

DEVELOPMENT OF A PRIORITY OF  
ACCESS TOOL FOR WMR LOCAL  
GOVERNMENT HACC PROVIDERS

FINAL REPORT



National Ageing Research Institute

September 2002

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

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## FINAL REPORT

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# Glossary

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ADL	Activities of Daily Living
BATS	Better Access to Services
CACP	Community Aged Care Package
CP	Care Planning
DHS	Department of Human Services
HACC	Home and Community Care
IADL	Instrumental (domestic) Activities of Daily Living
IC	Initial Contact
INI	Initial Needs Identification
LGA	Local Government Authority/Area
MAV	Municipal Association of Victoria
MDS	Minimum Data Set
NARI	National Ageing Research Institute
PCP	Primary Care Partnerships
POA	Priority of Access
PPPS	Practice, Process, Protocol and Systems
WMR	Western Metropolitan Region

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# Executive Summary

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Demand for HACC services is high with most Western Metropolitan Region (WMR) Local Government HACC services implementing some method of demand management. One approach is to prioritise clients according to who, amongst those eligible for and requesting HACC services requires services more urgently than others within the HACC target population. Determining priority is primarily concerned with determining urgency. It is an important first step in improving equity of access to HACC services in the WMR to have a tool that can be consistently applied by Local Governments.

It is important that the development of criteria is considered in accordance with developments at the Commonwealth (HACC dependency items) and State level (PCP Service Coordination tools). These developments and the introduction of a HACC Minimum Data Set emphasise the policy shift towards introducing consistent methods for determining need, relative priority and resource allocation. To address these issues the National Ageing Research Institute (NARI) received a HACC Development grant from the WMR Department of Human Services (DHS) to undertake a six-month project in 2002. The project aimed to examine the feasibility of introducing a consistent approach to prioritising access to and monitoring demand for WMR Local Government HACC services.

The project objectives were to:

- Consider the processes and tools for monitoring demand and prioritising access to WMR Local Government HACC services
- Examine the appropriateness and feasibility of standardising prioritisation tools and processes across WMR Local Government HACC services
- Develop a set of agreed criteria for use by WMR Local Government HACC services to monitor demand and unmet need
- Develop a strategy for implementation by WMR Local Government HACC services of project outcomes.

The anticipated outcomes of the project were:

- Standardised criteria to be used consistently by all Local Governments in the WMR for prioritising access to HACC services by HACC eligible clients;
- Consistent demand monitoring [process] by WMR Local Government HACC services to inform service management and planning;
- A strategy for implementation by WMR LGA HACC services, which would have the potential for wider application.

A project working party was formed including interested WMR Local Government HACC service providers, project officers and WMR DHS representation. Throughout the project

the Working Party met on four occasions to discuss the progress of the project and to provide input into the development of the Priority of Access tool.

The tool was developed through examining a number of sources:

- Current practice within and outside the WMR;
- Research evidence on indicators of need for HACC and related services; and
- Expert advice.

Through the above sources of evidence a number of indicators were identified that were currently used and/or had evidence of predicting use of community services. Through this analysis of indicators it became apparent that three core elements appeared to influence need for HACC services. These elements were; ability to complete Activities of Daily Living (ADLs) including personal care ADLs and domestic ADLs; cognitive ability; and level of informal support available to assist with ADLs and social activities. Other indicators that were identified included:

- Medical conditions/cancer/stroke/arthritis/diabetes
- Recent previous falls
- Poor self-reported health
- Sensory impairments
- Poor nutritional status
- Foot problems
- Hazards in the physical environment
- Not willing to accept services
- Not committed to staying at home
- Communication difficulties
- Risk of abuse/neglect
- Income/financial status

The identification of indicators and the exploration of current practice lead to the development of two POA tool options. These two options enabled the indicators to be operationalised. They both relied on responses from the INI tools for completion. The tool options were measurement tools that provide a consistent set of criteria that could be applied to minimise subjective input from assessment staff. This is essential for ensuring the tool can be consistently applied across HACC services and to demonstrate to potential clients how priority decisions are made.

The two POA options were developed for discussion with a group of NARI staff who had previous experience of developing and evaluating measurement instruments and/or knowledge of HACC services. The two options were also presented to the Working Party for discussion. The Working Party preferred Option 1 primarily as it had a score range of 0-28 that would enable a larger number of levels of distinction between clients. It was also more consistent with the structure of INI, making it straightforward to follow. Option 2 lead to

only three levels of high, medium and low, although it was possible that sub-categories of medium-low, medium-high etc could be extrapolated.

Based on the feedback from these two meetings Option 1 was modified. To examine its veracity and application in practice, NARI decided it was important to conduct a small pilot test of the modified POA tool. Three Local Governments who were routinely using the INI tools agreed to participate in the pilot (Brimbank, Moonee Valley and Melbourne). The pilot was undertaken over four weeks at Moonee Valley and two weeks at Brimbank and Melbourne.

Feedback from the pilot tool was obtained from pilot sites through a survey and a focus group with assessment staff who were involved in the pilot. Feedback was also obtained from non-pilot LGAs through a survey. Surveys at non-pilot sites were distributed by the Working Party member at each LGA to any managers or assessment staff who were involved in priority of access decision making. Feedback from these sources was analysed and used to further refine the pilot tool. Feedback from the NARI meeting, the Working Party meeting and the pilot process is reported in Chapter 4 of the report.

It is intended that the POA tool be used by Local Governments in the WMR to determine the level of priority of those accessing and not accessing services. In addition, it is also intended that the POA tool be used across Local Governments for making comparisons about access to services in relation to priority level. For example, which LGAs are able to provide some services to low priority clients and which ones aren't? To enable these comparisons to occur, a set of criteria have been developed for recording information about clients who do not gain access to one or more service types that they have been assessed as needing. These criteria also have value for managing demand for individual LGAs. The criteria are:

- Contact details (name/address/telephone/DOB)
- HACC Statistical Linkage key\*
- Interpreter required
- Date referred
- Referred by and phone number
- Priority Level\*
- Priority Score
- Type of assistance currently provided by this HACC agency\*
- Type of assistance requested but not available at time of assessment\*
- Is the person on the waiting list for a Linkages or Community Aged Care Package or a residential aged care place?
- Last contact with this agency
- Date for next contact
- Comments

These criteria are described in further detail in Chapter 5 of the report. The criteria that are marked with an asterisk could form the set of criteria that could be collected through a central body agreed upon by WMR LGA HACC services.

## Recommendations

The recommendations arising from the POA project address three key areas:

- An implementation plan for the POA tool
- Validation and refinement of the POA tool
- Implementation of a demand management plan

Within these three areas there are five major recommendations:

1. The POA tool and guidelines (refer to Appendix 4) be implemented by all WMR Local Government HACC services during or following the cross regional implementation of the INI tools.
2. The seven WMR LGAs develop and sign an agreement supporting implementation of the POA tool.
3. Assessment staff undertake training on correct use of the POA tool.
4. Validation and refinement of the tool is undertaken. This recommendation requires a number of research projects to be undertaken in the longer term and could include:
  - A study on the retest and inter-rater reliability of the POA tool;
  - A study on the validity of the tool for determining who most urgently needs HACC services;
  - A study on the appropriateness of the POA tool for families with children with disabilities;
  - Applicability of the tool for other HACC agencies both within and external to the WMR.
5. The demand management plan be accepted and implemented. This plan has two components:
  - Consistent reporting on the waiting list data set (Refer to Chapter 5)
  - Using priority levels for service planning. For example:
    - Investigation of service provision levels and their relationship with priority levels;
    - Longitudinal comparative study comparing a sample of low priority clients who are accessing HACC services with a sample of low priority people who are waiting to access a HACC service, to examine the impact of not providing services to those with lower needs

As the demand for home and community services grows, the need for agencies to provide a consistent and equitable process for determining access to services increases. This project aimed to provide a simple and consistent, yet comprehensive approach for WMR Local Government HACC services to determine priority of access for clients. A consistent method for determining priority has the advantage of providing consistent evidence of the unmet needs of those trying to access services in the Western Region. This evidence supports appeals for increased funding for agencies to adequately meet the increasing needs of people living in the community. However, it is important that other measures are taken to increase awareness of HACC services, particularly to isolated and vulnerable groups to ensure that those who need services most are able to access them.

# Chapter 1: Introduction

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According to the Victorian HACC Program Manual (Department of Human Services 1998), the “aim of the Home and Community Care Program is to provide a comprehensive and integrated range of support services for frail aged and other people with a disability, and their carers. Services are provided to assist people to be more independent at home and in the community and to assist carers in their caring role. Thereby preventing an inappropriate admission to long-term residential care and to enhance the consumer’s quality of life” (p 9).

HACC is a national program cost shared by Commonwealth and State/Territory Governments. Auspice agencies and user fees also contribute to the funding of HACC services. Local Government agencies in Victoria contribute significant funds to these services. The Western Metropolitan Region (WMR) Local Government HACC agencies report that they contribute between 32-50% of the funding for Local Government HACC services (National Ageing Research Institute 2001a).

HACC services are generally provided within people’s homes and include assistance with household tasks, home nursing, personal care, in-home respite, delivered meals and property maintenance. A number of services are not provided within people’s homes but are funded through the HACC program and aim to assist in helping people to remain living independently in their homes. These services include Planned Activity Groups, allied health services, community transport and maintenance grants to Senior Citizen Centres. For a comprehensive review of HACC service types and funding refer to the HACC Strategic Plan for the Western Metropolitan Region, 2000-2005 (National Ageing Research Institute 2001b).

A number of policy initiatives and the increasing population of older people have lead to increasing demands on HACC services. The introduction of ratios for residential aged care aimed to control the growth of costly residential services and replace residential care with community based care (Clare, DeBellis et al. 1997). However, it is argued that there has not been the commensurate increase in community based services required to replace residential care places (Clare, DeBellis et al. 1997). The reduction in length of stays within the acute setting has also impacted on demands for HACC services.

The demand for HACC services in the WMR was demonstrated in the report “The Analysis of demand for local government in-home HACC services in the Western Metropolitan Region” (NARI, 2001). The need to prioritise access to HACC services by eligible HACC clients occurs when demand exceeds supply. The HACC Demand report and the MAVs Status Report on the HACC Program (Howe 2000) have illustrated the need for addressing issues of prioritisation and demand monitoring in HACC generally as well as in the WMR.

To address these issues the National Ageing Research Institute (NARI) received a HACC Development grant from the WMR Department of Human Services (DHS) to undertake a six-month project in 2002. The project aimed to examine the feasibility of introducing a

consistent approach to prioritising access to and monitoring demand for WMR Local Government HACC services. The project is referred to throughout the report as the POA (Priority of Access) Project.

## 1.1 Policy Context

A number of recent initiatives within the HACC Program relate to defining priority and identifying needs and therefore have relevance to the present study.

### *1.1.1 HACC dependency data items*

The Commonwealth Department of Health and Aged Care commissioned a consultancy in 2000 (*Dependency Data Items project*) by the Centre for Health Services Development. The aim of this consultancy was to identify an appropriate tool for the measurement of dependency levels that can meet the needs of the HACC program. Inclusion of standard dependency data items, in the HACC Minimum Data Set (MDS) will provide the empirical data required to aggregate HACC clients into care classifications linked with data on types and levels of assistance available to them. Other purposes of having a dependency data set for HACC were identified in the stage 1 report:

- Assist consumers receive services that are appropriate to their needs;
- Assist providers to systematically assess the needs of individual consumers and provide services appropriate to those needs;
- Assist managers and planners to evaluate the appropriateness and success of the program. Aggregated dependency data will inform the development of effective planning strategies and funding mechanisms of HACC services, including the increasing use of funding linked to individuals and different consumer type".

(Eagar, Owen et al. 2001 p3)

The first stage of the project reviewed the literature and considered whether any tools in current use were suitable for administration to the HACC target population by HACC assessors. If no appropriate tools were identified new tools were developed. These tools were then piloted during stage 2 to examine the potential barriers to adopting these tools into current practice. The report recommended a two-tier approach to identifying dependency. The first tier is a screen designed to determine whether there is a need for a more comprehensive assessment. Someone screened as being of medium or high need would receive the more thorough functional assessment.

As no appropriate screening tool was identified, a two-page screen was developed and tested. The screen could identify the need for any combination of four assessments covering four domains of functional dependency. The domains and the assessment tool(s) recommended to assess each domain included:

- Domestic (instrumental) function – Barthel Index or the Functional Independence Measure (FIM), the Barthel was the preferred option with FIM scores mapped to the Barthel;

- Self Care (motor) function – modified version of Lawton’s IADL measure;
- Cognitive function – Mini-Mental State Examination (MMSE) only to be used where assessors are trained in its use;
- Challenging Behaviour – modified version of the Australian Resident Classification Scale (RCS) suitable for people living in the community.

Although these tools aim to capture what a person is capable of doing and include external factors such as the physical environment, they are not intended to measure the level of assistance required from a service. Level of assistance is not assessed as the availability of a carer to provide assistance is not taken into account. It was suggested that “the technical properties (particularly reliability) of instruments that capture only functional ability are generally better than those that capture carer burden or service need. Both carer burden and service needs...are influenced by the subjective judgements of raters” (Eagar, Owen et al. 2001 p5).

### *1.1.2 Primary Care Partnerships: Service Coordination Tools*

Primary Care Partnerships (PCPs) are voluntary alliances of primary care providers usually within two or three Local Government Areas. HACC services are only one of the many service types that are involved in PCPs. Some others include; community health, General Practice, aged care assessment teams, psychiatric disability support and dental health. The Better Access to Services (BATS) is a key undertaking of the Victorian PCP Strategy and aims to “ensure that consumers’ and their carers’ needs are met in a timely, cohesive and consistent way” (Department of Human Services 2000 p1).

#### **Initiatives at the State Level**

In 2001 a consortium of organisations, lead by the Australian Institute for Primary Care at Latrobe University, were contracted by DHS to develop Initial Needs Identification and Care Planning tools for use by agencies and practitioners involved in PCPs. The Centre for Health Services Development, which developed the national measure of functional dependency for HACC services in Australia, was also involved in this PCP work. Through a review of literature and consultations with PCPs, key stakeholders and consumers, a suite of tools were developed, piloted and evaluated. An evaluation report was completed in February 2002 and the tools and guidelines were subsequently revised.

Table 1 outlines the two-tiered screening and assessment model that is consistent with the model proposed in the HACC dependency items project. The INI project focussed on the first tier of this model and also developed the service coordination plan for consumers with multiple and complex needs. The tools developed for the INI project are numbered 1-4 in Table 1.

**Table 1: Tiered Screening and Assessment Model**

<i>Activity</i>	<i>Depth</i>	<i>Scope</i>	<i>Used for referral processes?</i>
<b>INI</b>			
Consumer Information <sup>1</sup>	Shallow	Narrow	Yes
Summary and Referral Information <sup>2</sup>	Shallow	Narrow	Yes
Supplementary Profiles <sup>3</sup>	Shallow	Broad	Yes, where relevant
<b>Assessment</b>			
Service Specific	Deep	Narrow	No
Specialist	Deep	Narrow	No
Comprehensive	Deep	Broad	Yes, where relevant
Care Plan	Deep	Narrow	No
<b>Service Coordination Plan<sup>4</sup></b>	<b>Deep</b>	<b>Broad</b>	<b>Yes, where relevant</b>

Source: Primary Care Partnerships: Better Access to Services (2002) Guideline 1: Completing Consumer Information as the first step in Initial Needs Identification.

The **consumer information** is a two-page form with demographic information and contact details. It has categories consistent with the HACC MDS. The evaluation found general support for the implementation of the Consumer Information for all consumers.

The **Summary and Referral Information** is a two page document with description for the reason for referral, current services in place and the agencies to which the referral is going, with checkboxes to ensure consumer consent has been obtained. The evaluation report recommended that this form be utilised for referrals between PCP agencies.

The **service coordination plan** was designed for use with consumers with both multi-agency involvement and complex needs. The main focus of the coordination plan is the identification of issues, goals, actions to be taken, responsible services and for specifying timelines for achieving goals and reviewing outcomes. The evaluation found that there was some uncertainty about the introduction of the service coordination plan. This was related to the early stages that PCP agencies are at in relation to the development of processes, practices, and protocols for service coordination between agencies. The evaluation stated that the service coordination plan should be recommended (but not required) and that acceptance may increase as service coordination between PCP agencies develops.

The **supplementary profiles** can be used at the assessor's discretion. They include; *Living Arrangements Profile; Health Conditions Profile; Psycho-Social Profile; Functional Screen; and Health Behaviours Profile*. The evaluation found that there was a general reluctance to use the supplementary profiles. The evaluation recommended that agencies can choose to use them to complement professional judgement in determining initial needs and making referrals. There were *"serious doubts that a practical, valid and reliable system of identifying needs across a structured set of content domains can be universally applied across all agencies, services and consumers in PCPs"* (p 48, Australian Institute for Primary Care, 2002). This concern may not apply across the HACC service system as demonstrated by the recommendation specific for HACC services that the *Living Arrangements* and *Functional*

*Screen* be used routinely during initial needs identification. The *Living Arrangements Profile* contains information already included in the MDS and the *Functional Screen* was the one developed for HACC services as described in the previous section.

