directly relates to service access by clients. The opportunities for common approaches to service prioritisation exist mainly between like organisations and those with the same program funding source.

### **3.8 Reassessment and review**

A review is a periodic mechanism for reassessment. The prime focus of the review should be the needs, views and preferences of clients and carers and the effectiveness of services in addressing those needs (Holten et al., 1992). Specific tasks of reviews may include:

- ensuring client participation in reviews;
- review the achievement of the care plan objectives and make necessary revisions;
- reassess current needs; and
- reappraise eligibility/priority for assistance (Holten et al., 1992).

The review of clients was an important part of assessment procedures for PCP organisations in the Grampians Region: 7.9% only reassessed routinely, 15.8% only reassessed in response to triggers, and 68.4 % reassessed routinely *and* in response to triggers. This means that 92.1% of services in the sample had some form of reassessment process in place. Of the 3 services (7.9%) which indicated that they did not review or reassess clients, these were spread across three agency sub-groups. For two of these organisations, ongoing service provision, and therefore having an ongoing role with clients, was not a part of their role.

While the proportion of organisations undertaking reassessment is very high, the figures do not indicate the quality of the practice. In particular, details such as the frequency with which the reassessments occur, how much time is spent reassessing individual clients, where the reassessment occurs, whether they are always face to face, or whether all relevant assessment domains are investigated, would add another layer of information to the available data. One interview participant indicated that the demand to reassess clients presents resource issues to the service:

*Trying to keep up a regular review of our clients is a huge administrative burden...we're chasing our tails...we have a policy to review every 12 months but it's not possible administratively ("Aged and disability/local government" organisation)*

Although the capacity to provide routine reassessment of all clients would provide the best outcome, service providers are often so stretched to meet the assessment needs for new clients that review in response to triggers is likely to occur as a higher priority than routine reassessment. The limited availability of time (and funding) is a serious issue for service providers in the Grampians Region in relation to reassessment.

Similarly, a study recently completed of local government aged and disability services in a Metropolitan Region of Melbourne found that although organisations had established policies to reassess routinely and in response to triggers, the time pressures on assessment officers meant that routine review, particularly for low needs clients rarely occurred. Rather, most clients were reviewed as a result of a change in circumstances, which generally became evident at a hospital visit or via a report from a Council carer, client or their family. This meant that high priority clients were more regularly reviewed than lower priority clients. Therefore, potential opportunities for reducing (or increasing) services, establishing and reviewing preventative strategies for these clients were lost (National Ageing Research Institute, 2001).

Limited research evidence has indicated that an increased emphasis on ongoing reassessment in the aged and disability sector, along with greater use of shorter periods of service where appropriate, would lead to a greater turnover of clients than presently exists (Turvey & Fine, 1996). These practices may lead to greater efficiencies in the use of assessment resources. However, at present there is insufficient empirical evidence on the effectiveness and outcomes of reviews and reassessments to provide information to adequately assist service planners/managers and assessors to determine the best mechanisms, timing and frequency of reviews and reassessments (National Ageing Research Institute, 2001).

The very high proportion of organisations with reassessment procedures in place in the Grampians Region indicates that this is an area that could be successfully redeveloped in line with the themes of best practice with the aim of achieving greater consistency within (and between, where appropriate) agency sub-groups. The development of some protocols to increase the efficiency of reassessment practices should be explored. For example, where more than one agency is involved in a client's care, it should not be essential for each organisation to conduct their own reassessment. Rather, ensuring that a "lead agency" arranges for a reassessment and communicates the outcomes with all other agencies involved, may be more client focussed and a more efficient use of assessment resources (National Ageing Research Institute, 1998).

### **3.9 Health promotion at the time of initial needs assessment**

For some primary care workers health promotion implied educating people about what they should do to improve their health, or providing screening services to detect early signs of health problems which are responsive to early health treatment (Sindall, 1992). More recently, health promotion has come to represent a unifying concept for those who recognise the need for people to increase control over and improve their health as a resource for everyday life. This contemporary view of health promotion includes the basic resources for health such as income, shelter and food, but also includes "lifestyles, opportunities for making health choices among goods, services and facilities, and favourable social and cultural conditions – a 'total' environment that enhances health" (O'Connor & Parker, 1995: 7). This represents a marked shift from regarding health promotion relating solely to the medical concepts of disease and illness.

The PCP strategy emphasises health promotion at initial needs assessment. One role of health promotion in the context of this strategy will be to assist in preventing ill health and disability for individuals and target groups, and to consistently capture unmet need and provide information to facilitate service planning and allocation. Such an approach will assist service planners and practitioners in working to improve the health of their communities.

Participants in the focus groups conducted during this research project were provided with a copy of the definition of initial needs assessment included in the draft policy framework (Department of Human Services, 2000a) and were specifically asked whether their current practice aligned with the definition. The use of the term health promotion in the definition prompted a range of responses in the focus groups, and while most agreed that they practised health promotion at initial assessment, there was great variation in interpretation. A more detailed definition of health promotion, such as the one shown above, was not provided to the participants, in order to capture the full range of practices and interpretations of the term. Some participants felt that they undertook health promotion evidenced by their "referral of clients for breast screening or cardiac rehabilitation if that was appropriate". Others took a much broader view of health promotion, suggesting that they systematically focussed on clients' environmental and social circumstances recognising that these play a big part in health. One participant questioned whether the definition related "to a medical or a social model of health", and noted that this was not clear from the description included in the "Better Access to Services" document. Interestingly, there was no discussion in the focus groups that indicated an understanding of health promotion at initial needs assessment encompassing the health of communities and the role that assessors could play in such an approach.

The commonly accepted contemporary principles for health promotion strategies of "integrated, intersectorial and participatory" actions (O'Connor & Parker, 1995) pose a challenge to the current practice of assessment. It has been highlighted elsewhere that the move towards a well planned, multidisciplinary and evaluated approach to community based health promotion has training implications, in that practitioners will often request training in addition to their own training and education backgrounds in order to attempt to meet these goals (Sindall, 1992). The range of interpretations of health promotion reported above, suggests too that a commonly accepted understanding of health promotion needs to be adopted and a range of accepted and realistic strategies need to be developed to fit with this common understanding.



## 4. Assessment staff

It is important to have an understanding of the range of staff responsible for undertaking both initial contact and initial needs assessment, including the skills found to be important for assessment roles. This information may be important for PCPs to consider in development of initial needs assessment practices. In particular, the information may be useful for workforce planning or training needs analysis and planning.

### 4.1 Staff responsible for initial contact and initial needs identification

A broad range of staff was reported to be responsible for initial contact and initial needs identification/assessment. The expertise of those staff usually reflected either the characteristics of the service or the organisation. The survey provided space for open-ended responses to a request for details on the staff responsible for initial contact. The different responses to these questions were categorised as one of 7 staff categories and summarised in Table 8.

**Table 8: Staff Responsible for Initial Contact**

Staff categories	Initial Contact (N = 38)	Initial Needs Assessment (N = 38)
1. Nursing or medical staff	9	11
2. Administrative staff	6	1
3. Community service officer or assessment worker	6	7
4. Counsellor, advocate or case manager	4	5
5. Service coordinator	4	3
6. Multidisciplinary professional staff (allied health)	5	8
7. Outreach or support staff	3	3
8. Missing data in survey return	1	

The professional expertise of those responsible at initial contact tends to be linked to the types of services provided by the organisation, staffing levels and rostering demands, and the referral type. For example in just over half the organisations of the "community health" and "district nursing" agency sub-groups, nursing and/or medical staff have sole responsibility at initial contact, while administrative staff are the next most likely to be responsible at this stage of assessment.

Protocols and eligibility criteria provide steps to follow but the gate-keeping role at intake is often accompanied with much freedom and individual discretion beyond the structure of organisational policy and procedures (Grimwade, 2000). Some of the literature suggests that reception and intake is sometimes completed by poorly prepared administrative staff who may be set in their ways of previous service patterns and may not have been fully trained in community care policy (Payne, 1995: 90). Training for all staff involved at intake is therefore a critical aspect of service development (Payne, 1995: 90).

One research participant pointed out that staff responsible for initial contact need to have skills in conflict resolution and to know how to "diffuse violent situations and recognise emergencies" ("Health and medical" organisation). Others emphasised the skills involved in confidentiality. For rural areas such as some of the smaller centres in the Grampians Region, the issue of privacy and confidentiality can be a major factor for the intake worker to consider. For example, in one of the focus groups, participants commented that people from smaller areas often go to larger towns to receive health services to protect their privacy. This is an important feature of rural areas that needs to be carefully considered in developing the PCP system. Client choice about where they can access services needs to be respected as far as possible: service structures should enable this choice, and intake staff should be

sensitive to clients' decisions and the reasons for making such choices. Again, there are training implications here.

Staff responsible for undertaking initial needs assessment may be different to those responsible for initial contact. The differences (less administrative staff undertaking needs assessments, and more emphasis on professional staff such as allied health or nursing) reflect the higher level of expertise and professional training generally expected of staff undertaking needs assessment.

The professional and educational backgrounds of assessment staff may be a determining factor in the types of forms and protocols that are in use. There is a perception amongst assessment staff that the professional expertise of the assessment worker provides many of the safeguards for making ethical and sound judgements, where only basic assessment data forms are used by individual organisations. The existence of formal organisational or system wide protocols to guide assessment may be perceived to take the place of professional expertise or may be more relevant for organisations that do not emphasise professional training for their assessment staff. It is also true that professionally trained staff, such as health professionals, will often tend to make use of more sophisticated assessment forms, and indeed have often been specifically trained in their application.

## **4.2 Skills of assessment staff**

In order to achieve a useful, meaningful assessment of older people, it has been suggested that those performing assessments need good communication skills, knowledge and expertise in caring for older people, and to have a positive view of ageing. Authors also point to the importance of intuitive assessment and reflective practice (Ross and Mackenzie, cited in Vernon et al., 2000). However, few references explore the skills required for initial needs assessment in great depth. Interview participants generally placed a high degree of importance on professional attributes thought to be essential for assessment staff. These were not exclusive to the assessment of older people.

The following list of key skills was adapted from one developed by Seed and Kaye (1994). The key skills of assessors, particularly at the initial needs assessment stage, can be identified as:

1. To be motivated to undertake the assessment accurately, in sufficient detail, and according to agreed processes/protocols
2. To recognise when fresh data needs to be gathered or existing data recorded
3. Systematic observation, reflection and planning opportunities for further observation
4. Self-insight to make objective judgements on another's needs
5. Ability to read research evidence, understand and critically evaluate assessment tools and their application
6. To record client information in ways that will make sense to the reader who does not necessarily know anything about the client
7. To understand what clients wish to communicate about their preferences
8. To interpret what clients are communicating, to look for patterns of consistency
9. Motivating the client/carer to participate, not always in easy circumstances
10. The ability to use a computer and understand the possibilities for data reporting
11. To be able to find out about the client's life in other contexts accurately and coherently
12. To be prepared to extend one's role to participate fully in assessment and care management (Seed & Kaye, 1994).