These tools currently **do not attempt** to determine relative priority of access to HACC services. There is space on page 2 of the *Consumer Information* template for "Notes, including alerts and comments on risks, urgency and access issues". The guidelines accompanying the template provide a number of examples for considering risk and also discuss urgency in relation to other consumers who require the same service. "*The use of urgency and priority descriptions should be based on the practices, protocols and processes adopted by agencies and PCPs*" (Australian Institute for Primary Care and Centre for Health Service Development 2002, p12). The use of the following set of codes is suggested:

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

### **Initiatives in the WMR**

In the Western Metropolitan Region, the three PCPs have developed a cross alliance and are currently working on goals outlined in the "Western Region PCPs Cross Alliance Whole of Region Service Coordination Plan, 2<sup>nd</sup> January – 30<sup>th</sup> September 2002". These goals were:

1. Development of a WMR Quality Practices and Continuous Improvement Framework for Service Coordination that encompasses agreed & shared best Practice, Process, Protocol and Systems (PPPS) for Initial Contact (IC), Initial Needs Identification (INI), and Care Planning (CP).
2. Improved community (consumers and providers) access to information about services available, support and referral by development of an electronic Comprehensive Services Information Facility.

After completion of projects associated with goals 1 and 2, Stage 2/goal 3 would field test and further develop the evolving PPPS for IC, INI and CP with specific cohort groups (carers, Culturally and Linguistically Diverse groups and adults discharged to community settings from acute mental health settings). It is anticipated that these projects will run from June through to December 2002.

One of the first objectives of goal 1 is to consolidate the three PCP service models developed to date. Work in progress shows that the three models reflect the DHS BATS framework with six operational service coordination elements:

- Initial Contact (IC);
- Initial Needs Identification (INI);
- Comprehensive Assessment;
- Service Specific Assessment;
- Specialist Assessment; and

- Care Planning (CP).

The INI includes the “Identification of eligibility, priority and risk” indicating that priority of access is to be determined in the INI phase rather than during a more in-depth assessment. The consolidation of the 3 WMR PCP models will involve developing a common framework of fundamental principles, definitions, goals, objectives and principles underpinning each service coordination element and preliminary competencies for each service coordination element. Complementary to this work, a project to develop and implement agreed and shared best Practice, Process, Protocol and Systems (PPPS) for INI will be conducted. This work aims to promote effective implementation of the INI developed at the State level as described in the previous section. These processes, however, do not prescribe how individual agencies will determine priority of access to their services. The feasibility of achieving a consistent approach to determining needs and priority across the broad range of services involved in PCPs is doubtful. The current Priority of Access project aims to meet this gap for WMR Local Government HACC services.

## 1.2 Current Practice for determining priority in the WMR

“The Analysis of demand for local government in-home HACC services in the Western Metropolitan Region” (NARI, 2001) explored the various assessment approaches used by WMR Local Government HACC services. To ensure this information was not outdated, Working Group members were asked to notify the consultants of any changes in assessment practices. One of the main changes were that some LGAs were now using the INI suite of tools. However, these tools were generally being completed in addition to previous priority setting processes. The other major change was that two LGAs were using a different approach to that reported in the previous report. The three approaches originally identified, however, were still being used across the region and included:

- Descriptive approaches to determine high/medium/low needs;
- Broad guidelines with clinical judgement;
- Score based approaches.

The descriptive approach defines areas of need for the target group/s as identified in a set of guidelines. A typical profile of clients in each of the priority categories is described, paying attention to key areas of need. Feedback from assessors suggested satisfaction with the approach and acceptance that not everyone will “fit” into categories.

One LGA relied on broad guidelines with clinical judgement. This Council’s targeting policy states that each client will be assessed in accordance with level of dependency and outcomes expected. Each level of dependency will have upper level time limits / service limits. In this way, targeting occurs according to both need and outcome expected. For clients receiving two or more services, the benefits of additional services should be considered to determine whether they will make a difference.

Score based approaches to assessment involved the use of an assessment tool containing a number of items covering areas that have previously been identified as important. Clients

are rated (on a 3 or 5 point scale) according to their level of need or risk in each area. An overall score is obtained by summing the scores for each individual item. The scores obtained can then be classified as falling into several broad categories, for example high, medium and low priority. To demonstrate the consistency of score based tools used in the WMR a fictional case study was developed by project staff. The case study was specifically developed to draw on the differences in each tool and found that while two tools resulted in a 'medium' priority allocation the other tool resulted in a 'high' priority allocation. The aim of this exercise was to demonstrate that one person could have a different level of priority allocated in different LGAs in the WMR. This demonstrates the importance of having a consistent approach to determining priority.

In the previous project the score based approach was reported by four LGAs. During this project, however, two of these four LGAs reported that they now used the descriptive approach. One of these LGAs was able to provide services to all potential clients and therefore, did not find it vital to have a clear process for determining priority.

For further details please refer to the "The Analysis of demand for local government in-home HACC services in the Western Metropolitan Region" (NARI, 2001).

### 1.3 This Project

Priority of access relates to determining who, amongst those eligible for and requesting HACC services, require HACC services more urgently than others within the HACC target population. Determining priority is primarily concerned with determining urgency. It is important in ensuring equity of access to HACC services in the WMR to have a tool that can be consistently applied by Local Governments.

It is essential that the development of a process for determining priority is considered in accordance with developments at the Commonwealth and State level (HACC dependency items- and PCP Initial Needs Identification –respectively). The development of these tools and the introduction of a Minimum Data Set for HACC services emphasise the policy shift towards introducing consistent methods for determining need, relative priority and resource allocation. The introduction of data dependency items, the Initial Needs Identification templates, and PCP Practice, Process, Protocol and Systems through the WMR Service Coordination projects, means that LGAs will be at a critical period of practice change in relation to assessment and referral in the later half of 2002. It is envisaged that the INI will be utilised across PCP agencies by mid 2003. Current tools being utilised in the WMR may overlap considerably with new INI tools and lead to duplication of assessment questions. It would be constructive to introduce a consistent method for determining priority that can be applied across all WMR Local Government HACC services during this critical period of practice change. The method for determining priority developed in this project builds on the refined approaches currently used within each WMR Local Government service.

This project focused on producing practical strategies that could be implemented by WMR Local Government HACC services to assist in demand monitoring and service prioritisation. A working group of key stakeholders was established to guide the project. Using a participative

and developmental approach, NARI worked with WMR Local Government HACC providers to explore the issues and possibilities for monitoring demand and standardising prioritisation processes. It was identified that working directly with the Local Government service providers and DHS was vital for reaching consensus on strategies and developing a sustainable approach to determining priority and monitoring demand. Links with local PCP alliances and relevant others has ensured that project objectives and outcomes were achieved within the context of broader service system directions.

### *1.3.1 Project Objectives*

- Consider the processes and tools for monitoring demand and prioritising access to WMR Local Government HACC services
- Examine the appropriateness and feasibility of standardising prioritisation tools and processes across WMR Local Government HACC services
- Develop a set of agreed criteria for use by WMR Local Government HACC services to monitor demand and unmet need
- Develop a strategy for implementation by WMR Local Government HACC services of project outcomes.

### *1.3.2 Anticipated Project Outcomes*

- Standardised criteria to be used consistently by all Local Governments in the WMR for prioritising access to HACC services by HACC eligible clients;
- Consistent demand monitoring by WMR Local Government HACC services to inform service management and planning;
- A strategy for implementation by WMR LGA HACC services, which would have the potential for wider application.

### *1.3.3 Project Scope*

The priority of access process that has been developed is designed for Local Government HACC services within the Western Metropolitan Regions: Brimbank, Hobson's Bay, Maribyrnong, Melbourne, Melton, Moonee Valley and Wyndham. However, it is anticipated that the process will have wider application and may eventually be used by LGAs in other regions and perhaps by other agencies providing HACC services.

The process for determining priority of access will be able to be applied across Local Government HACC services including personal care, home care, respite care, planned activity groups, delivered meals, home maintenance and transport. In some LGAs, however, some of these services may be provided upon request without a formal assessment or determination of a priority level. For example, home maintenance, which is generally a once-off or occasional service may automatically be provided upon request to people eligible for HACC services.

The criteria for managing demand, however, is concerned with access for all Local Government HACC services.

This report details the processes and outcomes of the POA project. Chapter 2 considers the methods used to achieve the project objectives. Chapter 3 considers the literature and current practice that informed the development of two draft POA tools. The fourth chapter reports the process used to decide on one of the draft tools and refine it through consultation with the seven Local Governments, DHS and NARI staff and through a pilot in three of the Local Governments. The fifth chapter meets the 3<sup>rd</sup> objective relating to the development of a set of agreed criteria for use by WMR Local Government HACC services for monitoring demand and unmet need. Chapter 6 outlines recommendations for WMR LG HACC services and DHS to implement the priority of access tool and demand management criteria developed through the POA project.

## Chapter 2: Methodology

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This chapter describes the methods and steps undertaken in order to achieve the objectives specified in Chapter 1. The methods utilised included a literature review; consultation with key stake-holders; data collection and analysis; pilot testing of a priority of access tool; survey of pilot testing sites and non-pilot sites and focus groups.

The sources of information used for developing the priority of access tool reflect the sources used in a Melbourne project that developed a risk screening tool for post acute discharge. In this project the risk screening tool was developed based on:

- A review of literature (focusing on evidence of what factors are likely to predict the need for services;
- Analysis of existing practice (drawing on the wealth of expertise of service providers and the work undertaken through years of refining the tools used currently);
- Expert advice.

(Thomas and Associates 1998)

The initial steps undertaken included developing a workplan and timetable as well as establishing a Working Party comprising membership from each of the seven WMR LGA's and the WMR DHS. An initial Working Party meeting was held to introduce the aims and objectives of the project to the Working Party and to discuss their role throughout the project. At this meeting, the Working Party provided crucial information related to the design, purpose and veracity of a priority of access tool.

Following the initial Working Party meeting a literature review was undertaken to examine factors associated with use of HACC services and current processes used for determining priority of access and eligibility for HACC related services. The review also considered literature about defining and assessing needs. Government documents about HACC policy, the development of dependency data items and PCP Service Coordination tools also were examined to provide context to the current project. Contact was also made with the consultant managing the PCP Service Coordination projects being undertaken in the WMR. This was to ensure that this project was complementing and not duplicating other work being conducted in the region. This literature review formed the basis for a Discussion Paper that was distributed to the Working Party for discussion at the next Working Party meeting.

Using the information obtained through the literature review, reviewing the current tools used within the WMR and also through information obtained in Working Party meetings, two POA tool options were developed for discussion. These two options were discussed within NARI with a group of staff who had experience developing and evaluating measurement tools or who had a good knowledge of HACC services. Their feedback was incorporated and two refined options were presented at the third Working Party meeting. At this meeting consensus was reached on which tool should be further refined and pilot tested. The tool

chosen was modified again based on feedback from these two meetings and was then used for a small pilot test.

The tool chosen required information that was obtained from the INI to be cross-referenced and completed on a one-page, double-sided POA form. It was essential, therefore, that those piloting the POA tool were already routinely completing the INI tools during assessments. Melbourne, Moonee Valley and Brimbank were the three LGAs who had already commenced using the INI and all agreed to participate in the pilot. Due to the short time frames of the project, there was only a brief period in which the pilot could be conducted. Moonee Valley was able to conduct the pilot over four weeks while Melbourne and Brimbank were able to pilot it for two weeks. Prior to the pilot a project member visited each site and met with assessment staff to provide instructions on how to complete the tool, answer any questions and discuss any potential difficulties. The meetings proved beneficial for both assessment staff and project staff in understanding the tool and some of the practical implications of using the tool in the field. Assessment staff were requested to complete the tool for all assessments and reviews of potential and existing clients.

At this meeting assessment staff were provided with a two-part survey. Part 1 was a running sheet to record the time taken to complete each assessment and to record whether the POA tool resulted in a high, medium or low priority allocation for each potential client. Assessors were also asked to indicate the priority level based on their clinical judgement. If assessment staff had time they were also requested to complete their own agency's POA tool, if there was one available, and to also record the priority level from this.

The second part of the survey was to be completed after the pilot was completed. This asked about the merits and limitations of the tools and suggestions for improving the POA tool. The survey also asked assessment staff to indicate their experience and qualifications related to assessing for HACC services.

A revised version of part 2 of this survey, along with the pilot POA tool and the INI suite of tools, was also sent to the non-pilot LGAs. This enabled staff from these LGAs to review the POA tool and provide their feedback and suggestions for improvement. Seventeen assessment and management staff completed surveys from these four LGAs with at least one survey returned from each of these LGAs. This indicates that feedback on the pilot tool was obtained from all seven LGAs in the WMR. However, given that the staff from the non-pilot LGAs have had no training in use of the POA tool and are not routinely completing the INI tools, their understanding of the POA tool may be limited.

After completion of the pilot period, project members revisited each of the three pilot sites and met with assessment staff. These focus groups provided an opportunity for project officers to listen to feedback on the tool. This method had the advantage over the survey method in that it allowed project staff to expand and clarify issues raised and to discuss feedback obtained from other LGAs on surveys and in focus groups. The focus groups took approximately an hour to complete.

Nine staff participated in the three focus groups and eight of these returned the survey and copies of anonymous POA forms that had been completed during the pilot. Information from Part 1 of the survey was obtained on 65 completed tools and copies of 51 tools were obtained.

Survey and focus group feedback was analysed and is presented in Chapter 4. This feedback was used for further refining the POA tool and also informed development of the guidelines for the POA tool (See Appendix 4 for the refined POA tool and guidelines for use).

The objectives of the project also required that a set of criteria be developed for using the POA tool for managing demand. LGAs were asked to provide details on the information they currently collected on people who were referred for HACC services but were not able to access the service(s) requested. Only two LGAs indicated that they maintained a waiting list and they provided either the outline of the file or the list of criteria that they record. This was reviewed and a set of criteria was developed that would enable LGAs to use information from the POA tool to record unmet demand and to be able to review the status of people waiting for a service. This work is described in Chapter 5.

The final process was to develop a set of recommendations and a plan for implementing the POA tool and demand management criteria. These are presented in Chapter 6.

# Chapter 3: Developing a tool for determining priority

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This chapter explores the rationale for developing an approach to determining priority of access and reports on the findings from a literature review and review of current practice that were drawn upon to develop two POA tool options.

## 3.1 Why determine priority?

With financial constraints on HACC services, Local Government HACC agencies may not be able to provide services to everyone who requests them. Eligibility criteria for HACC services are defined as “frail aged and other people with a disability, and their carers” (Department of Human Services 1998). This broad definition does not enable agencies to determine who, within the eligible target population, should have first access to available services. The HACC Act (1985) states “within available resources, priority is directed to persons within the target population most in need of home and community care (cited in Guidelines for the HACC program, National Service Standards, 1992). These definitions indicate that priority is a relative term judged in relation to others trying to access HACC services. How is it determined who is “most in need”? To explore this issue the following section examines the notion of need, how it is defined and more importantly, who defines it.

## 3.2 Defining Need

As previously indicated the aim of allocating priority is trying to determine who (amongst those eligible) is most in need of HACC services. To answer this question it is important to examine the concept of need. This section raises some of the issues and difficulties in trying to define and measure need.

One definition of need is “a value judgement that some group has a problem that can be solved” (McKillip 1987). This definition acknowledges that need relies on a value judgement and thus will vary depending on who is making the judgement. McKillop (1987) elaborates that there are four types of need. Normative needs are determined by expert definition of adequate levels of performance of service. Felt needs are expectations that members of a group have of their own outcomes. Expressed needs are evidenced through use and demand for services. Finally, comparative needs are based on expectations on performance of a group other than the target population. Using any of these approaches for determining need has strengths and weaknesses. For example, normative need can be perceived as elitist. These different types of need reflect that needs can be judged from two perspectives; from the perspective of an ‘expert’ or professional within the field, or from the perspective of the person or group in need.

Dill (1993) argues that social services have developed in a context of bureaucracy and professionalism. The bureaucratic context has promoted the importance of rational decision making, universalistic criteria, objective measures, predictability and fairness in decision

making. This has the potential for rigidity. Professionalism has a clear role in domains such as medicine where there is a clear problem (disease) and a solution that relies on the expertise of a professional. In social services the role is less obvious. Dill goes on to argue that "the development of technically oriented need assessment constituted one means through which social service systems created operations, structures, and service goals defined in terms of professional expertise" (p 456). The definition of need is goal oriented—there is a problem and it can be fixed by social support services. This definition fails to acknowledge that the quality of the interaction between the service and the individual can be a primary objective of the service. The author recommends that the definition of need be based on the perspective of the individual, their family and other informal contacts. It is also recommended that tools be developed across a number of organisations to reduce the impact of staff-driven motives and cultures operating within individual organisations.