In general, the interview participants articulated very similar themes. For example:

*Good counselling skills, be able to read anxiety, to be intuitive, to be able to bridge rapport, to be able to draw out information, to be able to give the client an understanding of the process, navigate them through the system, to have an understanding of the limits of what you can offer, to engender self responsibility, to be able to determine the impacting issues for the client, to seize opportunities, to have a broad base of experience ("Community health centre" organisation)*

Interview participants were asked to describe the main characteristics of a 'good' assessment officer:

*Interviewing skills, acuity for hidden agendas, rapport building ... qualifications and experience, clinical skills. The most qualified in the agency needs to be doing the assessments ("Child, youth and family services" organisation)*

*Listening skills, rapport building, show respect for the client's wishes ... you need an understanding that the role of the assessment worker is to keep people in their home, to recognise the independence of the client and assess what the client can do as much as what they can't ... skills to look at the person as a 'person' rather than an abstraction, depth in experience comes from more mature assessment workers ("Aged and disability/local government" organisation)*

*A good assessment comes about through how you frame the questions you need to ask, and being able to know whether or not you're getting the right answers, a willingness to enhance the life of the client and to encourage independence in the client. They should be aiming to make the client's contact with the agency a positive one ("Aged and disability/local government" organisation)*

*Good assessment needs sensitivity to need, listening skills, to be able to ask the right questions to draw out the elderly and develop rapport, interviewing skills, accurate observations, to know what is relevant, to understand your duty of care and be informed to make ethical decisions, an understanding of the disciplines relevant to the full assessment and for the navigation of the client through the system ("Health and medical" organisation)*

The most commonly recurring themes from interviews were that assessors needed:

- communication skills;
- decision making skills;
- public relations skills; and
- the ability to understand client options.

All respondents noted the value of tertiary education, and regarded it as essential. The importance of having the skills that enable a reflective approach to assessment was also evident in the responses. The interviews indicated that part of the expertise of the practitioner is to be reflective on the relationship with the client and to use that knowledge over time to get the most from the assessment.

Skills contributing to good assessment identified by assessors in the Grampians Region reflect a number of common themes across the different service types. Much of this commonality can be attributed to the desire to provide a needs led approach, whereby a collaborative relationship with the client/carer must be developed before exploring care and service options. This demand to build a special kind of professional relationship is consistent across the region and does not necessarily change with a change in service type, although the issues and needs do. It is also true that different client groups and service types require a certain degree of specialist knowledge:

*Have the ability to connect with families ... Experience in family welfare, knowledge of family issues and children's developmental issues, nothing less than a diploma, they need to be able to do risk assessment, understand indicators of family violence ("Child, youth and family services" organisation).*

In a summary of intake procedures in the child and adolescent mental health sector Grimwade identifies key attributes important at initial contact for the assessment of need for services in that sector (Grimwade, 2000). The key attributes he identifies are not very different from those described by Ross and Mackenzie above, or from the descriptions provided by the interview participants, but he introduces the idea that there is a sequence. This sequence encompasses the following: initial contact, public relations and greeting the client, listening skills, knowledge and information about community resources and alternatives, a willingness to consult with others about key issues, knowledge of the organisation's (or the service system) options for assisting the client, and of the processes whereby decisions are made. Finally there is capacity of the assessor to weigh options and make appropriate decisions (Grimwade, 2000).

The first part of this process is often assigned to the role of the 'receptionist', while the latter stages in the process are more commonly performed by trained professionals perhaps from specific disciplines (Grimwade, 2000). As a number of organisations have "administrative staff" performing intake roles, there are training implications which need to be considered. Also, being able to distinguish the various roles/functions of each stage of assessment, and the skills required, helps service managers in staff recruitment and training needs analysis.

The issue of interdisciplinary and interagency communication is also relevant in a discussion on assessment skills. Some of the difficulties experienced in communication between individuals and between providers may be influenced by the level and type of training assessment officers bring to the job, and could be improved by considering alternative training options as part of an overall strategy for reforming initial needs assessment practices in PCPs. Firstly, it is common for communication difficulties to arise between different professional groups. Information required by different professions varies, and the language used is often profession specific (Worth, 1998). Secondly, where staff have had exposure to interdisciplinary training, then some of these communication difficulties are overcome, as there is greater mutual understanding of the particular issues associated with different professional groups (Ikonen, 1998) (Fowler et al., 2000). This in turn helps to strengthen the trust existing between individuals and between providers resulting in more effective communication and cooperative working relationships.

Both the literature and assessment officer interviews highlighted the need for a certain level of training and careful attention to effectively engaging the client at both initial intake and initial assessment. Specific skills are needed within agency sub-groups plus generic skills common across all. Balancing these training and competency issues is an important part of developing assessment processes across the Primary Care Partnerships, and is an area that will receive attention through the redeveloped DHS "Better Access to Services" policy document (forthcoming).

## 5. Local considerations relevant to initial needs assessment

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A range of local issues, identified mainly in the focus groups, is relevant to initial needs assessment. In particular, the challenges of undertaking client assessments in rural contexts were emphasised by research participants. Cultural issues with particular relevance for the local area are also included in this section.

### 5.1 Challenges presented by a rural location

The most commonly articulated local issue was transport difficulties, both for clients accessing services, and for service providers in being able to provide flexible, quality services. Some service providers also pointed out that transport/travel was not adequately funded by programs. A higher than average rate of unemployment in the Region were also said to be a major issue for the local area as this caused high demand on welfare agencies.

Staff turnover is a big problem in rural areas. Health professionals, and particularly younger staff, will often only stay two or three years. Whilst this high turnover is attributable to many factors, some focus group participants identified the lack of educational and professional development opportunities for these staff as an important factor. This was less of a problem in Ballarat, but was a major issue identified for the more outlying areas of the Region. Another significant contributor to high staff turnover, identified in the focus groups, was that professional workers often end up as sole practitioners, or with minimal support, which can be demanding and unsustainable for long periods for many people. Also whilst housing can be cheap, the availability of rental accommodation can be very limited.

The lack of service availability on weekends was noted as a major issue in rural areas. This was a problem for assessors making decisions about the type of care that they can recommend in care plans. This was exacerbated in areas where discharge planning practices did not enable community care assessors sufficient time to arrange support for clients returning home (see 3.2.1).

An issue identified in one focus group peculiar to the local area (Horsham) was that they had numerous examples of the Housing Commission placing families in inappropriate housing, apparently a relatively common occurrence in rural areas. Whilst the housing is immediately available, there are no employment opportunities, there are significant transport problems, and families are at high risk of social isolation. In addition, some of the housing suitable for older, single adults was also used to place people with challenging behaviours. Some focus group participants reported that this had been very problematic for some of their older clients.

For smaller settlements, and outlying rural areas, the ability to match clients with appropriate direct care staff was often problematic for assessors. Not only was there a shortage of trained staff available in these areas, but many matches are inappropriate because of family connections or other issues typical of rural communities. Some assessment staff felt that this compromised the quality of their care planning decisions. On the other hand, the unique problems of rural areas often led to creative and innovative service delivery solutions.

In summary, the Grampians Region has characteristics which impact on assessors' ability to work according to the themes of best practice, particularly in their ability to be flexible and truly needs led in their approach to needs assessment and care planning:

- Difficulty in meeting client needs at weekends
- Inability to always suitably match clients with direct care workers
- Limited service availability and access

Other significant characteristics impacting on the quality of assessments include distance and transport problems (which can affect how assessments are undertaken as well as service delivery), and high staff turnover due to the difficulty in attracting and retaining professional staff. This requires extra effort in networking and communication.

Although not exclusively relevant for rural contexts, the need to have systems and structures that encourage good networking and referral was discussed by focus group participants. It was noted that networking had “gone out of fashion” for a while, with some organisations only now recognising the need to establish more formal networks to facilitate the contact required between workers in different organisations. For example, in Ararat, HACC workers meet fortnightly to discuss client coordination issues. A general networking meeting of all health and community service providers is held bimonthly to facilitate networking between staff. It was noted, however, that the high workload of staff required to undertake client assessment also prohibited the time individual workers could spend in local networking. Another simple strategy suggested to ensure that assessment staff were knowledgeable about the full range of providers in local areas was to have good information about local services available such as a directory of services to be updated regularly.

## **5.2 Cultural issues**

The literature highlights the importance for assessors to have the flexibility to tailor service plans to acknowledge the likely influence of variation in attitudes, beliefs and perceptions about service use across caregiver and care recipient age, gender, and ethnic sub-groups (Pedlar & Smyth, 1999). Cultural considerations are particularly important. A culturally sensitive assessment, or “cultural formulation”, can assist assessors’ in their interventions with the client and any recommendations made to other service providers involved in the persons’ care. It may also increase cooperation and compliance by the client and/or carer to the advice given by healthcare professionals (Panos & Panos, 2000).

Whilst assessors in the Grampians Region generally regarded clients’ perceptions of their needs, and attitudes to the care required, as an important influence to how they assess need, cultural factors were not regarded as particularly important by those who were interviewed. When asked if there were burdens delivering services to a wide range of cultural groups, all participants indicated that the Grampians Region was a *relatively* mono-cultural region, in that there was a relatively small proportion of people from non-English speaking backgrounds. However, there were particular issues in relation to Koori clients that were raised.

One assessment worker noted that there were difficulties getting services to the Koori community in the region surrounding Ballarat. A ‘best practice’ approach to assessment with the Koori community was said to take additional time and resources. However, because this additional time was not acknowledged in program funding, it was suggested that Koori clients might not always get a ‘best practice’ assessment. A comment made in correspondence to the research staff from the Budja Budja Aboriginal Cooperative suggested that mainstream providers could benefit from developing stronger links with the relevant staff at the Cooperative. Staff in

Aboriginal organisations have "... an intimate knowledge of indigenous individual circumstances, expectations and confidence... which in turn ensures confidentiality and appropriate referrals". More information about best practice for agencies in working with Koori clients and the indigenous community could be developed collaboratively between the Koori organisations and PCPs.



## 6. General Practitioners and initial needs assessment

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General Practitioners often act as the interface between clients and a range of other primary care services. Not only are GPs often the first to identify individuals' need for alternative care and support (initial needs identification), they are often the first point of call for individuals seeking some form of assistance but who may be unsure about other support options available to them (initial contact). For these reasons it is important that GPs are well linked with the full range of primary care service providers to ensure cooperative and coordinated assessment and service delivery. The draft policy document emphasises the importance of "engaging GPs" in the primary care reform strategy in relation to service access (Department of Human Services, 2000a).

### 6.1 *The current role of GPs in initial assessments in the Grampians*

The role of GPs in relation to initial needs assessment in the Grampians Region was explored via the survey and in the focus groups. This exploration did not aim to evaluate this aspect of the role of GPs, but set out to describe, in broad terms, the relationships between GPs and other primary care providers in relation to initial needs assessment. Given the emphasis placed on engaging GPs in the primary care reform strategy, it was considered important by members of the steering committee to have an understanding of the degree of involvement currently existing between GPs and other primary care providers in the Grampians Region. It was also felt to be important to begin to develop an understanding of the key areas that may need to be targeted by the PCPs, and the feasibility of any ideas proposed. Specifically, the survey requested estimates on the degree of involvement agencies have with GPs in the Region, and the focus groups provided an opportunity for service providers to discuss topics deemed important to their working relationships with GPs in initial needs assessment. Direct surveying of GPs was beyond the scope and brief of this project<sup>1</sup> as there are a large number of them in the Region and the nature and context of their work is very different compared to other primary care providers.

Understanding the common referral sources for primary care providers is important when considering mechanisms to streamline service access and improve clients' experience of the service system.

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<sup>1</sup> One survey was returned from a general practice surgery, having been obtained via a member of the steering committee. The survey was included in the data analysis.

**Figure A: How often GPs refer to PCP agencies**

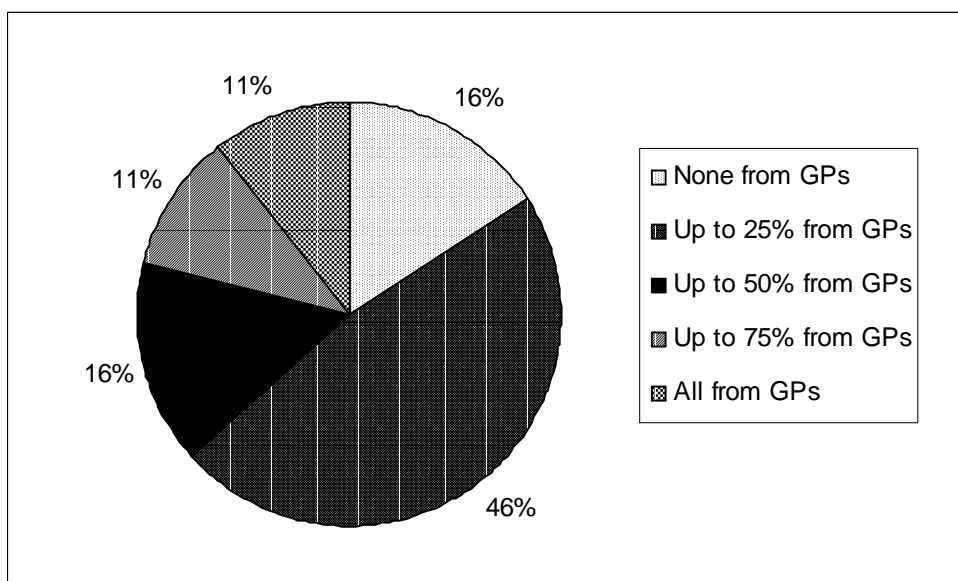


Figure A shows service providers' estimates of referrals received from GPs (represented as a percentage of all referrals received). Almost two thirds of the agencies that responded to the survey reported that 25% or less of their referrals originated from GPs (the estimates ranged from 0% - 25%). At the other end of the spectrum 11% of the services identified every case originating as a referral from a GP and approximately a quarter of the respondents estimated GP referrals comprised between 50 –75% of their client base. Closer analysis of this pattern showed no clear-cut relationship between the agency sub-groups and the likelihood of receiving referrals from GPs. The three largest agency sub-groups showed equal variance in estimates for the proportion of referrals "all from GPs" and "none from GPs" within each sub-group. It is likely that very localised variables are influencing this result. A closer analysis of the professional networks and systemic structures determining these relationships would be most fruitful.

**Figure B: How often agencies refer to GPs**

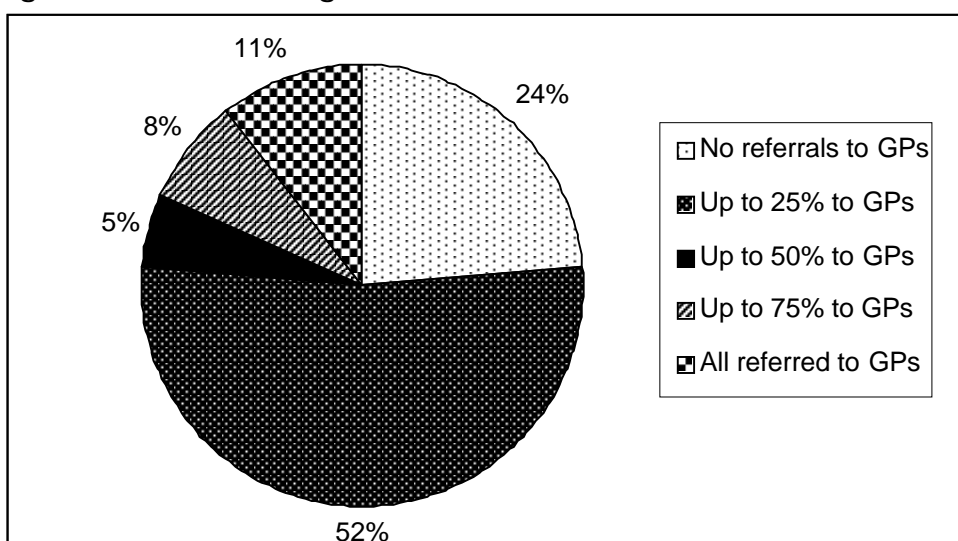


Figure B presents estimates of the proportion of their clients that service providers refer to GPs. More than three quarters of the respondents in the sample indicated that GPs were either not sent referrals by their agency or were sent referrals in no more than 25% of their client cases. The 11% of services that indicated that 'all' their clients were referred on to GPs belonged to the "district nursing" agency sub-group. In contrast, one service provider in the same agency sub-group indicated that they did not refer to GPs.

**Figure C: Estimates of GP involvement in case conferencing with other primary care service providers**

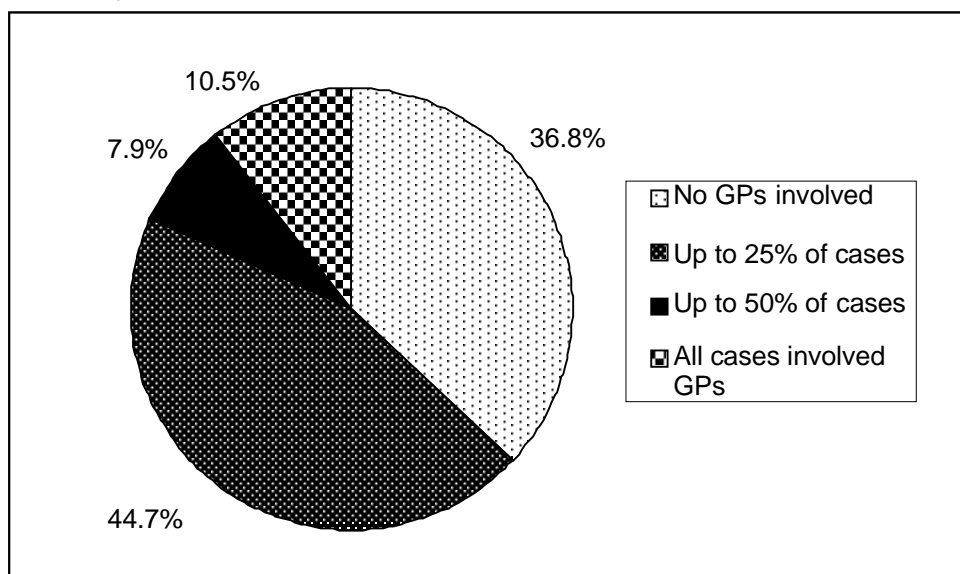


Figure C presents estimates of the degree of involvement, represented as a percentage, that GPs have in case conferencing with other services in the primary care alliance. Case conferencing with GPs was reported by more than three quarters (82%) of the survey respondents to either not occur or to be present for under 25% of their client base. Almost 11% of service providers indicated that they had GPs involved with all their clients. This group is comprised of "district nursing services", "aged and disability/local government", and "psychiatric services" organisations. A greater number of providers from "aged and disability/local government" organisations, however, also indicated that no GPs were involved in case conferencing. This variability needs to be considered in terms of local differences rather than difference between service categories. The vast majority of respondents (around 90%) reported the involvement of GPs in case conferencing ranging from none to no more than 50% of their client base.

These data describe in very broad terms the degree of involvement between GPs and other primary care providers. There is currently a proportion of about 10% of agencies working closely with GPs with no particular patterns across agency sub-groups evident. It should also be noted that GPs are likely to be providing medical care to clients of primary care services without the knowledge of the other service providers. This may be appropriate in most cases, but it may indicate that communication linkages between GPs and other primary care providers are limited.

Information collected in the focus groups strongly indicated that service provider relationships with GPs were not reliant on formal protocols. Rather, it was commonly articulated that the degree of involvement of GPs in assessment and referral depends largely on the personal relationships and informal networks established between GPs and local service providers. Further, it would appear that the service providers in the more outlying areas of the Region may experience greater connection with the local GPs than service providers closer to, or in, larger centres.

## 6.2 The future role of GPs in assessment

The new Commonwealth Enhanced Primary Care (EPC) initiatives provide strategies and funding to strengthen the role of GPs in the primary care of patients with chronic illness or multidisciplinary care needs. The expectation of this new strategy is that there will be greater participation by GPs in longitudinal care coordination of eligible patients, and that this new focus will be in cooperation with allied health professionals and other care providers (Royal Australian College of General Practitioners, 2000). There are three components of the EPC identified as Medicare Benefits Schedule items:

- General Practitioner involvement in coordinated care planning;
- multidisciplinary case conferencing; and
- voluntary annual health assessments for those aged 75 years and over (and Koories 55 years and over).

The role of GPs in the EPC strategy will be to conduct or coordinate health assessments and to participate in care planning and case conferencing of patients. The implications of this new initiative have been described as providing the opportunity for GPs to participate in a more holistic approach to health by way of their greater role in the promotion of 'healthy ageing' (Sims et al., 2000). A particular demand of this strategy will be the expectation that GPs broaden their knowledge of the community health services sector beyond the scope of the routine clinical pathways, to give their patients full advantage of the EPC arrangements. Divisions of General Practice are actively working on encouraging the implementation of all three components.