Mooney (1997) criticises the focus on diseases and problems when determining priority and need. When setting priorities it is important to determine how, with available resources, beneficial effects can be increased. Beneficial effects could include improving survival, quality of life, reassurance, respect for autonomy, and dignity. Need should be considered as 'capacity to benefit' rather than problem oriented (Mooney, Irwig et al. 1997).

Literature that examines assessment processes and identifying needs from social and health services' perspectives emphasise the importance of listening to peoples' stories about their life and helping people to express and identify their own needs (Bloom 1983; Dill 1993; Branch 2000; Fleming and McSparran 2001; Tanner 2001). Fleming recommends that professionals need to "let go" and embrace users definitions and solutions (2001).

The above discussion raises two difficulties in determining relative priority based on determining need. The first is that needs should be defined from the client's point of view of what is important to them. Therefore, needs vary according to life experience and the individual's perception of what they need and value. Thus, it is not practical to develop a formula to determine needs based on a set of characteristics that may not be important or relevant for clients. The second difficulty is that discussion on defining needs generally focuses on gaps that HACC services can meet and what people are not capable of doing. This fails to acknowledge the positive aspects of people's strengths and capabilities. These two difficulties highlight that assessment goes beyond determining priority to also consider in-depth the individual's perception of their needs and goals and to explore their strengths and abilities, i.e. what they are capable of doing. The assessment would, therefore, focus on developing a careplan that reflects the consumer's point of view, life experiences and personal identity.

### 3.3 Identifying Indicators of Need

A process for determining priority of access, therefore, does not aim to identify needs, per se, but aims to find a standardised method that can be consistently applied to all potential clients for identifying relative priority. This can be achieved by relying on a set of characteristics that tend to increase or impact on the need for services. The following section explores the evidence on which characteristics are likely to impact on need. Throughout this

report these characteristics are referred to as 'indicators of need' recognising that while they may not be the most important factors for all individuals, they are likely to have a strong influence on people's ability to remain living independently at home. First, the research literature is examined in relation to factors that predict use of services. As the research evidence is limited, current practice is also drawn on to examine indicators that are commonly used for determining priority. It is recognised that this approach is limited as it relies on the 'expert' definition of need and not the potential client's definition. However, as stated previously, determining these needs is the realm of the whole current assessment approach, and beyond the scope of determining priority.

### *3.3.1 Drawing on evidence from research*

A review of literature on community support services found that research in this area focused on predictors of community service use. Some studies, for instance, examined characteristics of a sample of older people and compared differences between those who used services and those who didn't. Some of the variables investigated included age, gender, physical health, living arrangements, and function. Although these studies provide some indication of the characteristics involved, it does not consider which characteristics are indicators of those with greater needs or most likely to benefit from accessing HACC services. Many of the characteristics are also strongly interrelated making it difficult to determine whether one particular characteristic is more influential than another.

In 1995, Michael Fine and Cathy Thomson completed a comprehensive literature review of research literature published since 1985 on the outcomes and effectiveness of community support services for people eligible for HACC services (1995). They identified numerous international studies that considered predictors of service use. Age, poor reported health, difficulty performing domestic ADLs, higher level of ADL dependency, living alone, having foot problems and having higher income were all found to predict home care and social service use in studies in the US and UK. One study found that unstable medical conditions, cognitive and behavioural problems and the absence of social support (especially as evidenced by those living alone) were all associated with institutionalisation. This study found that those on lower incomes were at greater risk of institutionalisation but less likely to use formal in-home supports than those on higher incomes (Coughlin et al, 1992 as cited in Fine, 1995). The influence of informal support appears to prevent the need for formal home care supports, with people living alone accessing services at a lower level of disability than those living with others. The provision of formal services does not replace the need for informal supports but rather helps carers to continue their caregiving role (Fine and Thomson 1995).

Another study considered the hours of care received by formal and informal carers in a sample of people trying to access services in the US (Kemper 1992). Kemper found, consistent with the studies cited above, that the amount of formal and informal care increased with increased disability and that the use of formal services increased and informal services decreased with higher income.

A Victorian study reported that formal services were used when informal supports were unavailable or when a crisis was reached. Despite evidence of the negative impacts on providing care, it was found that very few carers used community services (Nankervis, Schofield et al. 1997).

The finding that those with higher incomes are more likely to access formal services may reflect service systems in the US and may not occur in the Australian context. It does, however, indicate that factors other than health and disability impact on service use. This is supported by the Anderson framework for determinants of medical care utilisation that was developed in the US. This model is commonly referred to in the research in community services (Fine and Thomson 1995; Kosloski, Montgomery et al. 1999; Wang, Mitchell et al. 1999). This model defines three types of factors that predict service utilisation;

- predisposing factors such as age, education and ethnicity;
- enabling factors that facilitate use such as financial status, insurance cover and transportation; and
- need factors including ADL disability and health status.

Therefore, the finding that those with higher incomes are more likely to access formal services suggests that financial status is an enabling factor. One criticism of this model is that it fails to consider the availability of services, a clear determining factor in service utilisation (Fine and Thomson 1995).

More recently, a population-based study based in Sydney found that walking disability was clearly the strongest predictor of service use in a population based sample of older people, followed by visual impairment, living alone and stroke history (Wang, Mitchell et al. 1999). Other factors that were associated with service use included age, female gender, arthritis history, any falls in the last year, cancer history and low perceived health status. Although walking disability was the strongest predictor for men and women, there were some differences between males and females in other factors that predicted service use. For example, visual impairment, arthritis history, any falls in the last year and cancer history were significant predictors for women but not men. Diabetes was a significant predictor for men but not women (Wang, Mitchell et al. 1999).

This study however, highlights that investigation of predictors is limited to the range of characteristics that researchers have chosen to examine. Perhaps there are other key influences that are not considered. Wang et al's study (1999) does not account for cognitive impairment, and the measurement of domestic and self-care ADLs is limited to 'walking disability'. Although walking disability was found to be the strongest predictor it may not be the ability to walk that is most influential but the broader ability to complete domestic and self-care ADLs.

Predictors of service use in the literature, therefore, are not solely reflections of need but a combination of Anderson's predisposing, enabling, and need factors together with availability of services and characteristics considered worthy of examination by service providers and

researchers. Related to the availability of services is the impact of existing practices of priority setting. Comparing those who use services with those who don't may simply reflect how service providers decide who to provide services to within a context of limited resources. Although service providers may aim to provide services on the basis of relative need there has been limited evaluation to determine whether this has been achieved or to determine whether those who access services are the ones that would benefit the most.

### 3.3.2 Drawing on Current Practice in the WMR

To examine the indicators that have been deemed important by WMR Local Government HACC services, Table 2 summarises the indicators that they currently use to determine priority. Please note that some indicators are quite related but may have subtle differences due to different application by different LGAs. For example, isolation was sometimes described in relation to living arrangements and the availability of a carer, while others described it in relation to social contacts and ability to access transport, shops and other services.

**Table 2: Indicators of Need identified on WMR POA tools/guidelines**

Indicator	Description of application by WMR
Isolation	Isolation is consistently applied by WMR LGAs. A high priority client would tend to have few informal supports. Although living alone with no carer was considered a characteristic of a high priority client, a person could co-reside with a carer who also had limited outside supports/ unable to provide support and be considered a 'high' priority.
Carer Issues	Issues related to the carer's ability to maintain their caring roles are important in determining priority of access for WMR LGAs. While carer burden is generally associated with high priority, there is some variation in the terminology used. For example: "carer not coping", 'unable to meet caree's needs or carer 'is either unable to provide the level of assistance required and/or require time to participate in social, family and community activities. This issue is often considered alongside social isolation and living alone. For instance, living alone/isolated <u>or</u> has a carer not coping is indicative of a high priority. On 2 of the score based tools a separate question relates to the household's ability to cope.
Supports required / available	This appears highly interconnected with carer issues but is sometimes considered separately, e.g. in relation to formal supports and the ability of other agencies to meet needs. This is not consistent across LGAs. It appears that some only consider the ability of informal supports to provide care while others consider the need for additional support in the context of current provision of support from informal and formal supports.
Physical capacity	Is addressed by all LGAs. There is no consistent application. Some consider physical health separately from ability to perform Activities of Daily Living, while others link the two, e.g. one scoring method gives a high score for " <i>frailty/debility- medically unstable, mostly dependent, requires significant support to perform essential ADLs</i> ". " <i>High level of frailty or disability</i> " is another description of physical capacity.
Mobility	Generally overlaps with "physical capacity" above, however, 3 LGAs have a question with a 5 category response list ranging from ambulant/ independent with no aids through to bedridden

Indicator	Description of application by WMR
Sensory capacities	Two LGAs ask about sensory loss on a 5 point scale, another asks about sensory loss in relation to safety.
Cognitive and emotional capacities/ perceived memory function	Cognition considered but not always specified. Some consider cognition on its own, others relate it to function, one considers its impact on accepting help. Some LGAs ask about mental health either separately or in conjunction with cognition.
Communication /Impact of Cultural background	Not all LGAs explicitly consider communication. LGAs that consider it apply it differently. On 2 score based tools potential client's are ranked on a 5-point scale from 'able to communicate effectively' to 'not able to communicate needs'. One LGA considers communication under risk factors. Another LGA considers the impact of cultural background on capacity to organise appropriate help. Apart from this one LGA, most LGAs do not explicitly factor cultural background into priority of access.
Physical environment	The 4 score based tools considered the physical environment with slightly different focus: accessibility/safety/risk/sub-standard housing/health and safety issues
Risk abuse / neglect	Usually identified but inconsistently applied by LGAs. More explicit on score based tools. Some of the factors considered include: neglect; abuse by self or others, physical/emotional/financial or sexual abuse, threat to safety, confusion/dementia, inability to verbally communicate.
Household income / financial situation	Three LGAs specify finances in determining priority. One considers "financially disadvantaged", another considers different income levels and the third ranks from " <i>independent means</i> " through to " <i>pension only</i> "
Willingness to accept current services / increased assistance	One LGA considers willingness to accept services where willing to accept services results in a lower score (i.e. lower priority) and refusing services results in a higher score (i.e. higher priority).
Commitment to stay at home	Not explicitly considered by most LGAs- one measures on 3 point scale from 'considering other options' (low priority) to 'very committed' (high priority).
Nutritional status	Most LGAs do not consider nutritional status explicitly. One rates it on a 3-point scale from adequate and independent to unable to maintain adequate nutrition independently. Another considers the consumer's ability to prepare meals.

### 3.3.3 Drawing on current practice outside the WMR

The following section reports a number of priority and assessment instruments used for social, health and related services. They outline a variety of indicators of need and highlight some of the various approaches used for determining priority of access to services.

In 1999, the DHS commissioned NARI to develop guidelines for determining priority of client need for VICPACs (1999), now referred to as Personal Alert Victoria (PAV). It was recognised in the report that there was limited evidence to suggest who would benefit most from having a personal alarm. Guidelines, therefore, were developed by exploration of evidence on

reasons for emergency call-outs for current clients using personal alarms in Victoria. The data indicated that the majority of calls from personal alarms were as a result of a fall. To determine guidelines for priority, therefore, research evidence on risk factors for falls were drawn on. The final tool developed considered four key priority indicators: medical and physical conditions, emergencies in the past 12 months, contact with others and psychological factors such as fear of falling. A number of secondary factors were also developed and included: age, gender, chronic conditions, weight, medications, neuromuscular performance, cognitive impairment, activities and environmental hazards.

A study by Nankervis was undertaken in Victoria on the understanding that few carers use community services unless a crisis occurs (1997). The study involved undertaking unsolicited comprehensive home based assessments for identifying needs and creating links with services. Sixty-seven randomly selected carer and caree dyads participated in assessments completed by an Aged Care Assessment Team member accompanied by one of the researchers. The assessment involved the Modified Barthel, PGC IADL Scale, MMSE, Abbreviated Canberra Interview for the Elderly and observation. These scales were used to determine a 4 point rating of impairment (nil, mild, moderate, severe) in 6 areas (intellectual, psychological, sensory, communication, mobility and long-term health). Severity of disability was measured using the mean score across the 6 impairment ratings. Then carer assistance was rated (none, some, most, all) for each ADL and IADL activity. Care recipients were more dependent on IADLs than ADLs. Ninety three percent of the dyads had unmet needs identified. The severity of disability and carer subjective burden were key pointers to unmet need. "This study highlights the complexity of determining service need over and above clinical factors" (Nankervis, Schofield et al. 1997 p. 199). The study also found that despite identification of unmet needs and referral to appropriate services, systemic issues (such as waiting lists, service fragmentation, affordability and appropriateness) will ultimately determine the outcome of comprehensive needs assessment (Nankervis, Schofield et al. 1997).

The Resident Assessment Instrument for Home Care (RAI-HC) is an assessment and problem identification system modified from the RAI which was developed for nursing home use in the US (Morris, Fries et al. 1997). Items in the RAI include items on cognition, vision, mood, behaviour, health and nutrition. The modified tool has additional items relevant for people living at home and includes social functioning, IADL, informal support, service utilisation and environmental assessment. Clinical professionals including nurses, social workers, therapists and physicians can use the RAI-HC. It can be completed within an hour. The RAI-HC has two components including a Minimum Data Set for Home Care (MDS-HC) and a set of items that form triggers for further assessment and careplanning. These triggers are referred to as "clinical assessment protocols" (CAPs). There are 30 CAPs in total. The MDS-HC was pilot tested across 5 countries, including Australia. Most items were found to be highly reliable. It is anticipated that the development of this tool will provide the basis for future development of outcome measures (Morris, Fries et al. 1997).

In Israel, in 1989 a policy of Long-Term Care Insurance was developed to provide home care services to the rapidly ageing population (Morginstin, Baich-Moray et al. 1992). This

insurance program operated in a manner more closely related to pension and social security benefits in Australia, where an assessment of eligibility lead to entitlement and provision of services. The main advantage of this system is that it provides a consistent approach to assessment whereby all citizens know what they are entitled to and that they will be able to access it if eligible. It is based on principles of universality, equity and personal entitlement. This system, however, required the introduction of a rigid tool for determining two levels of eligibility; a low level equating to 11 hours of services per week and a high level equating to 16 hours per week. The higher level constitutes approximately 27% of the cost of a nursing home bed. Service hours can be made up of a combination of personal home care, home help, adult day care, provision of absorbent undergarments, and personal alarm units, depending on the careplan developed. Services not included are; medical nursing, therapeutic, rehabilitation and social support services (Morginstin, Baich-Moray et al. 1992).

The first step in the assessment considers whether the client requires assistance from others for Activities of Daily Living, specifically considering mobility in the home, dressing, bathing, eating and continence control. A score between 0-8 is determined based on assistance required and an additional 2 points are added if the client lives alone. If the client requires constant presence of another to prevent harming self or surrounding they score an extra 6.5. This appears to reflect a measure of cognitive impairment or psychiatric illness. Clients are considered ineligible if their score is between 0-2, a low level if between 2.5-6.0 and a high level if 6.5 or higher. The author recommends that due to the large difference between a score of 2.5 and 6.0 that it may be appropriate to split the low level into two or three categories.

Of interest in this model is that availability of carers does not come into the equation. "This decision was based on a strong commitment to client equity, ensuring a basic level of care in all regions, and...to encourage and support families to continue to provide care...to move away from the model whereby services are provided only when the family network breaks down" (Morginstin, Baich-Moray et al. 1992 p3). Eligibility, therefore, relies primarily on ability to complete ADLs, living arrangements and a measure that appears to relate to cognitive impairment or psychiatric illness.

The EASYcare tool was developed in Northern Ireland for multi-practitioner use for assessing the health and social functioning of older people in community settings (McCormick 1999). The tool was piloted with district nurses, social services and occupational therapy and contains the following domains:

- Accommodation adequacy
- Loneliness
- Economic situation
- Self-rated health
- Vision
- Hearing
- Reading
- ADL

- IADL
- Mental functioning
- Carer's needs
- Elder's needs
- Goals
- Goals attainment
- Elder's satisfaction with care.

Some of the advantages of the tool identified were having a standardised assessment, having a measurable form of monitoring clients' health and social needs and using outcome scores. It was also quick, easy to complete, reduced duplication and was easier to assess cognition and depression. It also provided evidence of need and a basis for bidding for extra resources. Some of the disadvantages cited were that some of the questions were considered intrusive, it required additional administrative support, and was too in-depth for some clients with straightforward need for one service (McCormick 1999).