The EPC health assessments for "over 75s" was discussed by participants in focus groups in the Grampians Region. Whilst this is relevant for only a proportion of primary care clients, the initiative was generally viewed positively by service providers as a way of ensuring that older people's needs were assessed and dealt with early. The strategy states that before any health assessment is made, GPs should check for existing care plans (Royal Australian College of General Practitioners, 2000). Some instances were reported in the Grampians Region where health assessments were performed with clients who were already well connected with the service system; in a small number of cases were regularly receiving district nursing and other ongoing health care.

It would be useful for service providers in the Region (including GPs) to consider adopting a mechanism that allows for communication of the outcomes of assessments and reassessments, to relevant providers. One focus group participant pointed out that when her service had routinely made information about individual clients' care and changed circumstances available to the local GP in the past, this had not been regarded as valuable by the GP. The practice was eventually discontinued and information provision about individual clients reverted to an "as needed" (and ad hoc) basis. However, this occurred prior to the introduction of the current reforms and is more likely to be well received in the current climate. This is an area where protocols to avoid duplication in assessment, or at least to encourage information sharing, may need to be developed.

In relation to GPs interface with HACC service providers, focus group participants highlighted the need for GPs to have a greater understanding of HACC target groups, service limitations and the broader role of the HACC program. A focus group participant stated that some GPs still held the view that their referral for a HACC service would automatically lead to the recommended service (at the recommended level) being put in place. However, this expectation was said to be changing, as GPs became more aware of the range of HACC service provision issues, including the role of HACC staff in needs assessments. Focus group participants also emphasised the

importance and benefits to clients for GPs to have a greater role in the early detection and referral (or intervention) of carer stress.

The wider literature suggests that regular and effective relationships between GPs and service providers outside the medical and allied health network is fragmented and lacks a collaborative edge (Feldes et al., 1994). Whilst this was also reflected in the Grampians Region, there is strong commitment from PCP organisations and GPs to reverse these trends. The main themes arising about GP engagement with improving access to primary care services related to improved communication and collaboration. The issue of client consent needs to be addressed in all cases:

- better collaboration between GPs and other service providers in sharing information generally, but especially for discharge and care planning;
- participating in processes designed to enable two way feedback about client needs within the wider service system; and
- providing brief inventories to other service providers in their PCP of completed health assessments and/or care planning for the EPC strategy (to avoid doubling up).

Further developmental work in Primary Care Partnerships involving considering the place of GPs in relation to service access to the broader service system, should begin with ensuring a mutual understanding of the different nature of GP services relative to other primary care providers. In particular, the differences in funding arrangement for GPs was said to place particular demands on them that may not be well understood by other primary care providers with different funding sources and accountabilities.



## 7. Client data collection

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The issue of client data collection is important to consider in detail because it forms the basis of communication between service providers who have similar client target groups (horizontal communication), and because accurate client data is a funding program requirement and is required for service planning (vertical communication). One dilemma of the assessment process is how to obtain systematic information in order to inform the broader needs analysis and planning whilst ensuring that on an individual level clients' views are not ignored and care received is not service led (Vernon et al., 2000). The paper work involved in administering services to clients in the Grampians Region is an extensive task for most service providers, and the fact that different funding programs have different client data reporting requirements adds further complexity. The information that is collected from clients, beyond basic client details, is often information that may be important to treatment, care planning, service provision, program evaluation, hand over or interagency collaboration. Copies of all data collection/assessment forms used by assessors were requested in the survey for this project. The specific items and categories (domains) used for this analysis were included in a previous section (3.6). This section discusses some of the main findings of this analysis.

### 7.1 Data collection instruments in use in the Grampians Region

The vast majority of service providers have some identifiable mechanism or form for recording assessment information, and whilst there is a degree of commonality between the individual items contained on these instruments, they can be designed very differently and given very different titles. There is a large number and wide range of forms in use. A preliminary analysis reveals that these forms can be grouped according to how and why the data is recorded:

1. Summary information about the client is represented by data contained in the following:
  - client record, medical profile or CIARR
  - prospective client or initial contact forms
  - admission forms
  - request for service forms
  - home support form
  - intake assessment form
  - request for service form
  - service referral forms
  - application for membership
  - client transfer form
  - service approval form
  - contact record
  - patient record
  - full client registration
2. Descriptive information gives details about client need whether in terms of deficits or capabilities
  - pre-admission assessment form
  - medical referral form
  - health summary
  - duty work form
  - initial contact form for specific programs i.e. licence disqualification
  - client referral form e.g. evaluation of client abilities; reasons for the referral; services supporting the client; social/emotional factors relevant to the referral
  - client transfer form or contact record e.g. risk assessments
  - risk screening forms
  - Blaylock risk assessment tool

- client referral form (recommendations)
- client transfer form or contact record e.g. plan of action; team response and/or plan
- objectives for referral program
- involvement with other agencies
- outcome of this contact
- duty form

However, assessment outcomes are also often recorded simply as notes in free text forms - case notes, file notes, or process notes. This approach to gathering information requires clear sets of criteria defined by the domains of assessment important to the assessor/service provider. Notes may then be expanded by a number of different sources for client information including feedback and dynamic interaction with the client:

*A case plan is developed with the client's input and their ideas about their own need for the service...we may also get information from other agencies, with consent, like the school pupil welfare officer or principal, the teacher... ("Child, youth and family services" organisation)*

The need for, and personal preference for, emphasising 'free text' by staff from particular backgrounds or service types needs to be acknowledged.

### **Degree of commonality**

Where service providers assess clients using parallel domains, there is also some commonality in the descriptive information agencies collect, although the information may be collected and used for different purposes. For example, both occupational therapists and local government assessment staff assess hazards in the house, however the assessments may vary in depth, purpose and application. Therefore the commonality between assessment domains may be inappropriate to develop beyond the level of client data in some cases.

A detailed analysis was undertaken of the common data items collected on assessment and client data forms in use in the three PCPs. A summary of this analysis (Table 9) shows that there is a moderate degree of commonality in the summary information required from clients by many of the service providers. The group with the highest degree of commonality was the "aged and disability/local government" agency sub-group. The "district nursing" and "health and medical" agency sub-groups produced a surprisingly low degree of commonality.

It should be noted that some services make heavy reliance on case notes or "free text" space on forms. In such cases, the information that service providers might commonly record in these spaces would not have been captured in the analysis.

Table 9: Data items collected by agency sub-groups

	Victims of crime/sexual assault (n = 2)	Aged and disability/local government services (n = 11)	District nursing (n = 13)	Health and medical services (including ACAS) (n = 4)	Child, youth and family services (n = 6)	Psychiatric services (n = 1)	Drug and alcohol services (n = 1)	Community health services (n = 2)	TOTAL (n = 40) <sup>2</sup>	
<b>Referral Information</b>										
Referral source	2	11	8	2	3	1	1	2	31	78%
Reasons for the referral	2	11	9	3	2	1	1	1	30	75%
Client's perception of the problem	1	1	1			1	1		5	13%
<b>Demographic information</b>										
Name	2	11	13	4	6	1	1	2	40	100%
Address	1	11	13	4	5	1	1	2	38	95%
Telephone	1	11	12	4	5	1	1	2	37	93%
Age/DOB	1	11	13	4	5	1	1	2	38	95%
Gender	1	11	10	4	3	1	1	2	33	83%
Marital status		2	9	3			1	1	16	40%
Ability/ disability	1	1	2		3				7	18%
Key contacts		11	12	3	2	1	1	2	32	80%
Country of birth		9	9	3	3		1	2	27	68%
Ethnicity	1	10	6	3	3	1	1	2	27	68%
Language spoken		10	9	2	4		1	2	28	70%
Religion		9	10	3	1				23	58%
Interpreter required?		9	6	1	2	1	1	2	22	55%
No. of dependants									0	0%
Living arrangements/ household composition		11	13	2	2		1	1	30	75%
Accommodation type		10	9	2	2	1	1		25	63%
Income type	1	10	11	2	2		1	2	29	73%
Occupation/employment status		1	4	1	1		1		8	20%
<b>Assessment record and/or tool used</b>										
CIARR		8	3	1	1				13	33%
Service specific assessment record		9	12	4	5		1	1	32	80%

<sup>2</sup> Although 38 surveys were returned, two organisations had programs that used very different assessment forms. These two programs were analysed separately to their 'parent' organisations and were placed in agency sub-groups that best fitted their role.

Risk screening tool/s			12	3				1	16	40%
Functioning										
Need for personal care and assistance		11	6	3	3				23	58%
Fitness to drive			2						2	5%
Independence in ADL's		11	11	2	2				26	65%
Use of equipment or aids		10	5	1	2				18	45%
Mobility and /or balance		2	11	2	1				16	40%
Communication		3	8	1	1	1	1		15	38%
Social/enviro. Context										
Availability of the carer		9	9	1	2				21	53%
Carer's ability to continue caring/ carer stress		9	8	1	2				20	50%
Spouse abuse										0%
Social support		1	8	1	1	1			12	30%
Needs of dependants/ ability to care for dependants		1	1	1		1			4	10%
Financial issues		1				1			2	5%
Geographical isolation/ transport issues		9	8	1	1				19	48%
Health										
Vital signs			6	2			1		9	23%
Ongoing medical conditions (e.g. disease/ disorder, hypertension)		5	9	4	2	1	1	1	23	58%
Previous operations			2	1	1	1	1		7	18%
Medications (e.g. number, need help administering)		1	12	4	1	1		1	20	50%
Medical equipment (e.g. pacemaker)			1	1					2	5%
Prosthetic items (e.g. dentures, hearing aids, glasses)			2	1					3	8%
Nursing care needs			10						10	25%
Immunisations			3	1					4	10%
Allergies			7	3			1		11	28%
Dietary requirements			11	1		1			13	33%
Oral health			2						2	5%
Sleep problems/habits			5	2	1	1			9	23%
Sensory – Visual		3	9	3	1				16	40%
Sensory – Hearing		3	10	2	1				16	40%
Continence/ bowel health		1	8	3			1		13	33%
Obese/under weight		1	7	2					10	25%