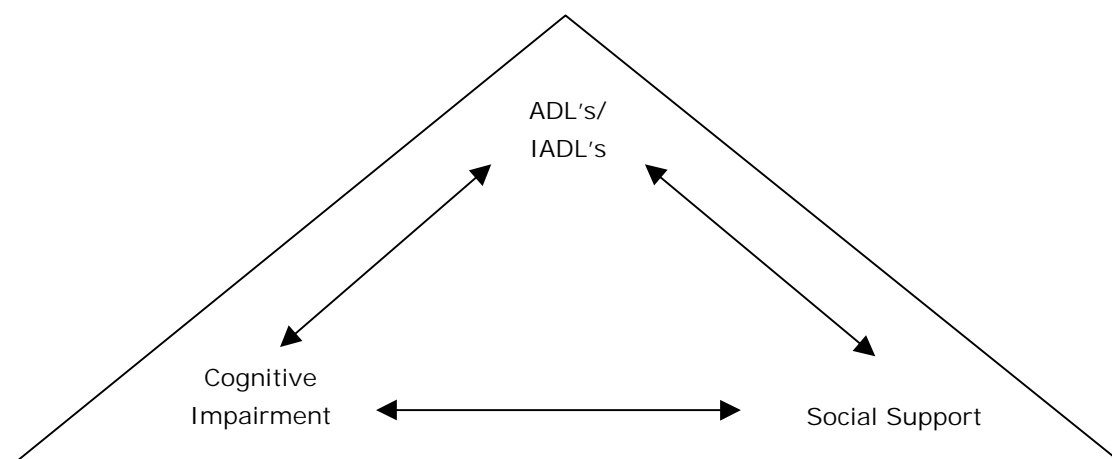
### 3.3.4 Summary of Indicators

This review of research literature and current practice indicates that three indicators appear to be central to predicting service use and determining eligibility and priority. These factors are:

- Activities of Daily Living – both domestic and self care ADLs;
- Cognitive Function; and
- Living arrangements (availability of a carer/living alone/isolation/carer issues).

Activities of Daily living relate closely with physical disability and mobility. Cognitive function is the second key factor and can impact on ability to complete ADLs and to remain living independently at home. The availability of social support and someone available to provide assistance mediates the need for assistance from formal services. The interaction of these three factors could be considered as the basis for determining need and priority and is illustrated in Figure 1.

**Figure 1: Elements for determining priority of access to HACC Services**



A number of other indicators were also identified in the previous review of research and current practice. These indicators include:

- Medical conditions/cancer/stroke/arthritis/diabetes;
- Recent previous falls;
- Poor self-reported health;
- Sensory impairments;
- Poor nutritional status;
- Foot problems;
- Hazards in the physical environment;
- Not willing to accept services;
- Not committed to staying at home;
- Communication difficulties;
- Risk of abuse/neglect; and
- Income/financial status.

These factors appear to be secondary when determining need for HACC services. For example, vision impairment can have very different impacts on wellbeing and independence for different people depending on numerous personal and environmental factors. Examining the ability to complete ADLs and the amount of social support, therefore, would provide a more useful indication of the need for services than the vision impairment on its own. Cognitive impairment is also important as it may reduce someone's ability to overcome specific restrictions that may occur as a result of vision impairment.

### 3.4 Why use a Tool?

This chapter indicates that the process for determining priority must be transparent to potential clients so they understand why they have or have not been able to gain access to services. It must also be able to be applied in a consistent manner so that all potential clients are prioritised in an equitable manner. Current practice indicates that measurement tools are commonly used within the WMR as well as throughout the world. The potential benefit of using a tool with clearly defined indicators is that it can take into account areas previously identified as important and can be based on more objective criteria than is possible when assessment decisions are based solely on clinical judgement.

Some of these points are described by Leutz (1993) who makes a number of recommendations in relation to community Long Term care services in the US. Some of these recommendations are relevant for HACC services in Australia:

Equity requires that applicants with the same types and severity of presenting problems be treated in the same way wherever and whenever they apply for benefits. Therefore the assessment system must be replicable, and each assessor must interpret the assessment items with high reliability. Efficiency requires that the assessment be simple (i.e. low cost to conduct and process) but without sacrificing effectiveness (i.e. it accurately measures functioning in relevant domains) (p 93).

The struggle of introducing measurement tools in a clinical setting and the advantages of a standardised approach is described in a report by Thomas and Associates (1998) on developing a risk screening tool for post acute discharge:

Some clinicians view measurement tools as an annoyance and in interference with their routine clinical practice whereas others find them to be an operationalisation of their current practice. However, the reason for developing tools is to ensure that the most accurate and standardised possible results are obtained for patients. There is substantial empirical evidence to suggest that different clinicians adopt quite different approaches to discharge decisions and to clinical decisions in general.

In other words, the particular outcome for a patient may be considerably impacted by the particular clinician with whom they happen to have dealt with if there is no shared systematic approach to making the decisions. Thus, in one setting versus another setting, or even in the same setting the patient may receive quite different services from different clinicians (p 13).

Assessors using measurement tools in the WMR reported that the system was a way of validating their assessment and increasing objectivity as much as possible. It also enabled the process to be transparent, helping potential clients understand why they have not been able to access services:

It's very useful because we don't have enough services to go round so you really need a system like that. It's a bit limiting ... each situation is unique. If we had the flexibility to ... give the services people need rather than trying to get them to fit. Sometimes there are unique situations where we extend services they need, in light of bad budget and not enough services to go round, it takes pressure off the assessment officer to have something that sets in place the criteria.

It makes it easier when you have to tell somebody that *'you are eligible – but you are not scoring very high which means that you may need to go on to a waiting list'*. It also makes it easier for us to take on those people who are really on high needs and be able to supply them with services.

I think the one (priority tool) we use now is really good... The new method is good and flexible. It covers the carers as well.

(Excerpts from National Ageing Research Institute, 2001a)

Developing a measurement tool requires consideration of the psychometric properties of reliability and validity. A reliable tool is able to produce a consistent result when completed by different assessors and on different occasions (if the client's situation has remained constant) (Eagar, Owen et al. 2001). Aspects of a tool that can improve reliability is having questions that are simple and unambiguous, a clear set of instructions and having assessors trained in the purpose of the question, how to interpret the question and how to record the answer (Leutz, Abrahams et al. 1993). Reliability also requires a fairly rigid approach to determining priority.

The validity of a tool refers to how well the tool measures what it is intended to measure (Eagar, Owen et al. 2001). Validity can be difficult to assess especially when there is no clear evidence on who benefits most from HACC services and who needs them more urgently. Therefore, available evidence on characteristics of users of HACC services and predictors of use of residential care provide an indication of what to assess. However, this is limited to only exploring the characteristics previously considered and researched by others. Perhaps there is some other factor which influences the need for HACC services and ability to maintain independence, for example, psychological qualities related to outlook on life or mental strategies for coping.

Sensitivity and specificity are also important and determine how well a tool discriminates different levels (Eagar, Owen et al. 2001). A tool where 90% of clients have a high priority rating has little use for a HACC service trying to determine who will access services first. A tool that is able to discriminate levels can have the disadvantage of having too much detail for some clients. For example, a client with low service needs may find a detailed measurement tool intrusive and unnecessary. This issue is difficult to overcome given that a POA tool needs to be applied consistently to ensure equity to all potential clients.

Another issue that needs to be considered is how to score a tool. One option is to add up different domains for a global rating. This has the limitation of not weighting indicators according to their importance and influence on need. This suggests that it may be appropriate to give some indicators greater weighting than others. However, as previously identified there is no strong evidence to suggest which indicators are the most important. Being able to nominate a numeric value to measure the extent that an indicator is more important than another is therefore not possible.

In summary, it is important that a process for determining priority of access is clearly articulated with a set of indicators that can be consistently applied. This will ensure that the priority allocation process is transparent to the client and equitably applied to all clients. A measurement tool is able to meet these requirements but must be examined in relation to reliability and validity. Although it is impossible to ensure that all indicators are interpreted and completed in an identical manner across all assessors, training can ensure that inconsistencies are minimised.

### 3.5 Additional requirements of a POA tool

To be successfully implemented by Local Government HACC services in the WMR and to consistently determine priority, it is important that the POA tool developed also:

- Has had input from WMR Local Government HACC providers;
- Has been agreed to by WMR Local Government HACC providers;
- Has been piloted to identify inconsistencies, problems and areas for improvement;
- Does not duplicate but complement the Initial Needs Identification tools being introduced in 2002-2003;
- Be clearly articulated and have well defined concepts to enable reliability across assessors;

- Be appropriate for the skill level of assessors working in WMR Local Government HACC services;
- Achieves a balance between being simple and easy to complete, yet comprehensive enough to effectively distinguish differing levels of priority; and
- Is accompanied by a set of guidelines.

### 3.6 Two POA tool options for further development

Based on the indicators of need identified in the review of research and current practice, two POA tool options were developed for discussion. The two options are included as Appendix 1.

During the development of these options, the Service Coordination tools (Initial Needs Identification tools-INI) were being introduced in the WMR with three of the four LGAs having commenced using the INI tools. This presented some advantages as well as disadvantages. The development of the INI tools involved a comprehensive analysis of the range of measures available that were tested and validated. For instance, measures such as the SF-36 have been validated and found to reliably predict future morbidity and mortality (Australian Institute for Primary Care and Centre for Health Service Development 2002). This provided a basis for developing a structured approach to determining priority. The second advantage was that LGAs were already in a process of practice change and having to review their assessment processes. Some of their assessment tools had questions that resembled those on the service coordination tools and duplication was apparent. It was possible that the POA tool could try to build on the INI tools by providing a framework for determining priority without needing to also complete existing assessment tools.

The limitation was that working party members reported that some of the indicators that were to be included on the proposed POA tool were not adequately assessed by the INI tools. In the second working party meeting, members requested the development of a list of indicators used by WMR Local Government and a description of how each of these indicators was addressed in the INI. The table produced is included as Appendix 2.

The first POA option developed used a similar structure as a number of tools currently used by Local Governments in the WMR. The tool has 14 indicators that are each assessed as high, medium or low based on information obtained for completing the INI. Then each of these indicators is allocated a score where a high scores 2, a medium scores 1 and a low scores zero. The scores for each of the 14 indicators are then calculated and an overall priority level is determined based on score ranges for high, medium and low.

Of the 14 items in this first option, 11 were currently used in the WMR by at least one LGA. Health behaviours, falls risk and psychological wellbeing were added as they were assessed on the INI and had evidence for inclusion based on other priority methods and predictors of service use.

The second Option was more directly related to the three core indicators identified in Figure 1: ADL function, cognitive function and social support. The tool followed a series of five

steps. The first step was to determine whether level of assistance required with ADLs (self care and domestic) was high, medium or low using the functional screen from the INI. The second step was to determine whether some cognitive impairment was present or not. These two factors (ADL and Cognition) were then cross-referenced in a matrix table to determine whether factors related to need were high, medium or low. The fourth step was to consider whether there was a carer and if there was, how well the carer was coping. High, medium or low social support was determined using the INI psychosocial profile's K-10 scale with the carer. 'High' indicated no carer available or that the carer was not coping well. The fifth step included another matrix where the combined ADL/Cognition level was cross-referenced with the social support level for an overall priority level.

The second option had the advantage of being straightforward and brief yet inclusive of the most important indicators of need. It was felt that other indicators such as sensory impairment, health status, nutritional status etc were important to the extent that they impacted on ability to physically and cognitively complete ADLs and on the carer's ability to cope with their caring role.

The two POAs options are included as Appendix 1. Chapter 4 reports the pilot testing and further development of the option chosen by the Working Party.

## Chapter 4. Refining the tool

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The two POA tool options developed and described in Chapter 3 were presented at two meetings described below. The second meeting was a Working Party meeting where the first tool option was chosen for further refinement and pilot testing. Feedback from the pilot test and from non-pilot LGAs is described in this chapter.

### 4.1 Feedback from NARI Round Table Discussion

A group of staff from NARI were invited to attend a meeting regarding the development of the POA Tool. Staff were invited based on previous experience of developing and evaluating measurement instruments and knowledge of HACC services. Prior to the meeting staff were provided a two-page summary about the project and what the tool aimed to achieve. The two tool options described in Chapter 3 (see Appendix 1) were presented at the meeting and then discussed.

Staff reported that the POA tool was concerned with factors that can be classified according to the International Classification of Functioning (ICF). In particular, the need for HACC services appears to reflect activity limitations and participation restrictions. According to the ICF activity limitations and participation restrictions have a unidirectional relationship with other factors including limitations of body structures and functions and of personal and environmental factors (World Health Organisation 1998). In this model an activity limitation may be a result of body impairment. However, not performing an activity may result in body impairment. It is not possible, therefore, to try to determine activity limitations and participation restrictions by simply considering body functions. The interactions of personal factors, such as coping styles, or environmental factors, such as social support or aids and appliances, also have a mediating impact on activity and participation. The ICF provides a classification system for each of these concepts except for personal factors. Even though these concepts are relevant to the need for HACC services, it is difficult to determine which combination of factors constitutes a high need for HACC services. It appears, however, that these concepts may underpin the indicators used in the two POA tool options.

Issues were also raised about the POA tool appearing to have to fit within the INI framework and suite of tools. Although this had the advantage of providing a set of indicators that have been tested and validated, there was the disadvantage of being restricted to what had been developed.

Limitations regarding the *Functional Screen* were discussed. One limitation was that it only addressed a limited set of ADLs and that these ADLs may not be ones that were most important to the client. It also seemed to focus on older people. Domestic ADLs for younger children with disabilities may include getting to places out of walking distance, however, getting the shopping and housework done may have less relevance than going to school or other recreational activities.

Another difficulty described was that the ADL measure asked what people were capable of doing. There was concern that this focussed too much on the individual. The key issue was whether the task got done, not whether the person was capable of doing it. For example, the individual being assessed for access to a HACC service may not be able to do the grocery shopping but the grocery shopping may be completed by another person in the household. This arrangement may have occurred before a disability occurred.

In option 2 the social support measure aimed to overcome the issue of whether the individual completed the task or whether the household completed the task. It did this by firstly determining whether there was another carer and if there was did this carer experience stress- suggesting they were not coping with their caring role. If the carer is stressed and caring is impacting on their wellbeing they may not be able to maintain their caring role. If the carer is coping well and able to complete the ADLs that the person with a disability is not, the priority for service would be lower than if the carer was very stressed and exhausted. There is a basic assumption in this model that if an individual is not able to complete an ADL, the presence of a carer will ensure that the ADL is being completed. There are a number of reasons, however, why a carer may not complete these tasks, including, not enough time, not having the skills required to complete the task or not seeing a need to complete the task. The option of altering the questions on the *Functional Screen* to ask "does the housework get done?" "does the shopping get done?", or "is the person routinely bathed?" would overcome this issue. However, this would require an add-on to the INI and increase complexity in completing the INI and POA forms for assessors. The process needed to be kept as simple as possible. The current *Functional Screen* is also compulsory for all HACC agencies to complete.

The third limitation was that the *Functional Screen* in the INI was only intended to identify the need for a further assessment of ADL function, not indicate need on its own. It was decided, however, that these further assessments may not be the realm of HACC assessments and that this broad screen provided some indication of level of ADL ability.

Staff also considered that some other important indicators were not included in either option. In particular, the omission of incontinence seemed to be the largest gap, followed by sensory loss. It was also discussed that sensory loss may impact on ability to complete ADLs and therefore, may already be incorporated in the measure of ADL.

The idea was raised of having a checklist on the other side of the page on option 2. This checklist could list indicators of priority that were not included in option 2, such as sensory loss, self-reported health, psychological wellbeing, household income, language, falls risk, health behaviours, nutritional status, incontinence and physical environment. If the majority of these indicators (e.g. 7 or more out of 10) suggested higher priority, the priority level determined on the first page could be increased by one level (i.e. a low priority would become medium and a medium priority would become high). A possible shortfall of this approach is that large numbers of people may be inappropriately allocated a medium or high priority. It would also remove one of the strengths of Option 2 in being a concise and

straightforward method for determining priority considering the three core factors relating to need for HACC services, as per Figure 1, Chapter 3.

Another concern was that the HACC assessment needed to be completed in one visit and generally in about an hour or two. Staff felt that this was not enough time to complete the INI, determine priority, investigate the individual's needs and priorities and, if necessary, meet with the carer and discuss their needs as well.

One staff member talked about using the terms 'survival' and 'thrival'. It appears that the main aim in determining priority is to consider the factors that are likely to threaten survival. General aims of HACC services, however, are about independence and quality of life. These aims are more about thriving rather than just surviving. The terminology inherent in determining priority is about limitations and restrictions. Focusing on these issues fails to consider the abilities, strengths and resources of individuals. However, for an organisation that is not able meet the demands for service, the focus on deficits is difficult to avoid.

Despite the limitations mentioned, staff preferred Option 2 and indicated that it was a useful starting point and seemed to capture the core issues. It was perceived to be a simple tool yet was able to capture they key elements and consider the interaction of individual and carer factors. It was also stated, however, that adding a checklist may be beneficial.

## 4.2 Feedback from Working Party Meeting (24/7/02)

Working party members were provided a kit of resources including a summary of a PowerPoint presentation; a rationale for the two POA tool options; the two POA tool options and an INI that had been completed using a fictional client. The two POA tool options were presented and then worked through with Working Party members using the fictional example presented in the INI.