General physical appearance			3			1			4	10%
Foot care				1					1	3%
Cognition										
Cognitive capacity (e.g. dementia)		3	10	3		1			17	43%
Intellectual disability (e.g. developmental or acquired brain injury)							1		1	3%
General mood			5	1		1	1		8	20%
Psycho-social										
Perceived quality of life/wellbeing			4	1	1				6	15%
Client's perception of his/her ability to remain at home	1		1				1		3	8%
Willingness to receive help						1			1	3%
Leisure activities	2				1		1		4	10%
Recreational needs			2		1				3	8%
Cultural issues						1			1	3%
Recent life events			3	1	2		1		7	18%
Challenging behaviours			2		1	1			4	10%
Client's or carer's service delivery preferences/priorities	1								1	3%
Risk (non-psychiatric)										
Nutrition risk		2	5						7	18%
Home hazards	10		9	1	2				22	55%
Risk of abuse/ neglect		1							1	3%
Psychiatric										
Psychiatric conditions			3	1	1	1	1		7	18%
Suicide risk						1	1		2	5%
Risk of harm to others						1	1		2	5%
Lifestyle										
Gambling										0%
Substance use			7	1		1	1	1	11	28%
Exercise			4						4	10%
Educational/vocational										
Need support to find or maintain employment/ educational placement/ occupation					1		1		2	5%
Forensic issues										
Offences (incl. drink driving)							1		1	3%
Other services received										
Listing of other services		10	12	3	4		1	1	31	78%

Informal assistance?		10	6	1	2				19	48%
Consent										
Form used to obtain consent from clients to release information	1	10	3	2	4		1	2	23	58%
Assessment outcomes										
Action required/ level of urgency		10	5	2	3	1	1	2	24	60%
Action taken		9	5	1	3				18	45%
Referral action		9	4	1	4	1		1	20	50%
Recommendations		9	9	2	2	1			23	58%

## 7.2 The practice of data sharing (confidentiality and privacy considerations)

The value of "inter-professional collaboration" is often cited in the literature (Allison & Ewens, 1998; Parry-Jones & Soulsby, 1999). However, the practicalities of developing systems to achieve this electronically in relation to sharing client data, requires careful consideration. Where this work has been developed overseas, a range of issues needed to be addressed systematically such as referral processes, service definitions, and confidentiality and participation guidelines, particularly where the more detailed clinical information desired by some agencies was included (Gaudet, 1996).

The implementation of policies by service providers to protect client confidentiality at initial contact (and initial needs identification) is reasonably well developed across services in the Grampians Region, and when there is the need to share client information between organisations, consent or release forms are often used:

*...to assess with other services in mind (Is helpful in planning care) and this means that consent from the client is important so that their need can be referred on to other service providers ("Aged and disability/local government" organisation)*

Of the agencies responding to the survey, 58% of 40 organisations/programs (Table 9) reported the use of a consent or release of information form in order to share client data (many of these agencies were those that used the CIARR); 90% of 38 organisations (Table 5) reported having either a release form or protocols to ensure client confidentiality. However, the ease of translating these practices to enable the *electronic* transfer of client data is unknown at this stage.

One organisation indicated that formalised protocols regarding client confidentiality were not applicable to the service. A further two organisations reported that they did not have formalised guidelines for the protection of client confidentiality, but cited unwritten 'codes of practice' instead. Where these codes of practice operated it is possible that the safeguard of client privacy relied on the experience of the staff, who would be expected to thoroughly understand the local community and be aware of all the issues important to that community:

*...Communities (in the Grampians Region) are close knit and there are issues around privacy and confidentiality...you've got to have an awareness of that built into the interaction before you can engage with the client's issues ("Community health centre" organisation)*

In the few cases where protocols or guidelines to protect privacy and confidentiality were considered unnecessary it was the nature of the service that had the greatest influence. That is, either their clients typically received a service from only one provider, or the organisation played only a limited role in relation to clients' care.

Client information collected at initial contact and used for referral (connection) to other service providers is likely to be much less detailed than client information collected in a more detailed initial needs assessment. Referral to other service providers can occur at either stage, however where more detailed client data such as health status are provided in a referral, the client consent issues are likely to be more involved. PCPs should consider the different information requirements and client consent issues relevant at both initial contact and initial needs assessment in the reform process.

### **7.3 Potential for using a common client data form**

Whilst there are many advantages in a range of service providers using a common form or minimum data set, there is a danger in thinking that such an initiative will offer more than is possible. In the United Kingdom it was recognised that the use of a common assessment form would not necessarily result in good interagency working and thus progress to seamless care, and that shared information about a client when transferred across agencies may not amount to an assessment but rather a referral (Vernon et al., 2000). Further, if the purpose of a common assessment is to have an assessment accepted by another agency then the easiest way may be to agree to accept each other's assessment documentation rather than attempt the difficult task of developing a joint one. It is recognised that this may pose difficulties of ownership, acceptability and commitment to its use (Vernon et al., 2000). Nevertheless, the analysis of data collection forms in use in the Grampians Region suggests that despite the variability in domains and definitions there is potential to develop a set of common data fields which could easily be adapted to a common referral form which records information collected at 'initial contact' at the very least.

The use of the CIARR amongst HACC organisations provides some hints at both the benefits and difficulties associated with adopting a common client data form for a group of service providers with common clients. The CIARR is a client held record of assessment and services information, initiated in the HACC Program in 1993 by the Commonwealth and States in response to concerns about multiple and duplicate assessments. The CIARR was designed to:

- promote a consumer focus in assessment;
- reduce duplication in assessment of clients;
- provide a consistent framework for recording core client information and assessed need for service; and
- facilitate referral between HACC and other service providers (Elton et al., 1995).

The range of information recorded on the CIARR contains what could be considered to be the most common information required and the minimum amount of information necessary on which to make a judgement about how to most appropriately assist people with relatively straightforward needs (McVicar & Reynolds, 1995). It was never intended to replace data collection forms or assessment instruments needed for specific services or purposes, but to be used in association with these other instruments. Despite widespread support for the concept of uniform and simple assessment, information sharing and collecting mechanisms, and wide support from consumers for the concept, the implementation of the CIARR remains highly variable (Lindeman, 2000).

The 1995 national review of the CIARR<sup>3</sup> stated that implementation of the CIARR had progressed more effectively and efficiently in areas where there had been a commitment of resources to encourage the engagement of service providers. In addition, the establishment of networks to develop and monitor assessment protocols was shown to increase the benefits of the CIARR for both service providers and consumers (Elton et al., 1995). Particular models for training assessment staff in the use of the CIARR have also been shown to be effective (Lindeman, 2000). However, one of the most significant issues contributing to variable take up of the CIARR appears to be that it was designed specifically for HACC services, despite the frequent involvement of services from other program areas in assessment and service delivery for the HACC target group. PCPs are therefore in a better position to

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<sup>3</sup> A second National review of the CIARR is due to report shortly.

be able to develop and implement a common client data form to improve the quality and efficiency of assessment by taking the client, rather than the program, as the point of reference. A high degree of optimism was expressed in the focus groups about the ability to achieve this within the Grampians Region.

One of the features of the CIARR was that it was designed as a client held record of assessment and services information as one way of ensuring a client focus in assessment and service delivery. Some focus group participants reported that this was not a useful aspect of the CIARR as some clients never referred to them again after they were given the CIARR folders, and that some clients had multiple copies of the folder indicating a poor understanding of its purpose. This is obviously an area of frustration for service providers; however, these occurrences should be used to highlight areas where assessment practice and coordination and the implementation of any tool could be improved rather than as a reason to discontinue the practice of client held assessment records. The CIARR was used by 32.5% of agencies surveyed, with the bulk of these from the "aged and disability/local government" agency sub-group (mainly HACC organisations), and not surprisingly, this was the group with the greatest degree of "within-group" commonality.

Rather than focussing on the use of a specific form, it is more useful to analyse the data items commonly collected. This information can then be used to determine the feasibility of adopting a common form for referrals and/client data collection, and for service providers to compare these items with the items they collect for their program funding requirements (e.g. HACC Minimum Data Set). Tables 10 and 11 show the items commonly collected by 50% or over, and 75% or over, of the organisations surveyed.

Only a very small number of items were commonly collected by the majority of organisations. However, these items are significant in that they represent the platform from which to develop the core of a common referral form between all PCP service providers. Most focus group participants agreed that reducing the number of separate forms that needed to be completed each time a referral was made would enhance practice.

Additional forms outlining specific agency sub-group needs could be developed as attachments to this basic form if required by those service types that had more specialised information needs. 80% of organisations surveyed used service specific assessment tools or forms. For these organisations in particular, moving to a system that relies on a set of core data items collected by all agencies which is then supplemented by agency or service specific assessment forms/client data forms may be relatively simple. This is a feasible option for Grampians PCPs in the short to medium term.

**Table 10: Data items collected by 50% or more of all surveyed organisations**

Referral Information
Referral source
Reasons for the referral
Demographic information
Name
Address
Telephone
Age/DOB
Gender
Key contacts
Country of birth
Ethnicity
Language spoken
Religion
Living Arrangements/household composition
Interpreter required?
Accommodation type
Income type
Assessment record and/or tool used
Service specific assessment record
Functioning
Need for personal care and assistance
Independence in ADL's
Social/ enviro. Context
Availability of the carer
Carer's ability to continue caring/carer stress
Health
Ongoing medical conditions (e.g. disease/disorder/hypertension)
Medications (e.g. number, need help administering)
Risk (non-psychiatric)
Home hazards
Other services received
Listing of other services
Consent
Form used to obtain consent from clients to release information
Assessment outcomes
Action required/ level of urgency
Referral Action
Recommendations

**Table 11: Data items collected by 75% or more of organisations surveyed**

Referral Information
Referral Source
Reasons for the referral
Demographic information
Name
Address
Telephone
Age/DOB
Gender
Key contacts
Living Arrangements/household composition
Assessment record and/or tool used
Service specific assessment record
Other services received
Listing of other services

## **8. Conclusion: future development of initial needs assessment**

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This document has reported on the current practice of initial needs assessment (including initial contact) in the three Primary Care Partnerships in the Grampians Region of Victoria. The research found that assessment practices generally reflected some of the themes of best practice. For example, assessment staff placed a strong emphasis on a client centred' approach in defining client need; interacting with clients with sensitivity and taking time, where available, to draw out and explore the main issues with the client. The approaches described in the interviews also reflected measures that aimed for inclusion and prevention, although further investigation and implementation of culturally appropriate assessment is warranted. Sensitivity to local issues such as geographical isolation and an awareness of some of the factors which marginalise clients in the Region, underline the work of assessors and point, generally, to inclusive targeting practices.

Whilst there was some variation in approach to initial assessments, it does not follow that this indicated poor practice. Rather, different approaches to assessment need to be considered in the context of agency type and goals, clientele, backgrounds of staff in assessment roles and philosophies of staff and programs. The PCPs are comprised of a diverse range of service providers so it is not unexpected that a degree of variation in approaches to assessment would be found. Potential to achieve greater commonality in approach to initial contact and initial assessment lies initially with client data collection and referral between PCP agencies. These, and a number of other areas for future development of initial needs assessment practices are proposed for consideration by the Grampians Region PCPs. The main areas that could be targeted for reform are summarised in Table 12 against the themes of best practice. More detailed discussion follows.