The two POA tool options presented were similar to the ones in Appendix 1 with the exception of changes based on the discussion with NARI staff. A checklist of other indicators (e.g. falls history, sensory impairment, poor reported health) was included in Option 2 as Step 4. The presence of 5 or more of the 10 indicators could raise the level of ADL/cognition from a low to medium or a medium to high. If the ADL/Cognition level was already high, assessors could skip Step 4 and continue to Step 5 on determining level of social support.

Discussion of Option 1 identified the following concerns:

- The tool may be too complex;
- Incorporation of the K-10 from the *Psychosocial Profile* for completion with the carer could generate anxiety on the part of the carer, moreover it is rarely completed unless indicated;
- The tool does not offer enough indicators to assist with determining Priority of Access;
- The use of the term Social Support is not appropriate as the relevant question focuses on the Carer. Assessors consider social support in relation to the level of social involvement that clients have with others;

- The indicator 'Household Financial Situation' should not be used as an indicator to determine priority as those with high incomes can pay full cost recovery but should not be discriminated against because of their ability to pay;
- The indicator on health behaviours was not considered relevant for determining priority.

The purpose of the POA Tool and the INI were debated. Concern was expressed that the POA Tool Option 1 was tied too closely to the INI. It was explained that the POA Tool Option 1 mirrored aspects of the INI as well as incorporating aspects of tools currently in use in several Councils. The design of Option 1 combined indicators from the INI with questions which were considered to be judicious in identifying client's needs based on ADL's, IADL's, Cognitive Ability and Social Support.

Working Party members stated they would like to see the following changes to POA Option 1:

- Replacement of Indicator titled 'Social Support' with an indicator related to the Carer and an indicator related to social activities undertaken by the client;
- Addition of an indicator related to identifying the 'health status' of individuals e.g. presence of chronic/multiple conditions; recent admissions to hospital;
- The indicator 'language' be developed to include broader issues related to communication;
- Deletion of the indicator 'Health Behaviours';
- Deletion of 'Household Financial Situation';
- Inclusion of a section entitled 'Other' where assessors could write about issues or conditions they had observed.

POA Option 2 was presented and discussed. There was a division among those present as to the merits of Option 2. It was considered by some to be a clear document and a 'simple way of capturing complexity', while others saw it as being a more complex document than Option 1. Several of the concerns raised in discussion of Option 1 were re-iterated for Option 2.

After presentation and discussion of the two tool options the working party agreed that POA Option 1 was the preferred choice for piloting. One of the key advantages to Option 1 was that it enabled more levels of priority to be determined. Whereas Option 2 only enabled a high, medium or low priority (or possibly 6 levels), the score range of 0-28 enabled 29 levels to distinguish clients. This could be useful, for example, when an LGA was able to provide services to some but not all of those assessed as low priority. In this way, an individual LGA, for example, could decide to provide services to those who scored above 5 even though the score range for a low priority is 0-9. Another advantage for having a score was to determine which clients would have services replaced during staff absences. It was important to note, however, that in relation to service planning and future assessment of service access across the region, the scores outlined on the tool for high, medium and low would need to be reported.

A further point of discussion at this meeting was the use of the POA tool as an assessment tool. The POA tool was not designed as an assessment tool but as a process for determining a priority level. There was concern that completing the POA tool, the service coordination (INI) tools and the Local Government's own assessment tool was a burden on assessment staff. The information recorded on the service coordination tools, including the service coordination plan, however, appear to enable recording of all the measures currently recorded on individual LGA assessment tools in use. It also enables the recording of client's perception of issues, goals and how these goals can be achieved- areas that are not covered on the POA tool.

Although most indicators that are currently used on WMR assessment tools are included on the INI, some of these indicators are reported in a descriptive way without a clear definition and set of response items. For example, "family and personal relationships" on the psychosocial profile is the title for a free text box. This appears to be the only place to record how well the carer is coping (unless a separate INI is completed for the carer). Communication issues are addressed on the Consumer Information form by either identifying the main language spoken at home or whether an interpreter is required. Issues such as speech production can be reported in a free text box on "preferred language, including sign language, & any required communication devices or special and interpreter needs". Although free text boxes are useful in allowing flexibility for recording issues, it is less useful for having a structured approach to determining priority.

### 4.3 Tool Pilot

A pilot of the POA tool was considered essential for determining the practicability and sensibility of using the tool in the field. Option 1 was selected and modified according to feedback from the Working Party meeting. The changes included removing the items on health behaviours and household financial situation. The question titled "social support" was altered to two items covering carer availability and carer status in relation to how well they were coping. Another item was added that asked about how often the client was able to go on social outings. The question on language was broadened to incorporate speech difficulties and literacy and was renamed "communication". The most significant change was that four items no longer required assessors to refer back to the INI. The questions on social outings, communication, carer availability and carer status were not addressed in the INI in a manner that enabled categorisation into high, medium or low. New questions and corresponding categories were developed for the pilot tool.

As the POA tool links closely with responses from the INI it was necessary for those piloting the tool to be routinely using the INI. If the INI were introduced in conjunction with the POA tool it would be difficult to determine whether issues and concerns were related to the INI or the POA. Three Local Governments were routinely using the INI tools during assessment at the time of the tool development. All three agreed to participate in piloting the tool. Project staff visited assessment staff at each of the three LGAs to explain how to complete the tool. Staff were also given a survey requesting feedback on the POA pilot. Assessors were able to identify a number of limitations with the tool at this early stage and these issues are reported below. After the pilot period, assessment staff were requested to be involved in a focus

group. At the end of the pilot, project staff obtained copies of the completed pilot POA tool to examine characteristics of tool completion. Information from the initial meeting, the focus groups, the survey and the pilot tools are described below.

### *4.3.1 Initial Meeting*

In the initial meetings with assessment staff regarding implementing the pilot for the POA tool, a number of issues were raised. The largest concern was in relation to the use of the K-10 score from the *Psychosocial Profile* for assessing psychological wellbeing. Most assessors indicated that they did not use this scale on a routine basis, nor did they complete the *Psychosocial Profile* very often. Staff reported that they felt it was inappropriate for clients and may even make them feel depressed. At the first meeting it was decided that the question could be modified. If a client was referred or case managed by a psychiatric/mental health service or facility or had a diagnosed psychiatric illness, the 'high' category for this indicator could be selected without having to complete the K-10 scale. Alternatively, if depression was not evident during the assessment the assessor was to record 'low' on the POA tool.

Although staff were initially reluctant to use the K-10 at the first LGA, debate led to acceptance of using this in some circumstances. Therefore, if the client indicated some depressive symptoms and did not fit any of the categories above regarding psychiatric illness, then the K-10 would be completed. Although assessors believed it might be intrusive it was agreed that the scores from the scale were only valid if the client was asked each question and given the response options. Some strategies were discussed for introducing the scale to clients. If there were any difficulties or reluctance to use the K-10 scale assessors were instructed to record these on the pilot survey. The two following LGAs were more reluctant to use the K-10 scale but would try and use if considered appropriate.

The second issue related to the use of carer issues and the need to carefully define "carer". There was some discussion that while some people may not have a carer they may not need one. It was recommended that a "no carer needed" option be added. It was decided that this category would not be added for the pilot of the tool. If the absence of this option became evident during the pilot, the item could be considered for inclusion in the revised version. If no carer was needed it was speculated that this would become evident on the other items and that the client would probably have a "low" score anyway. Furthermore, although they may not have a high level of physical disability, risk is likely to be increased if there are no support networks and the client is living alone. Scoring high on this particular indicator, therefore, would appear appropriate.

Another issue that arose was the confusion created by the inconsistent use on the POA tool of the scoring for domestic ADLs and self-care ADLs based on the *Functional Screen*. It was decided that the scoring for these two items would remain the same for the pilot but that it was likely that these would need to be reviewed for the revised tool.

### *4.3.2 Pilot Focus Groups*

After the completion of the pilot period focus groups were held at each of the three participating Local Government services with assessment staff involved in the pilot. Staff were asked to describe their experiences using the tool, to identify positive aspects and limitations of the tool and to suggest ways of improving the tool. Agreed features of the POA pilot tool were the time to complete, the layout, the consistency with the INI and the potential benefits. The feedback has been summarised and reported below.

Staff at all trial sites were generally satisfied with the layout of the tool. The most popular aspect was that it was able to fit on one page, double-sided, that could then be attached to the INI. It was generally agreed that a place to write the date and assessor's name should be included. Staff also appreciated that the tool matched completion of the INI, making completion a straightforward cross-referencing of questions. Staff asked whether it could be incorporated in the INI with a running score calculated as they worked through the INI. However, the INI tools have been developed for a much broader range of agencies across Victoria and therefore inclusion of the POA process is not appropriate.

Staff indicated that after the first or second time they used the POA tool it became very quick to complete with most saying it only took a minute or two once they were familiar with the tool. The first couple of times they completed the POA they found some of the scoring a little confusing but commented that this usually occurred when first using a new form. Some indicated that the tool was quicker than they were anticipating; "it didn't take as long as I thought to fill out".

One issue that became apparent was that very few clients were rated a high priority. Staff from one LGA reported that they had not assessed anyone with high needs during the pilot period, however, another indicated that one or two clients would have previously been identified as a high priority but were only a medium priority according to the POA tool. It was agreed that the cut-off for a high priority may need to be lowered. This issue will be examined in more detail in the data analysis for the pilot.

There was mixed responses in relation to when the POA was completed. Some felt it was easier to complete the form back in the office as clients were often overwhelmed with paperwork. However, one assessor also pointed out that if the client was not satisfied with the allocation of services, showing them the completed POA tool helped them to understand service allocation decisions.

Most of the indicators were reported as important with staff at one LGA stating that all indicators were important for providing a holistic view. There was some indication that there was too much emphasis on sensory impairments as they had the potential of contributing to the score to the same extent as domestic and self-care ADLs combined. However, the suggestion of combining the vision and hearing indicators were rejected at another LGA where they suggested that if both hearing and vision impairment were present, that this would have a significant impact on independence and ability to leave the house.

As in the initial meetings there was discussion about the use of the K-10 score on the *Psychosocial Profile*. Most assessors were reluctant to use the tool and if they were to use it they would not complete it in the manner intended. For instance, if the client mentioned that they were feeling anxious the assessor would select an option for the anxiety question without offering the range of responses to clients. It appears that referring to the K-10 scale on the POA tool is unsatisfactory for assessors. It was considered a practical solution to remove this indicator but have some reference to depression and/or psychiatric illness in the "other" category as assessors are not qualified to undertake a psychiatric assessment of the client.

The communication indicator was considered valuable but there were a couple of queries regarding how to complete it and its placement on the POA form. As language is recorded on the *Consumer Information*, the first form of the INI, it was suggested that the communication indicator should be first on the POA tool. The query about how to complete the item points to the need for explaining this clearly in the POA guidelines. There was a misunderstanding that the ability to communicate needs related only to ability to communicate needs within the assessment context. The indicator, however, relates to all areas of life.

It became evident that the guidelines need to clarify who constitutes a carer and what is meant by availability of a carer. One assessor felt that the POA tool did not adequately identify the needs of the carer.

The "other" options category was considered important for addressing key issues of concern that may not be included in the specified indicators. Pilot sites also considered that some of these key issues of concern were very important and should be included as an indicator in their own right. For instance, incontinence can have just as great an effect on need as vision or hearing impairments. It was also recognised that it was not practical to have many more indicators.

The limitation of the POA tool in identifying carer's needs was cited with particular reference to the needs of parents with children with disabilities. It was stated that the POA tool was not able to adequately prioritise these clients as it was unclear whether the parent or the child should be assessed as the client. Social and family dynamics were considered more relevant for these families. Being a single parent, employment and financial issues and the presence of other children were all raised as influencing the need for HACC services. It was felt that the POA tool would rarely lead to a medium or high priority for these families as many of the indicators were less relevant for younger children. For example, the domestic ADL measure on the INI was considered irrelevant for young children as was the question on availability of a carer. One assessor reported that these issues were inherent to HACC services and could not easily be overcome within the scope of this project.

One assessor reported that the POA did not meet the needs of someone requiring palliative care.

Staff were asked to indicate whether they would want to use the tool and what purpose it would have in their assessments. Two of the LGAs involved in the pilot were not faced with issues of determining relative priority and therefore felt it had little benefit for managing demand. They did acknowledge that demand may increase in the future and the POA tool would be a useful method for determining priority. The third LGA did not assess clients prior to placing them on a waiting list and therefore did not think it would be useful for managing demand. It was agreed that it could be a useful way of comparing those who were not accessing services across different LGAs, at a regional level.

Despite this they did report other benefits in using the tool and one assessor reported it was a “pleasure to use” and would be happy to replace their current tool with the POA. Assessors indicated that the tool enabled them to view the assessment from a different perspective and that it made the assessment process a more objective one. Some indicated that the process provided a confirmation of their clinical judgement. Some assessors indicated that when they were in a client’s home it was sometimes very difficult to remain objective and to determine that someone was a low priority. The POA tool enabled them to feel confident that the client was a low priority, it provided a means of confirming their own judgements. Staff at one LGA found that the POA tool provided a priority level that matched their clinical judgement to a greater degree than the current tool they were using. Staff also reported that it helped to justify their decisions about service provision to clients and to other agencies. It also enabled more consistency between assessors within and across LGAs; “it’s a transparent process and could be used with other Councils for purposes of comparison”.

#### *4.3.3 Pilot Survey data*

Eight staff across the three LGAs (3 from 2 LGAs and 2 from the other) completed the survey after the pilot period. Feedback on the survey generally confirmed the information obtained through the focus groups and was overall positive. Assessment staff who completed the surveys had many years experience in HACC services with some having worked in HACC for more than 5 years. Some had qualifications in welfare, social work and health sciences as well as courses in HACC assessment and care planning.

All staff reported the layout of the tool was easy to follow with one indicating it was very easy. Comments related to the placement of the communication indicator and that the two ADL questions were confusing as they used a different scoring approach. One respondent stated that it was “not initially straight forward”.

**Table 3: Responses regarding layout of the tool**

	<b>Respondents (%)</b>
Very Easy	1 (12.5)
Easy	4 (50.0)
Somewhat Easy	3 (37.5)
Difficult / Very Difficult	0 (0)
<b>Total</b>	<b>8 (100)</b>

Most staff indicated that there were no questions that were difficult to find the corresponding items on the INI. However, there was reference to the *Psychosocial Profile* and the behaviour and cognition questions.

All 8 staff indicated that they preferred to complete the POA tool back in the office.

Table 4 indicates the ratings of how important each indicator was considered. Responses were received from all 8 respondents for all indicators except self care ADLs and the “other” category. Only three respondents provided a response to the indicator “other”, perhaps as it does not relate specifically to an area of client or carer need.

**Table 4: How important is it to include the indicator?**

	Very Important	Somewhat important	Not sure	Not very important	Not at all Important
Domestic ADLs	75%	25%	-	-	-
Self Care ADLs **	62.5%	25%	-	-	-
Cognition	75%	25%	-	-	-
Behaviour	50%	37.5%	12.5%	-	-
Psychological wellbeing	37.5%	37.5%	25%	-	-
Self Rated Health	37.5%	50%	12.5%	-	-
Sensory-Vision	62.5%	12.5%	12.5%	12.5%	-
Sensory- Hearing	62.5%	12.5%	12.5%	12.5%	-
Falls Risk	75%	25%	-	-	-
Nutrition Status	75%	25%	-	-	-
Communication	75%	12.5%	12.5%	-	-
Social Outings	50%	50%	-	-	-
Carer Availability	87.5%	12.5%	-	-	-
Carer Status	87.5%	12.5%	-	-	-
‘Other’ (separate box)**	25%	12.5%	-	-	-

\*\* denotes missing data

Table 4 indicates that the majority of staff reported that all indicators were ‘somewhat’ or ‘very’ important. Questions relating to the carer were most frequently considered very important. There was less importance placed on the two sensory questions, the question on self-rated health, psychological wellbeing and on behaviour. None of the indicators were rated “not at all important”. Respondents indicated a number of other indicators that could be considered for inclusion. These were:

- Pain
- Occupational Health and Safety and client risk
- Needs of children with disabilities and their families

- Use of aids
- Resistance to use services.

The majority of respondents indicated that clients:

- did not react with discomfort to any questions (75%)
- did not refuse to answer any questions (62.5%)
- understood all the questions (75%)

As discussed in the focus groups and the initial meetings with assessment staff, the K-10 scale from the *Psychosocial Profile* was the most contentious factor with half the staff stating it was inappropriate for the clients they assess. Generally staff did not ask these questions because they felt it would create discomfort for clients.

Staff also confirmed that information from the *Health Behaviours Profile* was inappropriate for their clients, however, only the Nutrition Risk Screen was referred to in the pilot POA tool. Evidence and feedback from the Working Party suggests that consideration of nutrition risk is important for inclusion in the POA tool.

Respondents were asked whether the priority level determined using the POA tool, was discrepant with their own tools and/or clinical judgement. One respondent stated that the tool reflected their in-house method well. Four respondents indicated that there were issues in relation to the cut-off scores, in that very few clients were assessed as a high priority and one indicated that the tool resulted in a low priority when they felt the client was a medium priority. One also stated that the POA tool only resulted in a low priority for a family with a child with a disability when the assessor felt they were a higher priority. Despite these limitations staff indicated that they were fairly confident with the result from the pilot tool (75%) with one staff member very confident and another not responding to the question. Lowering the thresholds for high and medium priority may increase respondents' confidence with the results.