**Table 12: Summary of recommended areas for reform**

Themes of Best Practice	Main areas to be targeted for reform in Grampians Region PCPs
Client centred practice	<ul style="list-style-type: none"> <li>• Two tiered training program for assessment staff (i.e. initial contact and initial needs assessment staff).</li> </ul>
Inclusive and preventative targeting strategies	<ul style="list-style-type: none"> <li>• Develop system wide protocols for assessing Koori clients</li> <li>• Staff training on culturally appropriate assessment</li> <li>• Develop agreed definition and strategies for health promotion at initial assessment, including a training program for assessment staff.</li> </ul>
Structural/systemic integration	<ul style="list-style-type: none"> <li>• Rationalise initial contact and referral forms for all agencies</li> <li>• Rationalise initial needs assessment and referral forms (as attachments to initial contact forms) for agency sub-groups</li> <li>• Develop mechanisms for communication/networking for assessment staff, and for monitoring protocol implementation</li> <li>• Develop IT systems to enable electronic communication, ensuring adequate training and infrastructure</li> <li>• Consider protocols and system for streamlining reassessments (potentially a 'lead agency' model)</li> <li>• Establish a working group to consider appropriate assessment models in each PCP and Region wide</li> <li>• Ensure that PCP reform processes in areas of interaction with other service providers (e.g. disability services and acute hospitals) are undertaken collaboratively and effective partnerships are developed.</li> </ul>
Needs led and flexible assessment practice	<ul style="list-style-type: none"> <li>• Training for reception/administrative staff involved in initial contact</li> <li>• Ensure assessments contribute to broad service planning data by highlighting gaps between assessed need and service availability (needs led).</li> </ul>

## 8.1 Streamlining initial contact

The number of different client data collection/assessment forms and referral forms in use in the Grampians Region is extensive, even within agency sub-groups. However, most organisations collect a small amount of client data in common with other agencies and these items could provide the basis of a form or 'system' designed to streamline initial contact and referral. Some potential to further streamline initial contact and referral may be possible *within* agency sub-groups, and *between* those agency sub-groups who are more likely to share clients. However, more investigation of this, particularly the different information needs of individual organisations, is recommended, as there was a high degree of variation within most of the agency sub-groups.

As a first step towards streamlining initial contact, organisations would need to agree to rationalise the number of separate forms in use, concentrating instead on the content of forms, and redesigning their systems accordingly. The development of a single referral form<sup>4</sup> (with sub-group or agency-specific attachments) is feasible and is likely to improve clients' experience of accessing the service system.

<sup>4</sup> The anticipated work of the Department of Human Services in developing an Initial Needs Identification Template in 2001 is acknowledged.

## 8.2 Protocol development

There were several areas where protocols to assist assessors to effectively and efficiently carry out their role could be developed to improve clients' access to and experience of the service system:

- **Koori clients:** The provision of cultural awareness information to assessors and the development of protocols to assist mainstream service providers assess Koori clients and work with the Koori community is required.
- **Referrer feedback:** Most assessors agreed that feedback about the outcomes of their referrals (information loop) would be beneficial.
- **Post hospital discharge clients:** Protocols to facilitate the provision of services for post hospital discharge clients could improve practice. Discussion at assessor level is required, as well as discussion at management level to consider the broader context of program constraints and interagency relations.
- **Over 75s health assessments:** The conduct of health assessments (for "over 75s") was an area highlighted for protocol development, as it is likely that many people targeted for these assessments will be existing clients of PCP service providers. These health assessments are also available to Koories 55 years and over. Integration of this practice within the Region could also be addressed.
- **Client consent/confidentiality:** Consent/confidentiality system-wide protocols for shared or referred clients in relation to the collection and sharing of client data is a high priority for protocol development.
- **Reassessment and review:** Where more than one agency is involved in a client's care, it may not be essential for each organisation to conduct their own reassessment. Rather, establishing protocols to ensure that a 'lead agency' arranges for a reassessment and communicates the outcomes of the reassessment to other providers involved in the client's care could lead to more efficient and client centred practice.

Management and agency endorsement of protocols, training in the use of the protocols for assessment staff, and involvement of assessors in negotiating the terms of the protocols to ensure they are realistic are all important factors in effective implementation and practice improvement. Establishing a mechanism for monitoring the implementation of protocols should also be considered. Such a mechanism could be linked to communication/networking groups for assessors.

## 8.3 Training for assessors

Areas where training needs to be conducted have been identified throughout the report. In summary, these are:

- use of protocols (developing and working with them);
- training staff for initial contact (particularly where this role is undertaken by administrative staff);
- health promotion at the time of initial needs assessment;
- theory and applications of different assessment models and local implementation issues; and
- promoting needs led and client focussed assessment with particular attention to client choice, involvement of family/carer, confidentiality, care planning.

An important issue for assessors in moving towards a more structurally and systemically integrated approach to assessment was that organisations needed to have trust in the practices of the workers and organisations with whom they had most contact. As one focus group participant said: "we need to have confidence in

what others are doing and the recommendations they make". There are numerous examples in the literature that recommend multidisciplinary and interagency training opportunities to encourage an understanding of the roles and perspectives of the range of staff involved in assessment and service delivery (Fowler et al., 2000; Ikonen, 1998). Any training offered in relation to assessment should be developed according to this principle and with the needs of an audience with potentially diverse backgrounds and experience in mind.

#### **8.4 Improving communication and coordination**

Whilst assessors in the Grampians Region reported a high level of informal networking, particularly in the outer areas of the Region, there are opportunities for strengthening communication and coordination mechanisms. Relatively few formal links or coordinating protocols exist between diverse service providers, and even within service provider categories, these appeared underdeveloped. This suggests that coordination of assessment may be ad hoc, and relies largely on informal processes. Whilst informal networking was viewed as a positive attribute, there is a case for formalising networks throughout the three PCPs to ensure assessment coordination. In areas in the Region where structures exist to provide opportunities for case discussions these were regarded as very worthwhile. It is recommended that individual PCPs consider appropriate models to enable appropriate coordination and communication. Models adopted in other rural regions, involving a three tier structure which allows for frequent case discussions for assessment staff, coordinator/manager networking, and overall sub-regional planning and coordination may be appropriate to consider (National Ageing Research Institute, 1998).

#### **8.5 Information technology to support data sharing**

Information management and technology issues will be addressed in a parallel project occurring in the Region examining the IT capacities and needs of PCP organisations. Whilst not discussed directly in this report, a theme commonly raised in the Region was the need to have an integrated and compatible electronic system for communication available to all PCP service providers. Some assessment staff reported being poorly resourced in relation to both computer systems and available staff (number and level of training).

#### **8.6 Service planning and assessments**

A true needs led assessment, by definition, will focus on the needs of the client rather than on the availability of services. Assessors then use this information about client needs to develop a care plan. It is at this stage that information about service availability becomes relevant to the assessor. However, it is still important in needs led as opposed to service led assessments to have a range of options available (Seed & Kaye, 1994: 26). In rural contexts, the limited range of service options can cause difficulties for assessors in conducting needs led assessments and care plans. However, it is clear that information about the gaps between assessed need and service availability should be used for service planning purposes, and to this end PCPs should discuss mechanisms for routinely collecting and analysing such data. Some organisations would have more difficulty in contributing such information than others due to staffing and resource constraints, and differences in role and approach to client assessment. However, an opportunity exists to capitalise on assessment information that clearly identifies 'assessed need', along with 'available services'.

## **8.7 Which assessment model?**

The Primary Care Partnership strategy provides flexibility in the model for assessment that can be adopted by PCPs. Whilst not a theme actively pursued in the research in the Grampians Region, the view was expressed by some focus group participants that vesting the assessment process with a specific assessment agency would not work in rural areas. An attempt had been made in Stawell to develop a model that would enable assessments to be done by one organisation, but this did not progress. In general, individuals preferred to have assessors available at all, or most, of the agencies involved in service provision. This ensured that there was both a good geographical spread of available assessors, and that there was 'expert' advice about the local area and about particular client groups. Adopting this model of initial needs assessment, however, has implications for the proper resourcing and training of assessment staff, which was regarded by those consulted as presently inadequate.

Whilst it is beyond the scope of this project to discuss the range of models that could be considered, the provision of multidisciplinary training opportunities, and systems and structures which support good communication and liaison activities, have been recommended as strategies to adopt in any assessment model (Parry-Jones & Soulsby, 1999). It is recommended that the issue of models of assessment is actively debated in appropriate regional forums, and that a trial and evaluation of the proposed model/s is undertaken.

## **8.8 Conclusion**

This project has developed a picture of initial needs assessment practices in the Grampians Region of Victoria, which is important for informing further work during the Primary Care Partnership (PCP) planning and development processes. Whilst the main aim was to obtain a "snapshot" of initial needs assessment practice (including intake, needs assessment and referral), some areas for future development of initial needs assessment practices in the Primary Care Partnerships in the Grampians Region have been identified. These areas relate to streamlining initial contact through the rationalisation of client data and referral forms; protocol development across a range of areas; training for assessors involved in both initial contact and initial needs identification; improving communication and coordination; information technology to support assessment practice; strategic use of assessment data for service planning; and deciding which assessment model would best suit the Grampians PCPs.



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### 10.1 Survey Returns

The following organisations returned completed copies of the paper-based survey by 15/1/2001:

1. Avoca Health service
2. Ballan District Health Care
3. Ballarat CASA
4. Ballarat Child and Family Services
5. Ballarat Community Health Services\*\*
6. Ballarat District Nursing Society
7. Ballarat Health Services (HITH, PAC)
8. Ballarat Health Services (Psychiatric Services)
9. Carers Choice
10. Carn Brae Clinic
11. Central Highlands Coordinated Community Care
12. Central Highlands Division of General Practice\*
13. Centrecare (Ballarat)
14. City of Ballarat
15. Djerrivarrh Health Services\*\*
16. Dunmunkle Health Services
17. East Grampians Health service
18. Grampians ACAS
19. Grampians Community Health Centre
20. Harrow Bush Nursing Centre
21. Hepburn Shire
22. Hindmarsh Shire Council
23. Horsham Rural City Council
24. Lake Bolac Bush Nursing Service
25. Northern Grampians Shire Council (Stawell)
26. Palm Lodge Centre
27. PINARC\*\*
28. Pyrenees Shire Council
29. Rural North-west Health
30. St John of God Health care
31. Stawell District Hospital
32. Stawell Neighbourhood house
33. West Wimmera Health Service
34. West Wimmera Shire
35. Western Victoria Division of General Practice\*
36. Wimmera Health Care Group
37. Wimmera Uniting Care
38. Wimmera Volunteers
39. Women's Health Grampians
40. Yarriambiack Shire Council

\* Owing to the different nature of the Divisions of General Practice to other service providers these surveys could not be collated with the others.

\*\* These organisations returned multiple copies of the survey. A description of how these survey returns were handled in the analysis follows:

**Djerriwarrh Services (categorised as “district nursing”)**

- Provided a copy each for their community nursing and counselling services, but the counselling copy was incomplete and there was insufficient data to count as a separate item.
- Information about the allied health services was supplied with the survey and were handled as programs within the service.

**PINARC (categorised as “child/ youth and family services”)**

- Provided multiple copies of the survey for each program run through the agency but was regarded as a single service because:
  - only two of the programs constituted what could be relevant to initial contact procedures (the allied services, holiday camps and library services were excluded).
  - the information supplied in the two surveys remaining showed such similar responses for each item, that they were collapsed to form one case.

**Ballarat Community Health Service (categorised as “community health services”)**

- Provided multiple copies of the survey for each program run through the agency but was regarded as a single service. The surveys completed for community health and mental health programs could be entered as one case as they showed like responses to each survey item.
- One survey copy was not fully completed and was omitted from the analysis.
- The allied health services i.e. ante-natal services, dietician, physical health education and podiatrist were considered less likely to represent services involved at initial contact and were therefore not counted separately in the survey analysis.
- The victims assistance program is represented separately in the itemised list (client data), as the client data collected for this program was significantly different.

## 10.2 Survey

### SURVEY OF INITIAL NEEDS ASSESSMENT PRACTICES

Please complete the details for your organisation below, once.  
Then if your service has a number of different assessment practices for diverse client groups or the range of services you provide, please duplicate pages 2 - 6 to repeat the audit for each assessment practice.

#### **YOUR ORGANISATION**

1. Name of your organisation

.....

2. Name of the person completing this survey

.....

3. Position in the organisation

.....

Phone..... Fax.....Email.....

4. List the main client group or groups that your service provides services to:

a) .....

b) .....

c) .....

d) .....

(continue on a separate page as required)

5. What are the main services provided by your service?

a) .....

b) .....

c) .....

(continue on a separate page as required)

## DEFINITIONS

(Please read thoroughly the definitions below and answer the questions that follow)

**Initial Contact** (also 'process of entry', screening processes or intake procedures)

Initial Contact is the point at which a client has first contact with the service system. It may include the provision of service information, health promotion literature and/or a discussion about health promotion opportunities. Initial Contact may also involve the recording of basic details about the client and may require interpreter services. Initial Contact should facilitate direct access to Initial Needs Identification.

**Initial Needs Identification** (also assessing or prioritising client eligibility and/or risk) Initial Needs Identification is an assessment where the client's needs and health promotion opportunities are identified and where consumers are subsequently informed about the range of appropriate service options and available services to meet their needs.

(Taken from *Better Access to Services*, Victorian Government Department of Human Services, 2000)

## PROCEDURES FOR INTAKE

(Please label all attachments appropriately e.g. 'Initial Contact Proforma' or 'Assessment Guidelines')

6. Do you have a client information form or proforma that is used to collect client information at intake (Initial Contact)?

NO

YES (Please attach photocopies and/or a clearly outlined schedule. Please label the attachment and mark the question number it pertains to)

7. Do you have a proforma/s used at the full assessment (Initial Needs Identification)?

NO

YES (Please attach photocopies and/or a clearly outlined schedule. Please label the attachment and mark the question number it pertains to)

8. Does your organisation have guidelines or protocols for staff to follow at intake (Initial Contact)?

NO

YES (Please attach photocopies and/or a clearly outlined schedule of guidelines. Please label and specify question number on attachment.)

9. Does your organisation have guidelines or protocols for staff to follow at the full assessment (Initial Needs Identification)?

NO

YES (Please attach photocopies and/or a clearly outlined schedule guidelines. Please label and specify question number on attachment.)

10. Record the position title of those staff responsible for screening at Initial Contact.  
(Please stipulate if the positions conducting the Initial Contact are based 'in-house' or elsewhere)

a) .....

b) .....

c) .....

(continue on a separate page as required)

11. Record the position title of those staff responsible for undertaking Initial Needs Identification (assessments) for your service.  
(Please stipulate if the positions conducting the assessments are based 'in-house' or elsewhere)

a) .....

b) .....

c) .....

(continue on a separate page as required)

12. Please estimate the percentage (%) of your total client assessment, where a GP is likely to:

- a) have referred clients to your organisation .....%
- b) be involved in case conferencing or consultation.....%
- c) have had a referral made to them by your organisation.....%

13. Do you have a Proforma or guidelines that you require other agencies to follow when referring a client to your service?

(Please attach a copy and label it 'Proforma' or 'Guidelines', as appropriate)

- Proforma
- Established criteria or guidelines
- Other (Please specify overleaf)

.....

.....

.....

14. Do you have a system whereby you acknowledge receipt of referral to the referrer?

- NO
- YES (Please describe)

.....

.....

.....

(continue on a separate page as required)

15. If you answered YES above, is this required within a stipulated time period?

- NO
- YES (Please provide details)

.....

.....

16. Do you have a system whereby you feedback assessment outcomes to the referring agency?

- NO
- YES (Please describe)

.....

.....

.....

.....

(continue on a separate page as required)

17. What protocol is established in your service to ensure client confidentiality when inter-agency communication requires client data to be made available?  
 (Please provide a photocopy and/or a clear outline of the guidelines set up to protect client confidentiality)

.....

.....

.....

.....

(continue on a separate page as required)

18. Does your service reassess clients? (Please indicate **a** or **b** or **both**)

a) Routinely (i.e. every 3, 6, or 12 months)

- YES
- NO

If YES please specify how often.

.....

(continue on a separate page as required)

b) In response to triggers?

- YES
- NO

If YES please specify the triggers that facilitate the reassessment of a client?

.....  
.....  
.....  
.....

(continue on a separate page as required)

General comments:

## 10.3 Interview Schedule

### DATA COLLECTION

**Describe how client data is handled for the assessment process.**

For example:

- What do you record?
- What happens to the client information after it's collected
- Do time constraints effect how the information is supposed to be handled?

**What administrative burdens or staffing demands are there in collecting client information?**

For example:

- The time required to process the new information;
- Duplication of workload or information for external requirements;
- Difficulties implementing assessment for a wide range of cultural groups...etc?

**Is the data collection system adequate for making decisions about service provision?**

- What things can't it include?
- What advantages might it have for including sufficiently relevant information?
- Are there different levels of need that it may be sensitive to?

**What kind of client contact is the most helpful when defining the level of need of a new client?**

For example:

- face to face
- in their home
- with the carer present or not present

### DECISION MAKING

**What client details are necessary for prioritising services?**

- The ones that need to be recorded
- The things not written down but needed in assessing new clients

**What are the features of a high needs client?**

**How does an assessment differ between a client with low levels of need and one more dependent on support?**

**What role does observation play in an assessment?**

- What kinds of things can be observed in the interaction with the client that can add to the quality of the assessment?
- What kinds of things may be observed in the environment to improve an assessment?

## QUALITY CONTROL

**What characteristics are important for a ‘good assessment officer’?**

For example:

- Formal qualifications
- Personal characteristics

**What role does professional expertise play in developing a thorough assessment?**

- Does it enhance the kind of assessments you make?
- What competencies do you bring to the job that enhance the outcomes?

**What should always be included in any needs assessment?**

- What should never be overlooked?
- What universal standards ensure good assessments?

**Explain how an assessment done by your agency might differ from one by another agency?**

**What information, in addition to the assessment interview, might be important for a complete assessment?**

- Where might the additional information you require come from?

## **10.4 Focus Group Participants**

### Ballarat

1. Cheryl Hines, Carer respite, Carers Choice
2. Robyn Fletcher, Division of General Practice
3. Deborah Hopwood, Central Highlands PCP
4. Heather Thewlis, PINARC
5. Kevin Harris, Geriatric Psychiatric Assessment Team
6. Frank Hall, Centrecare, DASH
7. Jacinta Wainwright, Child and Family Services (Intake and Referral)
8. Gabrielle Fraser, Hepburn Shire

### Daylesford

1. Deborah Hopwood, Central Highlands PCP
2. Lynden Hayes, City of Ballarat
3. Chris Kennedy, Diabetes Educator, Hepburn Health Service
4. David McPhail, Centrecare, Ballarat/Hepburn
5. Maritsa Gronda, District Nursing, Hepburn Health Service
6. Brian Dunn, Disability access, Hepburn Health Service
7. Maureen Gleeson, Hepburn Health Service
8. Julie Gittes, Occupational Therapist, Hepburn Health Service
9. Glenn Robotham, Hepburn Health Service
10. Wendy Grayland, District Nursing, Ballan Hospital

### Edenhope

1. Sandra, West Wimmera Health Service
2. Paula Clarke, Yarriambiack Shire
3. Helen, West Wimmera Health Service (Goroke)
4. Jenny Ackland, Edenhope Hospital
5. Gwen Edgar, Edenhope Shire

### Horsham

1. Anne Richards, Wimmera Health Care Group
2. Helen Tory, Wimmera Health Care Group
3. Julie Spink, Linkages
4. Kath Gellaway, Dunmunkle Health Services
5. Anthony Amor, Welfare Officer, Horsham Council

### Stawell

1. Robyn Leslie, Carers Choice
2. Lowan Tirrell, Social Worker, Grampians Community Health Centre
3. Lauryn Matheson, North Grampians Shire
4. Jean Parson, Central Grampians PCP
5. Beth, Linkages
6. Allison Duxson, Linkages
7. Carolyn Barrie, Project Officer, Grampians Effective Discharge Strategy
8. Melissa, Family Violence Worker, Grampians Community Health Centre

### Ararat

1. Sue Cashin, Community Health Nurse, Ararat Hospital
2. Pam Quintan-Randall, Social Worker, Grampians Community Health Centre
3. Yvonne, District Nurse, East Grampians Community Health Centre
4. Jean Parson, Central Grampians PCP

## 10.5 Information Bulletin

# Audit of Assessment Practices for Grampians Region Primary Care Partnerships

Project Information Bulletin  
October 2000

### Background

The Primary Care Partnerships (PCP) draft policy *Better Access to Services* (2000) describes one of the keystones for the implementation of partnerships as the successful integration of a range of primary care services. The success of this integration will depend on the design and workability of the information management systems and on a transparent, generative and confidential interface between service providers. This project will contribute to developing an understanding about the range of assessment activities and approaches used by services in the 3 PCPs, and related organisations in the Region.