Suggestions for improving the tool were:

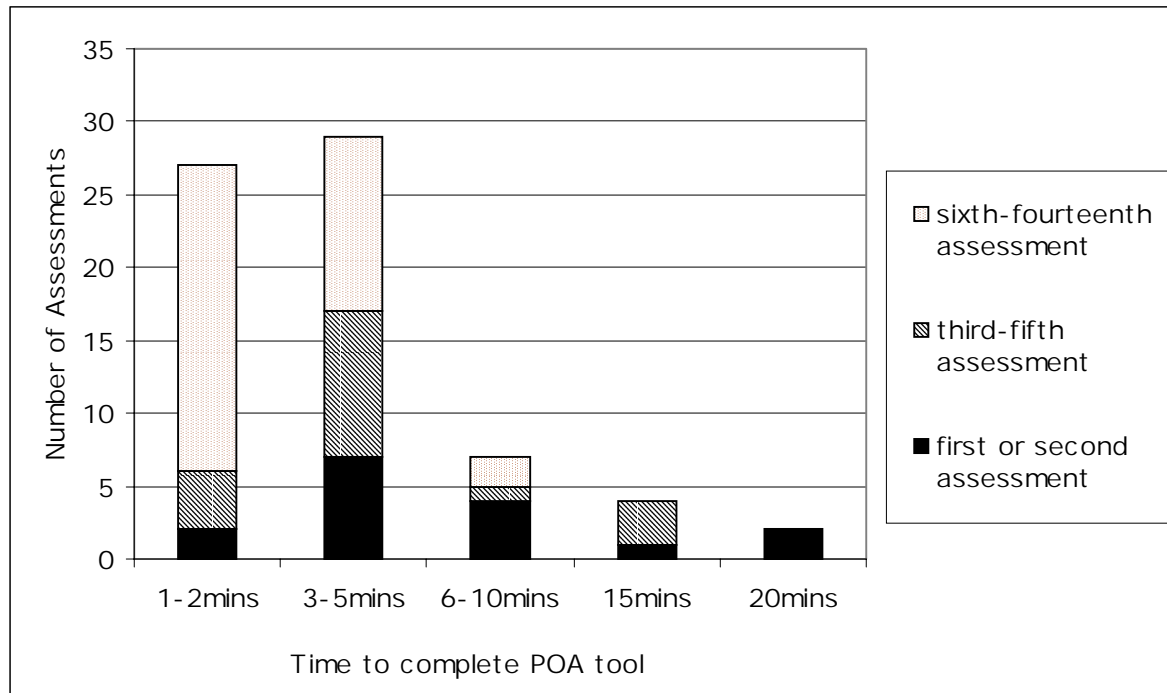
- Allow additional points if there is more than one risk identified in the "other" category;
- Behaviour & cognition more defined - include level of behaviour & cognition;
- Incorporating the POA tool into the IN template;
- To be made more suitable to the needs of parents with children with disabilities; and
- To be shortened & simplified.

#### 4.3.4 Pilot data analysis

Fifty-one completed POA tools were returned after the completion of the pilot. Broad information obtained from Part 1 of the survey was available for 65 assessments in total. These 65 assessments were completed by eight assessment staff across the three pilot sites.

Assessment staff reported taking between 1-20 minutes to complete the POA tool, however, the majority of assessments were completed within 5 minutes. Figure 2 indicates that the more assessors used the tool the quicker assessments became. By the time an assessor had completed the POA tool ten times, none of the assessments took longer than 5 minutes to complete. Some assessors were also able to complete the tool within 2 minutes on the first or second time they completed it.

**Figure 2: Time taken to complete the POA by experience using the POA**



Scores from the 51 POAs indicated that 20 clients were assessed as a low priority (39%), 27 were assessed as a medium priority (53%) and 4 were assessed as a high priority (8%). Scores ranged from 1-24 out of a possible score range of 0-30. The mean score was 12.5 (standard deviation=5.17, median=13). Figure 3 shows that the distribution of scores reflects a normal distribution although a larger number of assessments would be required to confirm this. These score ranges suggest that it is very difficult to obtain a high priority score and indicate the need for reducing the range of scores for the medium level given that most clients fell into this category.

Figure 3: Frequency of POA pilot scores (n=51)

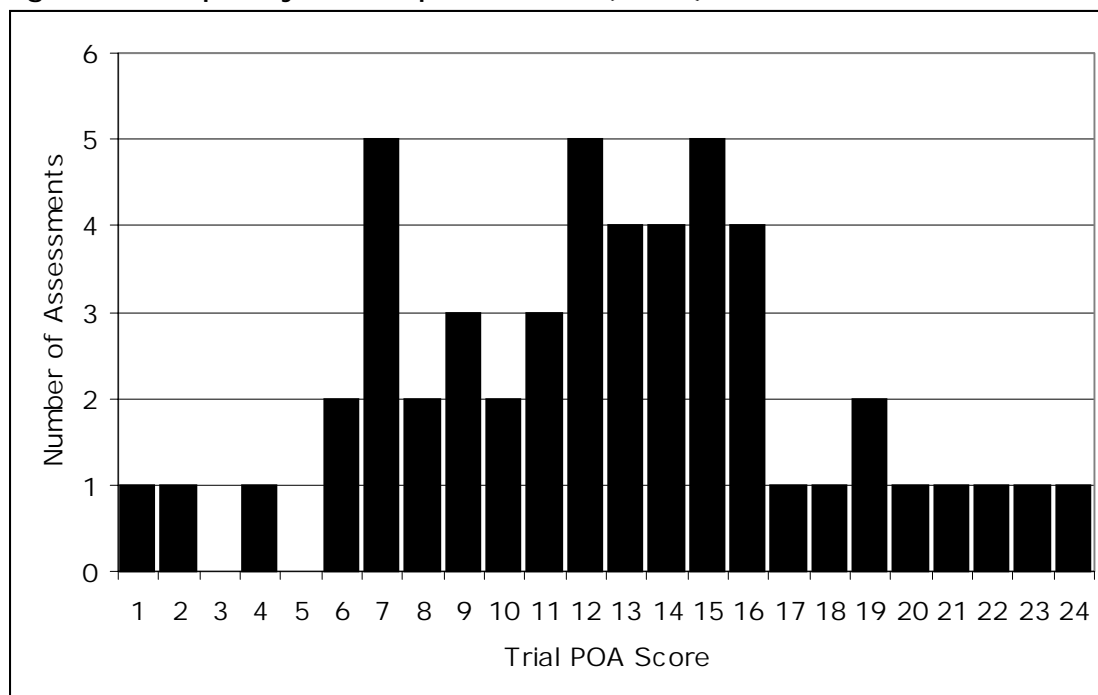


Table 5: POA priority level by assessor’s clinical judgement

		Clinical judgement				
		high	medium-high	medium	low-medium	low
POA tool	high	<b>3</b>				
	medium	4	1	<b>18</b>	3	1
	low			6	2	<b>13</b>

**Bold numbers** indicate a match between POA tool and clinical judgement

Thirty four out of 51 (67%) assessments resulted in the same priority level according to the assessor’s clinical judgement and the POA tool score. Six assessments were reported as either medium-high or low-medium according to the assessor’s clinical judgement. The assessment of medium-high resulted in a medium priority according to the POA tool. For the 5 low-mediums 3 were medium and 2 were low priority according to the POA tool.

Eleven assessments (22%) had inconsistent priority levels according to the POA tool and the assessor’s clinical judgement. Ten of these assessment discrepancies related to the POA tool having a lower priority level than the clinical judgement, providing further support for lowering the cut-off scores for medium and high. Only three of the assessors reported these discrepancies with 8 of the 10 discrepancies being reported by two assessors.

Some further investigation of the discrepancies found that one assessor had misunderstood the scoring for the two carer questions and thought that if no carer was available the items were not rated. The assessor indicated that although the POA tool scored a low priority for one particular client, the assessor felt they should have been medium. However, when there

is no carer available the assessor should score 2 points for both carer items. Accounting for these four points increased the score for this assessment from low to medium.

One of the assessments that scored medium on the POA tool when the assessor indicated they should have been high, achieved a score of 20 on the POA tool, the highest possible score for a medium priority. This client scored high on domestic ADLs, cognition, psychological wellbeing, hearing, nutrition, social outings, carer availability and carer status. They had an additional two points as their finances were managed by a trust and they also scored medium on self care ADLs, self-rated health, vision and communication. This client should clearly have a high priority for HACC services. This provides further support for lowering the cut-off for high priority.

Despite arguments that the tool would not be able to score in the high priority level for families with children with disabilities, there was a 2-year-old client whose priority level was one of the few high priority ratings throughout the pilot.

Only one client was assessed as a higher priority level on the POA tool compared to clinical judgement. Further evaluation of this assessment showed that the POA tool scored 12 (at the low range of the medium scores). Although the client was independent with ADLs, they had some cognitive impairment, no available carer, vision impairment and some issues with nutrition and communication and the assessor also added the 2 points in the "other" box (reason for extra 2 points not specified). According to these factors it appears that there are some issues of independence and safety that would warrant a medium priority.

Figure 4 indicates the responses for each of the 14 indicators for 51 of the pilot assessments.

Figure 4: Results for each indicator for pilot assessments (n=51)

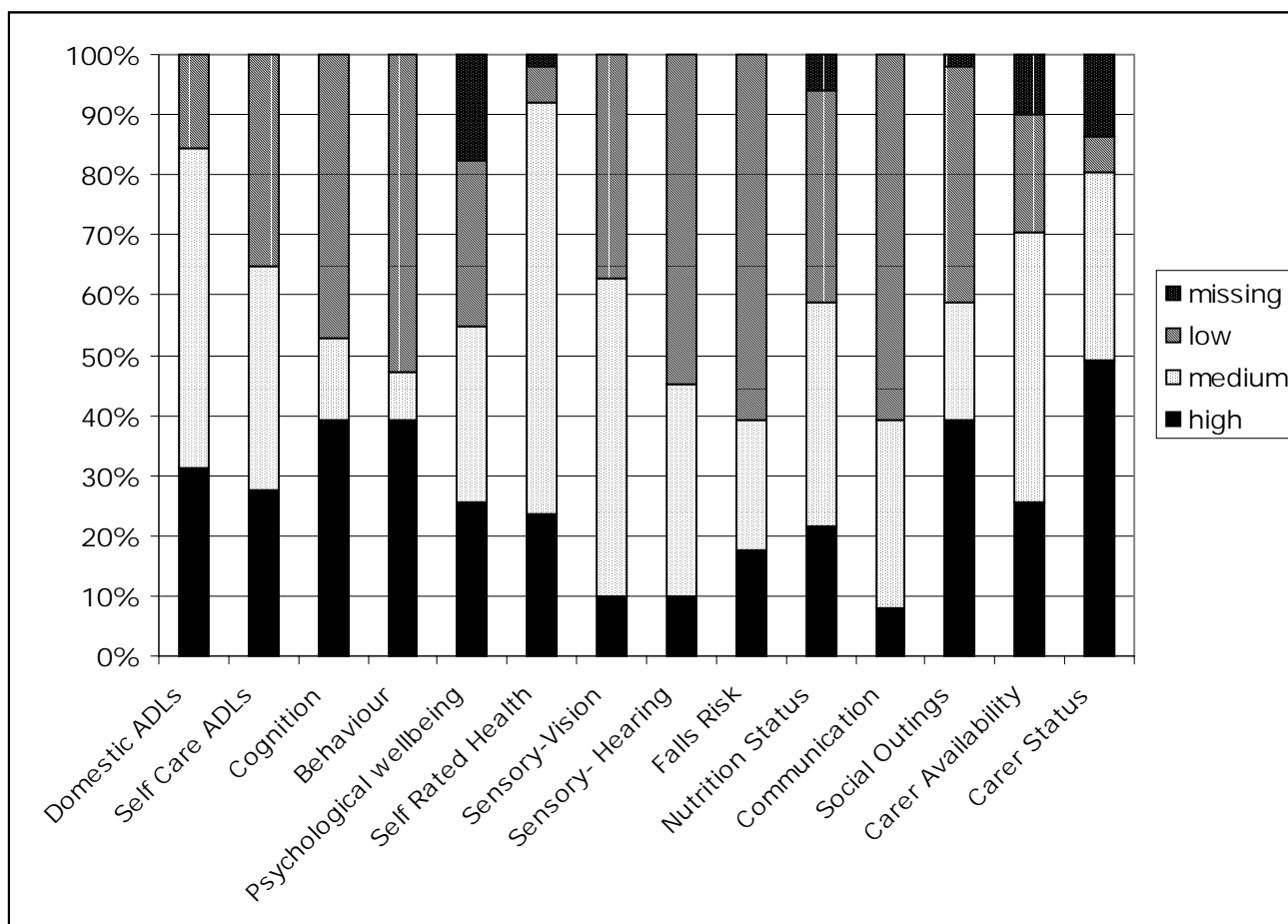


Figure 4 indicates that most of the indicators had responses across the high, medium and low response categories. There is some indication of errors in completing the form in the small number of times that “medium” was indicated for cognition and behaviour. Medium for these two indicators was not an option, suggesting that there was some confusion about how to interpret the “NA” in the medium column on these two indicators. The Psychological wellbeing indicator has the largest amount of missing data supported by staff feedback on their reluctance to use the K-10 measure. This suggests that the indicator may need to be removed from the set of indicators and perhaps a reference to depression and psychiatric illnesses can be included in the “other” category. There was also a substantial amount of missing data for the carer indicators. This can be partly explained by the misinterpretation of the question from one particular assessor who thought that if there was no carer the question was not appropriate and not completed. This highlights the importance of training and following up this training with discussion after assessors complete the tool on numerous occasions.

Eighteen assessments included the additional bonus 2 points. There appeared to be a trend for particular assessors to use this option more often than others. A more comprehensive pilot test would be required to examine this issue further. The issues cited, however, appeared to be appropriate. Incontinence (5 times) and environmental hazards (4 times) were most commonly indicated in this optional box. Pain was indicated on two occasions. Health conditions and issues included; dialysis, amputee, tube feed, uncontrolled epilepsy,

heart transplant and health deterioration. Four other clients had the following issues indicated:

- Neglect;
- Abuse;
- Unmotivated to cook/shop and drinking problem;
- State of mind.

## 4.4 Non-pilot survey data

The four WMR Local Governments that were not using the INI during the pilot were sent the pilot tools and a survey to provide their perceptions of the tool. Seventeen staff returned the survey with at least one survey returned from each of the four non-pilot LGAs. There were many concerns raised by the respondents from the non-pilot LGAs. Most of these concerns were that the tool was too complex and time consuming and having to cross-reference with the INI tools was cumbersome. These concerns, however, were contradicted by staff who piloted the tool and who were routinely using the INI suite of tools. These pilot staff indicated that the POA tool took only a couple of minutes to complete and once it had been completed a few times was very easy to complete. These discrepancies in feedback highlight the importance of pilot testing and training for better acceptance and understanding of the POA tool.

Staff had a wide range of skills and experience ranging from 1-25 years of experience in the field. Five assessors reported having more than 10 years experience. Most had Bachelor degrees across the fields of social work, social sciences, occupational therapy, nursing and disability studies.

Most of the non-pilot survey respondents indicated that the layout of the tool was easy to follow (82% "easy to follow" and 6% "very easy to follow"). Two indicated that it was somewhat difficult to follow but no one indicated it was very difficult. Three comments were positive indicating it provided a "good framework and checklist to guide assessor", that it was "good that it fitted on one page" and was "quite straightforward". Negative comments were that it was cumbersome and that there was too much information on each page, it would be time consuming "flicking back and forth through INI" and that it would be better if it was part of the INI. It is possible that as the non-pilot assessors were not routinely using the INI tools, that the feedback may have also related to the idea of using a completely new set of tools including the numerous pages of the INI along with the POA tool.

Table 6 indicates that the majority of respondents found the scoring method easy with 3 respondents (18%) indicating the scoring method was difficult.

**Table 6: Responses relating to the scoring method of the POA**

	Respondents (%)
Very easy	2 (11.8)
Easy	9 (52.9)
Somewhat easy	3 (17.6)
Difficult	2 (11.8)
Very difficult	1 (5.9)
Total	17 (100.0)

Respondent's comments for the question on the scoring method, however, were less positive and covered a range of issues outside the scoring method. Concerns were raised about the amount of cross-referencing required and that it was complicated and time consuming. A couple of comments were specific queries about the scoring relating to specific questions. These issues will be clarified in the POA tool guidelines and during training. One raised the concern that the different scoring method used on the INI and POA tools was confusing as the INI used 2 to indicate independence and the POA tool used 2 to indicate high priority/dependency. One respondent mentioned that for CACP clients the range of considerations can change frequently. Another felt that the questions did not reflect clients' needs. Another stated there were "many categories (options), difficult to read, many categories that may not be relevant/appropriate".