### Project aims

The primary aim of the Audit of Assessment Practices is to develop a picture of how initial needs assessment practices are currently being carried out in the Grampians Region of Victoria. The audit will aim to develop an account of these practices, including tools currently used in client data collection, to inform further work on PCP planning and development processes.

### Steering Committee and Project Staff

The project is being conducted by the National Ageing Research Institute, and managed by a steering committee.

The Steering Committee is comprised of members from three primary care partnerships within the Region: the Central Highlands PCP, the Central Grampians PCP and the Wimmera PCP. Committee members are:

- Ms. Tracey Chenoweth, Wimmera PCP
- Ms. Robyn Fletcher, Ballarat and District Div. of General Practice
- Dr. John Garner, Carnbrae Clinic/ Div of General Practice
- Ms. Wendy Glenister, Central Grampians PCP
- Ms. Lynden Hayes, City of Ballarat Aged and Disability Services
- Ms. Deborah Hopwood, Central Highlands PCP
- Ms. Melissa Lindeman, National Ageing Research Institute (project officer)
- Dr. Adri Van der Kniff, Ballarat Health Services
- Ms. Jacinta Wainright, Child and Family Services, Ballarat

Project staff come from the Public Health Division of the National Ageing Research Institute (NARI), which is affiliated with Melbourne Extended Care and Rehabilitation Service (MECRS) and the University of Melbourne.

## The Project

During the week beginning October 30<sup>th</sup> 2000, a survey will be distributed by mail to all signatories to the three PCP's and related services, to derive an overview of initial needs assessment practices currently in use.

A few individual interviews with specific service providers and some focus group interviews will follow the survey. These will explore in greater detail the requirements needed for successful assessments at intake, the congruency and incongruency in the current feedback and referral procedures, and discern the systems in place that ensure client confidentiality particularly in relation to the different information required by different services.

## Focus Groups

Below is the proposed list of dates when the focus groups will be conducted.

Date	Time (exact times to be confirmed)	Location (venues to be advised)
NOV 27	am pm	Ballarat Daylesford
NOV 29	pm	Edenhope
NOV 30	am	Horsham
DEC 4	am pm	Stawell Ararat

## Individual Interviews

A small number of in-depth interviews will be conducted. These will begin during the week

13<sup>th</sup> – 17<sup>th</sup> November and will be conducted in person or by telephone.

A list of interview questions will be available prior to the interview. Times and venues are yet to be arranged.

## Project staff contact details

For further information about the project or to obtain details about the interviews or focus groups, please contact project staff Francine Hanley or Melissa Lindeman.

Francine Hanley or Melissa Lindeman  
Tel. (03) 9389 7148  
Fax. (03) 9389 7153

Address:  
National Ageing Research Institute  
(NARI), PO Box 31, Parkville, 3052

Email:  
[f.hanley@nari.unimelb.edu.au](mailto:f.hanley@nari.unimelb.edu.au)  
[m.lindeman@nari.unimelb.edu.au](mailto:m.lindeman@nari.unimelb.edu.au)

## 10.6 Primary Care Partnership Mailing List

### Primary Care Partnership – Central Grampians

Contact Name	Position	Organisation	Address
Ms Yvonne Byron	Aged Care Assessment Service	C/- East Grampians Health Service	PO Box 155 ARARAT 3377
Ms Linda	Co-ordinator	Ararat Family Care	4 Banfield Street ARARAT 3377
Ms Robyn Mason	Co-ordinator	Ballarat Centre Against Sexual Assault <small>(part of Ballarat Health Service)</small>	PO box 577 BALLARAT 3350
Dr. Andri Van der Knijff	Director Primary Care	Ballarat Health Services	PO Box 577 BALLARAT 3350
Mr. Peter Appledore	Chief Executive Officer	Beaufort & Skipton Health Services	Havelock Street BEAUFORT 3373
Mr. Tim Chatfield	Chairman	Budja Budja Aboriginal Cooperative	PO Box 43 HALLS GAP 3381
Mr. Kevin Zibell	Chief Executive Officer	Child and Family Services Ballarat	115 Lydiard Street North BALLARAT 3350
Ms Jill Waixel	Director of Nursing	East Grampians Health Service	PO Box 155 ARARAT 3377
Ms Anne Boadle	Community Health Co-ordinator	East Wimmera Health Service	PO Box 31 ST ARNAUD 3377
Ms Yvonne Dridan	Nurse Manager	Elmhurst Bush Nursing Centre	Green Street ELMHURST 3469
Ms Lou Tehan	Chief Executive Officer	Grampians Community Health Centre	40-44 Wimmera Street STAWELL 3380

### Primary Care Partnership – Central Grampians

Contact Name	Position	Organisation	Address
Ms Marjorie McKenzie	Chief Executive Officer	Lake Bolac Bush Nursing Centre	Montgomery Street LAKE BOLAC 3351
Bernie Waixel	Chief Executive Officer	Maryborough District Health Services	PO 155 MARYBOROUGH 3465
Louise Feery	District Nurse	Maryborough District Health Service Avoca Health Service	PO Box 75 AVOCA 3467
Mr. Martin Walmsley	Human and Community Services Manager	Northern Grampians Shire Council	PO Box 580 STAWELL 3380
Mr. John Dixon	Manager, Community Services	Pyrenees Shire Council	45 Lawrence Street BEAUFORT 3373
Mrs Christine Reid	Community Services Officer	Rural City of Ararat	PO Box 246 ARARAT 3377
Ms Wendy Glenister	Manager, Clinical Services	Stawell & District Hospital	PO Box 116 Sloane Street STAWELL 3380
Ms Tamara Peachey	Co-ordinator	Stawell Neighbourhood House	PO Box 374 STAWELL 3380
Ms Joanne Bates	Co-ordinator	Wimmera Centre Against Sexual Assault Service <small>(*part of Wimmera Health Baillie St, Horsham 3400)</small>	9 Robertson Street HORSHAM 3400
Mr. Brendan Kelly	Manager Family Services	Wimmera Uniting Care	14 Sloan Street STAWELL 3380

### Primary Care Partnership – Central Grampians

Contact Name	Position	Organisation	Address
Ms Annie Reeve	Chief Executive Officer	Women's Health Grampians	PO Box 1757 BALLARAT MAIL CENTRE 3354
Ms Maggie Burrows	Senior Project Officer	Department of Human Services	PO Box BALLARAT 3353

### Primary Care Partnership – Central Highlands

Contact Name	Position	Organisation	Address
Ms Ros Fahey	Chief Executive officer	Ballarat Community Health Centre	PO Box 11546 BALLARAT MAIL CENTRE 3354
Dr. Ambikapathy	Director of Medical Services	St John of God Healthcare	PO Box 20 BALLARAT 3353
Mr. David Beaver	Director	Centacare	PO Box 576 BALLARAT 3353
Ms Lynne McLennan	General Manager	Customers & City Services Ballarat City Council	PO Box 655 BALLARAT 3353
Ms Marg Card Attention: Mrs. Chris Boyd	Mayor's Assistant	Moorabool Shire Council	PO Box 18 BALLAN 3342
Mr. Glenn Rowbotham	Manager	Community Health Service	PO Box 465 DAYLESFORD 3460
Mr. Neil Klemm	Human Services Manager	Golden Plains Shire Council	2 Pope Street BANNOCKBURN 3331
Ms Faye McLeod	Manager, Corporate Services	Hepburn Shire Council	PO Box 21 DAYLESFORD 3460
Mr. David Lenehan	Chief Executive Officer	Hepburn Health Service	PO Box 465 DAYLESFORD 3460
Ms Judy Gregurike	Director of Primary Care Services	Djerriwarrh Health Services	PO Box 3 MELTON 3337

### Primary Care Partnership – Central Highlands

Contact Name	Position	Organisation	Address
Ms Jenny Sewell	Chief Executive Officer	PINARC	PO Box 1841 BALARAT MAIL CENTRE 3354
Mr. Cliff Barclay	Executive Director	Uniting Church Outreach Centre	PO Box 608 BALLARAT 3353
Mr. Shane Dawson	General Manager	Ballarat & District Division of General Practice	PO Box 36W BALLARAT 3350

### Primary Care Partnership – Wimmera

Contact Name	Position	Organisation	Address
Mr. Anthony Amor	Welfare Officer	Horsham Rural City Council	PO Box 511 HORSHAM 3402
Ms Cheryl Quick	Unit Manager	Rural North West Health	Post Office BEULAH 3395
Ms Tracey Chenoweth	Primary Care Manager	Dunmunkle Health Services	Church Street MINYIP 3392
Ms Olinda Poulton	HACC Co-ordinator	Yarriambiack Shire Council	PO Box 243 WARRACKNABEAL 3393
Ms Anne Richards	Community Rehabilitation Centre Supervisor	Wimmera Health Care Group	Baillie Street HORSHAM 3400
Ms Gwen Edgar	Community Services Officer	West Wimmera Shire Council	PO Box 201 EDENHOPE 3318
Ms Charmaine Hill	Director of Nursing	Edenhope District Hospital	PO Box 75 EDENHOPE 3318
Ms Pauline Scottow	Director of Clinical Services	West Wimmera Health Service	PO Box 231 NHILL 3418
Mr. John Krygger	Chief Executive Officer	Wimmera Health Care Group	Baillie Street HORSHAM 3400
Ms Dianne McLean	Charge Nurse	Harrow Bush Nursing Centre	Blair Street HARROW 3317

### Primary Care Partnership – Wimmera

Contact Name	Position	Organisation	Address
Ms Joan Reichelt	Community Services Officer	Hindmarsh Shire Council	PO Box 250 NHILL 3418
Ms Eileen Hoffmann	Community Services Officer	Hindmarsh Shire Council	PO Box 250 NHILL 3418
Mr. Nick Bush	Director Primary Care	Rural North West Health	Post Office BEULAH 3395
Ms Debbie Coyle	Manager	Wimmera Volunteers Inc	PO Box 267 HORSHAM 3402
Mr. Peter Perry	Executive Director	Wimmera Community Care	PO Box 442 HORSHAM 3402
Ms Meredith Perry	Director	Palm Lodge	PO Box 501 HORSHAM 3402
Ms Joanne Martin	Project Worker	Women's Health Grampians	PO Box 1033 HORSHAM 3402
Ms Bella Kennedy	Chairperson	Goolum Goolum Aboriginal Cooperative	145 Baillie Street HORSHAM 3400

## **10.7 Interview Participants**

List of organisations whose staff participated in interviews

1. Wimmera Volunteers
2. Grampians ACAS
3. West Wimmera Health Service, Nhill
4. Stawell District Hospital
5. City of Ballarat
6. Centrecare, Ballarat
7. Wimmera Uniting Care, Stawell
8. Grampians Community Health Centre, Stawell
9. West Wimmera Shire, Edenhope