Only two respondents indicated that there were questions that were difficult to find the corresponding indicator on the INI. These indicators related to the self care and domestic ADLs from the *Functional Screen*. These difficulties are likely to be overcome when the POA tool has accompanying guidelines and training. Routine use and training for the INI tools is also likely to help overcome these difficulties.

There was mixed feedback as to whether it was preferable to complete the tool in the client's home or back in the office. Nine (53%) stated they would not complete it in the client's home and one stated "Due to time - would probably prefer to do at the office". Seven (41%) stated they would prefer to complete it in the client's home with four completing it alongside the INI and 3 after the INI was completed. One respondent reported that the "client will want to know what possible assessment outcomes are, therefore, it would be better to do at their house."

**Table 7: Staff responses to “How important is the indicator?”**

	Very Important	Somewhat important	Not sure	Not very important	Not at all Important
Domestic ADLs	71%	23%	-	6%	-
Self Care ADLs	88%	12%	-	-	-
Cognition	88%	12%	-	-	-
Behaviour **	65%	23%	-	-	6%
Psychological wellbeing	47%	29%	6%	-	18%
Self Rated Health	41%	47%	-	6%	6%
Sensory-Vision	65%	29%	-	-	6%
Sensory- Hearing	65%	29%	-	-	6%
Falls Risk	94%	-	-	-	6%
Nutrition Status	76.5%	23.5%	-	-	-
Communication	94%	6%	-	-	-
Social Outings	35%	53%	-	6%	6%
Carer Availability	82%	12%	6%	-	-
Carer Status	59%	35%	-	6%	-
'Other' (separate box) **	35%	-	12%	-	-

\*\* denotes missing data

Table 7 indicates that self care ADLs, cognition, falls risk, communication and carer availability were considered the most important indicators with more than 80% of the 17 respondents indicating they were “very important”. Most of the remaining indicators were also considered very important by the majority of respondents with the exception of psychological wellbeing, self-rated health, social outings and the “other” box. However, even these indicators were considered at least “somewhat important” by the majority of respondents with the exception of the “other” box. There was a large amount of missing data for this last indicator with more than half leaving it blank. It could be argued that as the indicator does not specify a particular area of client need and therefore respondents may have been unsure how to respond. Three respondents reported that the indicator on psychological wellbeing was “not at all important”.

Respondents were asked to identify whether there were any other indicators they thought should be included. Five of the 17 respondents suggested one or more indicators. The suggested indicators were:

- Dementia/Alzheimer’s & degree of affect on client;
- Carer frustration;
- Medical conditions;

- Physical ability;
- Family supports / other supports;
- More in communication, behaviour, self-help skills, routines/structure, mobility, eating, medical diagnoses;
- Sensory indicator should include other senses such as touch; and
- Willingness to accept services.

Most of these indicators have some reference in the pilot POA tool. For example, cognitive impairment, behaviour, nutrition, communication and carer issues are considered. Medical conditions/diagnoses may be reflected in measures of self-rated health and ability to complete ADLs. Physical ability is reflected in ability to perform ADLs. Although vision and hearing are considered other senses such as touch are not included, nor is willingness to accept services.

One respondent reported that no other indicators were required and that it was “very thorough”.

Respondents were asked to indicate whether they thought any of the questions on the POA were inappropriate for their clients. Responses indicated that there was some confusion between the POA and INI tools. For example, 6 (35%) respondents indicated that questions on the *Health Behaviours Profile* of the INI were inappropriate, particularly those on pap smears, breast screens and exercise. However, although there was reference to these factors in the original Option 1 of the POA tool, the pilot POA tool that these staff were reviewing only contained reference to the nutrition risk screening tool on the *Health Behaviours Profile*. Current priority of access and assessment tools in the WMR indicate that nutrition status is assessed by a number of LGAs and is important in relation to need for HACC services. Another respondent reported that the *Functional Screen's* reference to memory problems and confusion could be improved.

Another concern was consistent with that raised by pilot LGA staff in that the POA tool was not appropriate for children with disabilities (3 respondents, 18%). This is an area that requires further investigation.

Two comments related to the amount of time and the number of forms that needed to be completed. It was also stated that the POA required completion of all of the INI Supplementary Profiles when only two were compulsory for HACC services. However, the POA tool only requires completion of one section of the *Health Behaviours Profile* and the *Psychosocial Profile*. In relation to the *Health Conditions* profile, feedback from the Working Party suggested that this profile was important and routinely completed anyway. Therefore, the main concern appears to relate to the use of the K-10 scale on the *Psychosocial Profile*.

Eight of the respondents (47%) reported that they would be fairly confident with the results of the tool whereas another 7 (41%) were undecided. One stated they would be “not at all

confident and another one did not respond to the question. Pilot testing and further use of the INI and POA tools for these respondents may improve confidence in the results.

The following list outlines suggestions provided for improving the tool:

- Assume that will only be able to have clear picture of POA for top 10%.
- Could be less cumbersome.
- Does not reflect needs of young family - both child and parents.
- Could expand on assessment of carer.
- If all forms are not filled out the total is lower priority when there may be a particular issue that makes it a top priority.
- Indicators could be in same order as they are in INI
- NA on Cognition & Behaviour - suggest that take out tick box or shade in whole area.
- Part of INI rather than having to refer to specific screens.
- Perhaps too much detail which makes it difficult to read.
- Think it is good but would like to check overall scoring.
- Very long - but do appreciate that info is required in some cases.

## 4.5 Summary of Feedback

In summary, the feedback reported in this chapter, suggest that the following alterations to the pilot tool require consideration:

- Removal of the psychological wellbeing indicator from the list of 14 indicators and include "depression and psychiatric illness" in the "Other" box.
- Lowering the cut-off scores so that a lower score is required to be allocated a high or a medium priority. An alternative to lowering the scores could be to give higher weighting to the self-care ADLs, cognition and carer questions. This would add complexity to the tool and would also require significant modifications to the layout. This additional scoring requirement may mean that it would no longer fit on the two sides of a page.
- Adding additional indicators for incontinence, environmental hazards and perhaps pain. This would also require considerable modification of the current tool although one of these issues could replace the psychological wellbeing indicator;
- Altering the order of questions to put the communication question first to resemble the order of the INI;
- Further investigation is required into the applicability of the tool for families with children with disabilities;
- Whether a medium level for cognition and behaviour required and, if so, how is this level to be determined without a comprehensive cognitive assessment by an appropriately qualified practitioner.

These alterations were discussed at the final Working Party meeting and a number of revisions were agreed:

- The communication indicator was to be moved up to become the first indicator;
- The score range for the high priority category would be increased from 21-30 to 19-30;

- The psychological wellbeing indicator was to be replaced by an indicator of environmental hazards, and reference to psychiatric illness and depression were to be added to the “other” box.

The environmental hazards indicator was chosen as there was no reference to the external environment of the client in the remaining 13 indicators. Incontinence, however, was considered to be related to self-care ADLs and in some instances would be related to cognitive impairment. It was therefore considered a lower priority for inclusion as an indicator than environmental hazards. It was also agreed that it would be difficult to include a medium level for cognition and behaviour without a comprehensive cognitive assessment.

A number of issues need to be clearly articulated in the guidelines, especially in relation to the questions on carers, dealing with the NA for cognition and behaviour, and not including the score of “9” that is used in the *Functional Profile* and which indicates “not applicable”.

A number of other possible changes were identified in the pilot process but are not able to be readily incorporated. They may, however, be areas for consideration in future reviews of the POA tool. For example, although some respondents recommended additional items, it was also stated that the tool should be simpler and shorter. Given that the tool takes less than 5 minutes to complete once a number of assessments have been completed, it does not seem essential to abbreviate the tool further. Another option recommended was to add two additional points for every additional issue recorded in the “other” box. However, this undermines the scoring system of the tool and reduces the objectivity of the tool.

It was often raised that the tool should be incorporated on the INI forms. However, the INI suite of tools is used for a broader range of services than Local Government HACC services in the WMR and it is therefore not possible at present to incorporate the POA tool. As the form is only one page it could readily be attached to the back of the INI.

The issue of when and where to complete the tool did not appear to cause concern for staff. It appears that staff generally complete the POA tool back in the office after completing the assessment. When priority and service allocation issues are raised during the assessment, however, completing the POA tool in the client’s home provides a means for justifying the allocation of services and making the process transparent for clients.

The modified Priority of Access Tool along with its accompanying guidelines is included as Appendix 4.

# Chapter 5: Using the Priority of Access tool for managing demand

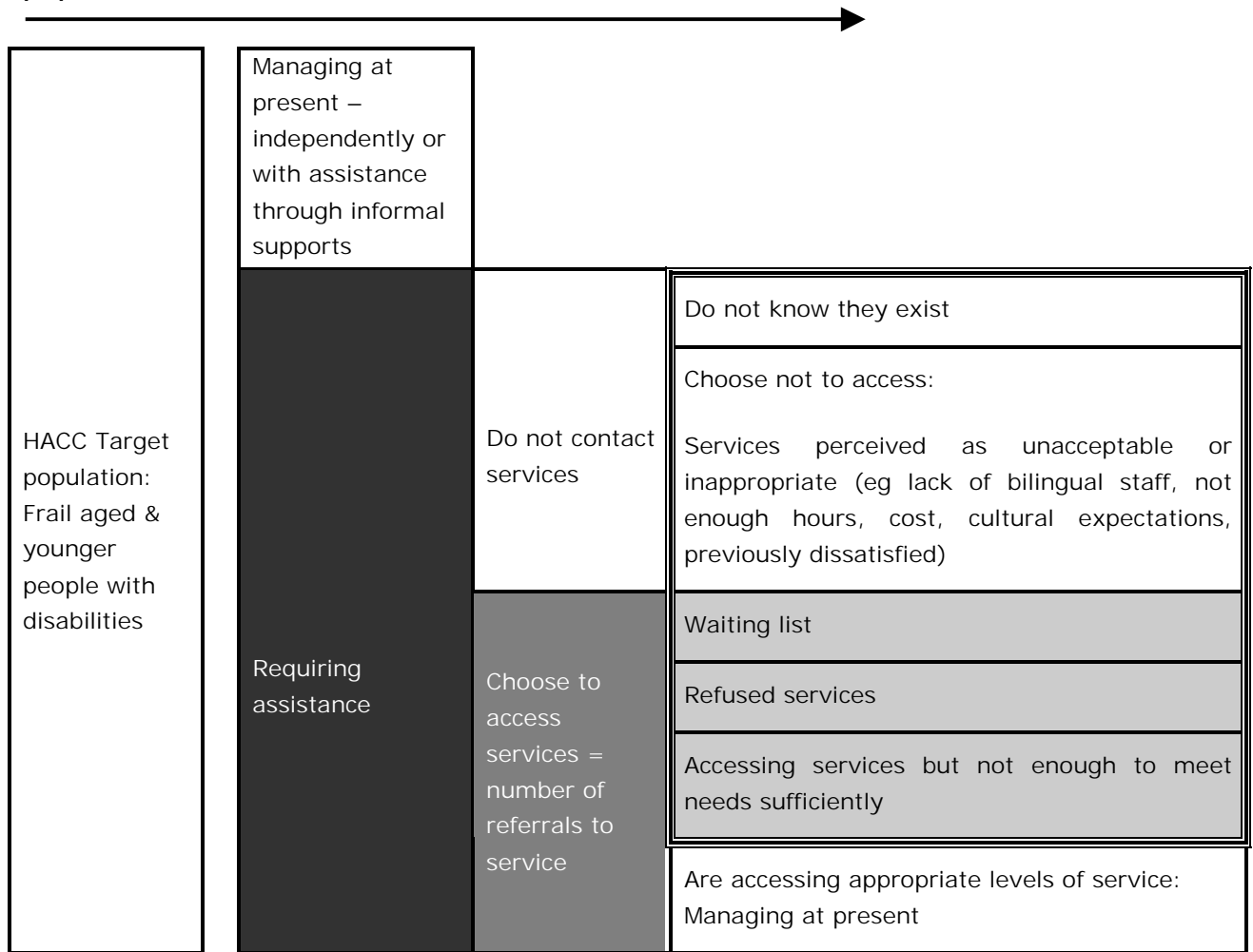
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The primary objective of introducing a consistent tool for determining priority of access is to improve equity of access to these services. Although service outcomes may differ according to different LGAs' ability to provide services, a consistent method for grouping client priority provides the means for examining which clients are not accessing services across different LGAs. This enables policy makers and funding bodies to address inequities through directing funds to LGAs that are unable to provide services to those with a higher priority in comparison to other LGAs. To enable this comparison to occur, data about those who are not accessing services needs to be recorded.

This chapter addresses the third objective of the current project: to develop a set of agreed criteria for use by WMR Local Government HACC services to manage demand and unmet need. The criteria proposed in this chapter requires completion of the POA tool. The purpose of this objective is to provide a standardised method for identifying those who are unable to access Local Government HACC services. Figure 5 (over page) shows the HACC target population and a way of conceptualising need, unmet need, demand and unmet demand (the size of the boxes do not represent relative sizes of each group). By introducing a set of agreed criteria, the aim is to identify those who request a service but are unable to access it according to relative priority.

Although an important issue, developing a measure of unmet need for those who are not referred to Local Government HACC services is outside the scope of this project.

**Figure 5: The relationship between need and demand within the HACC target population**



Note: the proportions for each category do not attempt to represent the real proportions that exist in the population.

**Key:**

Need

Unmet need

Demand for services

Unmet demand for services

Source: (National Ageing Research Institute 2001a)

Unmet demand and unmet needs can be assessed on a number of levels:

- Global level- access to any LGA HACC service;
- Service type level;
- Amount of service level.

Unmet demand/unmet need at the *global level* is the number of people who are referred to a LGA HACC service and are assessed as eligible and needing a service but are unable to gain access to any LGA HACC service. By applying a consistent method of determining priority level this information can provide a meaningful indicator to policy makers and funding bodies who is not gaining access to services. This information can be analysed to examine issues such as whether those assessed as high priority are always able to gain access to a service.

At the *service type level* we can determine how many people are requesting and needing a particular service type such as personal care. The people who are not able to access personal care, despite needing it, may be receiving food services or home care so do not have unmet needs at the global level.

The third level looks at *amount of service* received. Someone may be accessing personal care services but not at an appropriate level. For example, they may be receiving assistance with showering once or twice a week, when three or more times would be more appropriate.

Having consistent data about unmet demand and unmet needs at different levels is useful for service planning and determining where growth funding is a higher priority. However, developing a consistent approach for determining each level has limitations. Using a consistent method for determining priority level enables the global level to be measured with consistency and in relation to indicators of need.

At the second level, it is possible to determine whether someone is or is not getting a particular service type. Determining whether they need the service type is based on the assessment process and the identification of needs agreed by the client and assessment officer. This is less consistently applied but still enables a useful indicator of unmet and met needs.

When considering the third level, however, determining the "appropriate" level is very difficult to determine on a consistent basis across assessment officers and different LGAs. The example given previously about the "appropriate" number of showers per week demonstrates the subjective nature of amount of service required. However, the need for assistance with showers is probably more clearly identifiable. Based on these levels of unmet demand and unmet need, the proposed waiting list data set only considers the global level and the service type level, not the amount of service level. The third level requires the development of benchmarks for specific service types.

To inform the development of a set of criteria to manage demand, LGAs who reported using waiting lists when there were insufficient services to offer potential clients, were asked to provide details of the information recorded on waiting lists. Two LGAs forwarded the

variables they currently used and these have been considered in the development of the criteria for managing demand outlined below. One LGA also outlined a number of difficulties they encountered when trying to manage and maintain a waiting list. These difficulties were:

- Clients at this LGA are not assessed before being placed on a waiting list. If no hours are available at this LGA people are automatically placed on the waiting list without level of need or priority being assessed. When hours become available an assessment is completed. It was considered a waste of resources to assess the client when there were no services to offer. It was likely that by the time services were available the clients' circumstances would have changed.
- Sometimes the clients' circumstances have changed without the LGA knowing. For example, they have gone into hospital, or have made other arrangements such as residential care or moved in with another family member.
- When hours of service become available it is difficult to prioritise between those who have been waiting a long time and their current priority level is unknown with those who have recently been referred and have been assessed as a high priority. This issue reflects a concern about how long should someone have to wait, even if they are a low priority.
- Data management becomes more complex when some clients are on a waiting list for one service type but are able to access another service type from the same LGA.

## Proposed variables for waiting list data set

Variable	Options	DHS
Name/Address/Telephone/DOB	Free text	
Statistical Linkage Key (SLK)	5 characters (alphanumeric)	✓
Interpreter required	<input type="checkbox"/> No <input type="checkbox"/> Yes, if yes which language?	
Date referred	Date	
Referred by and phone number	Free text	
Priority Level	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	✓
Priority Score	Range 0-30	
Type of assistance currently provided by this HACC agency (if unsure refer to definitions in the HACC data dictionary version 1.0)	<input type="checkbox"/> None at present <input type="checkbox"/> Domestic assistance <input type="checkbox"/> Personal care <input type="checkbox"/> Centre-based day care <input type="checkbox"/> Meals <input type="checkbox"/> Other food services <input type="checkbox"/> Respite care <input type="checkbox"/> Home Maintenance <input type="checkbox"/> Home Modification <input type="checkbox"/> Provision of goods and equipment <input type="checkbox"/> Transport	✓
Type of assistance requested but not available at time of assessment (if unsure refer to definitions in the HACC data dictionary version 1.0)	<input type="checkbox"/> Domestic assistance <input type="checkbox"/> Personal care <input type="checkbox"/> Centre-based day care <input type="checkbox"/> Meals <input type="checkbox"/> Other food services <input type="checkbox"/> Respite care <input type="checkbox"/> Home Maintenance <input type="checkbox"/> Home Modification <input type="checkbox"/> Provision of goods and equipment <input type="checkbox"/> Transport	✓
Is the person on the waiting list for a Linkages or Community Aged Care Package or a residential aged care place?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Last contact with this agency	Date of last assessment/review	
Date for next contact	Date	
Comments	Optional free text	

## Guidelines for managing the waiting list

This waiting list data set operates as a living document that can be continuously updated. A computerised database needs to be developed for recording information. The database can be managed by using the following steps:

**Step 1:** A client is referred to a service (although they may not be a client at this point these guidelines will refer to the person trying to gain access to services as a 'client').

**Step 2:** Assessor organises a home visit to determine priority level and assess the client's needs. It is recognised that currently some LGAs manage waiting lists without completing a home visit or assessment until services are available. While this is a common sense approach if there are no services available, it has a number of limitations:

- It prevents monitoring of demand to provide evidence of a lack of resources to meet demand;
- It prevents the identification of need for other services that may be referred to after an assessment;
- When services do become available it is difficult to determine who should be contacted first.

**Step 3:** Client is able to access all of the services requested and required and are not placed on the waiting list, OR services required are not available. Clients who do not access all the service types they need are entered on the waiting list.

**Step 4:** Complete data on waiting list: Enter client's name, address, telephone number and date of birth, HACC Statistical Linkage Key, whether an interpreter is required and if yes, for which language; enter the date that the client was referred and who they were referred by. Then enter priority level (high, medium or low) and priority score based on the POA tool. Select from the checklist any HACC services the client received at the time of assessment or which will be put in place as a result of the assessment. Then move to the next question and select any services that the client needs but is unable to access. Enter the date of the first assessment under "last contact". For "date for next contact" enter the date to review the client's circumstances. Those on a waiting list should be contacted on a regular basis to determine whether there is no longer a need for service or that the need has increased. Contact may be a phone call to check that they still need a service and to determine whether another assessment is necessary. Individual LGAs could determine timeframes for follow-up or, alternatively, a cross regional set of recommended timeframes could be developed.

If follow up contact indicates that the client no longer needs the service they are waiting for then their name can be deleted from the list. If required services commence they can also be deleted from the list. Regular follow-up will reduce the number of people on the waiting list who do no longer need services and therefore provide a more accurate reflection of unmet demand. Enter free text under comments if there are special circumstances that assessors need to be aware of.

**Step 5:** Assessment officers will need to review the waiting list on a basis determined by LGAs to check whether any clients are due for contact (based on the “date for next contact” field). Assessment officers will ring all clients who are due for contact. They will determine whether the client still needs the service or whether circumstances have changed. If they no longer need the service they will be deleted from the waiting list and reasons for not needing the service will be recorded on the client’s file. If circumstances have changed the assessment officer may need to revisit the client and complete the POA tool to determine whether priority level has changed. Although it may be difficult to ring clients when there is still no service to offer them, it may help clients feel reassured that there is a possibility of services in the future. Assessment officers may also identify needs that may be met by services outside LGA HACC services.

**Step 6:** If the client is still needing services after this follow-up contact, details on the waiting list will be updated. The “HACC services currently provided” and “HACC service requested but not provided” will be altered according to any changes in service provision. Priority level and score will also be updated if necessary. The date for this latest contact will be updated under “last contact” and a new review date will be entered. By continuously updating these fields, the waiting list remains relevant and you will be able to determine how long someone has been on the waiting list by looking at the initial referral date.

**Step 7:** At set intervals, for example, monthly or quarterly, waiting list data should be reviewed either at an agency level or through a central body agreed up by WMR LGA HACC services. For example, number of client’s who weren’t able to gain access to any LGA HACC service according to assessed priority level could be calculated. At another level the number of people waiting for a specific service type could also be calculated. Length of time waiting for a service could also be reviewed. This data is valuable to illustrate the extent of unmet demand and unmet need within LGAs for planning distribution of growth funds and for lobbying for additional resources.

Although this does capture a significant proportion of unmet demand and unmet need it does not capture all unmet need. Some people may be accessing a particular service type but not accessing enough hours to fully meet their needs. However, these clients are able to access some service and therefore receive the benefits of having some regular contact with a service, such as identification of changed circumstances and increased needs.

# Chapter 6: Implementation Plan

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The fourth objective of the current project was to develop a strategy for implementation by WMR Local Government HACC services of project outcomes. This plan is described according to three key areas of activity:

1. Implementing the POA tool (includes training)
2. Further validating and refining the POA tool
3. Implementing a demand management plan

These activities are outlined below.

## 6.1 Implementation plan for the POA tool

### *6.1.1 Formal Agreement*

The success of the POA tool relies on it being adopted by each LGA in the WMR and that it be used correctly and consistently. The completion of the POA tool is not a formal requirement of service agreements, it has come about as a result of the work to date in the region and interest from representatives of the LGA'S. At the final Working Party meeting there was discussion on the merit of forming an agreement to be signed by each LGA that formally recognises the POA tool. This agreement could incorporate (but is not limited to) the following items:

- Implementation and use;
- training requirements;
- recording and collection of waiting list criteria;
- information sharing and use of data collected;
- review process for the POA tool; and
- Implementation of the demand management plan.

### *6.1.2 Training*

If LGAs agree to use the POA tool it is recommended that training be conducted. NARI is to request funds through WMR DHS to undertake training in the region. It is important that training for a tool is undertaken by a central leader to ensure that all assessment staff are receiving the same information in a consistent format. This helps to improve the reliability in which forms are completed (Leutz, Abrahams et al. 1993). Implementation of a tool in Northern Ireland relied on individual service managers developing and administering training for their own staff. Focus groups with staff after the training found that different staff groups were using the tool differently. It was considered essential that training needed to be standardised to improve consistency (McCormick 1999).

In the current project, the follow up focus groups after the pilot test found that despite training of the tool prior to the pilot, there were a number of misinterpretations regarding

completion of the tool. This follow up process after assessors have used the tool on a number of occasions, helps to identify problems early and to prevent errors becoming a routine practice. Training and follow-up training, therefore, improves the reliability in which assessors are interpreting and completing each question on the POA tool.

The ongoing need for training also requires consideration.

### *6.1.3 Alignment with the introduction of the INI*

It is important that the implementation of the POA tool coincides with or closely follows the introduction of the INI tools. Completion of the POA requires information to be transferred from the INI to the POA. At the completion of this project only three WMR LGAs were using the INI tools and therefore, implementation of the POA at this stage would be premature.

## 6.2 Validation and refinement of the POA tool

If the POA tool is implemented in the WMR, it is recommended that further testing and evaluation of the tool be undertaken. Testing of reliability of the tool across different assessment staff and different LGAs is important for ensuring the tool is being applied in a consistent manner. Comprehensive validity testing is also important, although a challenging task to undertake. It is recommended that after a year of implementing the POA tool that a project is undertaken to review how it is being applied, whether there are any inconsistencies in completing the form across staff and across agencies, and whether there is any areas that need revision and further refinement. This project could also explore the appropriateness of the cut-off scores for determining service access.

Further investigation is required to determine whether the tool is appropriate for children with disabilities. An initial step in this analysis could be to compare the proportions of high, medium and low priority clients in this specific subgroup of clients, with the proportion of high, medium and low priority for the remaining clients. This would enable consideration of the score ranges obtained for different client groups. Another line of investigation could be to examine the range of issues that are most significant for younger families with children with disabilities. Some potential methods for exploring the issue include:

- Interview parents and children about issues and need for services.
- Consultation with the Disability Services Network;
- Review relevant literature;

Further testing could enable investigation into whether the POA tool would be able to prioritise clients for other services. For example, could the tool be used for other HACC services within the WMR or for other Local Government HACC services outside the WMR, who also use the INI.

## 6.3 Implementing a demand management plan

Two components, the POA tool and the waiting list data set form the basis for a demand management plan. The POA tool provides information about client demand, determined as

high, medium or low priority. When coupled with the information from the waiting list data set, managers and planners have access to information in order to make decisions relating to resource use.

A demand management plan assumes that following the implementation of the POA tool, LGA's will apply the waiting list data set (refer to Chapter 5) to those applicants who are not accessing the services required. This process will identify the number of applicants waiting as well as their level of priority for service access. In this way the data will fully reflect the demands upon services.

LGA's should determine how and by who the demand management data should be collected and collated. Centralisation of the process will simplify it for all involved. It is recommended that the process be undertaken on a routine basis at a time suitable to service providers. For example, agencies could elect to send the data along with their MDS collections on a quarterly basis to DHS. Alternatively the LGA's could seek a service development grant to fund a consultant to collate and analyse the data. Upon agreement by the LGAs regarding the waiting list data set, it is recommended that a template be developed as an electronic file. This should be developed centrally to simplify collection of data across different agencies. A Microsoft Excel or Access database would be conducive to this data collection. It is envisaged that this would not require a large amount of resources to set it up.

The POA tool enables LGA's to develop profiles related to HACC services. These profiles could include, the number of clients accessing services at high, medium and low priority levels, the mix of services provided at each level. These profiles can be used strategically by LGA's for the purpose of funding applications, comparison of data within the LGA and service development.

Further development of the service planning concept could lead to comparative studies. For example, a longitudinal comparative study could be undertaken that compares a sample of low priority clients accessing HACC services, with a sample of people assessed as low priority but placed on a waiting list. This could provide valuable evidence about the impact of not providing services to those with lower needs.

The consistent use of the POA tool and the waiting list data set will provide the basis of a demand management plan for LGA's. It also forms the foundation for service planning comparisons should LGA's elect to do this.

## 6.4 Summary

A short term goal for implementing the POA tool requires the seven WMR HACC LGAs to develop and sign an agreement that formally recognises the POA tool. Training for the POA tool is a medium term goal and relies on the roll out of the INI suite of tools. Further validation and refinement of the POA tool are longer-term goals but are important for ensuring the process is a reliable and valid one for determining priority of access to WMR Local Government HACC services and for examining the applicability of the tool beyond these

seven HACC agencies. Implementation of the demand management plan should align with the implementation of the POA tool.

As the demand for home and community services grows, the need for agencies to provide a consistent and equitable process for determining access to services increases. This project aimed to provide a simple and consistent, yet comprehensive approach for WMR Local Government HACC services to determine priority of access for clients. A consistent method for determining priority has the advantage of providing consistent evidence of the unmet needs of those trying to access services in the Western Region. This evidence supports appeals for increased funding for agencies to adequately meet the increasing needs of people living in the community. However, it is important that other measures are taken to increase awareness of HACC services, particularly to isolated and vulnerable groups to ensure that those who need services most are able to access them.

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## Appendices

### Appendix 1: (Options for NARI Round Table) Option 1

<i>Indicator of need</i>	<i>How to complete</i>	<i>High</i>	<i>Medium</i>	<i>Low</i>
Domestic ADLs	Refer to <b>Functional Screen</b> items 1-5. Count the number of '2's selected and tick appropriate box:	<input type="checkbox"/> 0-3 items	<input type="checkbox"/> 1-2 items	<input type="checkbox"/> 3-5 items
Self Care ADLs	Refer to <b>Functional Screen</b> items 6 and 7 Calculate score for these 2 items and tick appropriate score.	<input type="checkbox"/> 0-1	<input type="checkbox"/> 2-3	<input type="checkbox"/> 4
Cognition	If dementia has been diagnosed previously tick high. If it hasn't refer to <b>Functional Screen</b> items 4 & 5 on page 1 and item 8 on page 2	<input type="checkbox"/> Scored 0 on item 8 OR <input type="checkbox"/> Scored 0 on Item 4 or 5 (with no physical disabilities or problems with literacy taken into account)	<input type="checkbox"/>	<input type="checkbox"/> scored 2 on item 8 OR <input type="checkbox"/>
Behaviour	Refer to <b>Functional Screen</b> item 9 on page 2	<input type="checkbox"/> Scored 0	<input type="checkbox"/> NA	<input type="checkbox"/> Scored 2
Household financial situation	Refer to <b>Living Arrangements</b> profile, trade-offs question:	<input type="checkbox"/> Yes	<input type="checkbox"/> Not sure	<input type="checkbox"/> No
Social Support	Refer to <b>Living Arrangements &amp; Psychosocial Profiles</b> . 'Carer' refers to non-resident and resident carers.	<input type="checkbox"/> Lives alone and has no carer OR <input type="checkbox"/> Has a carer who scores 30+ on the K-10 scale	<input type="checkbox"/> Carer scores 16-29 on K-10 scale	<input type="checkbox"/> Lives with carer who scores less than 16 on K-10 scale.
Psychological wellbeing	Refer to <b>Psychosocial Profile</b> : mental health and wellbeing. Consumer's score on K-10	<input type="checkbox"/> 30+	<input type="checkbox"/> 16-29	<input type="checkbox"/> less than 16
Self Rated Health	Refer to <b>Health Conditions Profile</b> : In general, how would you say your health is?	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good OR <input type="checkbox"/> Very good OR <input type="checkbox"/> Excellent

Sensory-Vision	Refer to <b>Health Conditions Profile</b> . Consider responses for reading and long distance eyesight (with glasses)	<input type="checkbox"/> Both responses poor OR <input type="checkbox"/> One poor and one fair	<input type="checkbox"/> Both fair OR <input type="checkbox"/> One fair and one good	<input type="checkbox"/> Both either good or excellent
Sensory- Hearing	Refer to <b>Health Conditions Profile</b> . Hearing	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Excellent OR <input type="checkbox"/> Good
Falls Risk	Refer to <b>Health Conditions</b> profile	<input type="checkbox"/> More than 1 fall in past 6 months	<input type="checkbox"/> 1 fall in past 6 months	<input type="checkbox"/> No falls in past 6 months
Health behaviours	Refer to <b>Health Behaviours</b> profile and tick appropriate boxes: <input type="checkbox"/> Currently smokes <input type="checkbox"/> Has a drink containing alcohol 5 or more times per week <input type="checkbox"/> Female-has not had a breast screen in past 2 years <input type="checkbox"/> Female-has not had a pap smear in last 2 years <input type="checkbox"/> Does less than 30 minutes of physical activity <input type="checkbox"/> The hardest physical activity during the past 4 weeks was "very light" <input type="checkbox"/> Reference to another health risk, e.g. substance abuse, unsafe sex etc.	Female <input type="checkbox"/> 5+ ticks  Male <input type="checkbox"/> 3+ ticks	Female <input type="checkbox"/> 2-4 ticks  Male <input type="checkbox"/> 2 ticks	Female <input type="checkbox"/> 0-1 tick  Male <input type="checkbox"/> 0-1 tick
Nutrition Status	Refer to <b>Health Behaviours</b> nutrition risk screening tool. How many items were ticked?	<input type="checkbox"/> 4-10 items	<input type="checkbox"/> 1-3 items	<input type="checkbox"/> None
Language	Refer to <b>Consumer Information</b> : interpreter required and preferred language.	<input type="checkbox"/> Interpreter needed	<input type="checkbox"/> Preferred language is not English but doesn't need interpreter	<input type="checkbox"/> Preferred language is English

Calculate score: high=2, medium=1, low=0

Scores between 20-28= High Priority

Scores between 10-19= Medium Priority

Scores between 0-9 = Low Priority

Factors that seem most important are cognitive impairment, social support and ADL- perhaps we should give these factors a greater weight eg 10, 5, 0.

## Option 2

### Step 1: Determine High, Medium or Low ADL

Refer to items 1-7 on the *Functional Screen*. Please note that you will need to put a score next to each of the 7 items. If items 6 and 7 were not completed as they were not required, please assign a 2 for each of these items. Please add up the scores for all 7 items (and note that a 9 should not be included in calculation). Determine priority level for ADL using the total score:

- High** 0 – 3- with at least one zero on either Items 6 and/or 7.
- Medium** 4 – 7
- Low** 8 - 14

### Step 2: Determine whether cognitive impairment is present

Please tick the relevant boxes:

- Consumer has been previously diagnosed with dementia or related disorder
- Functional Screen* Item 8 = 0
- Functional Screen* Item 9 = 0
- Living Arrangements profile*, no, person is not capable of making own decisions.

If you have selected any of the above boxes you have determined that some cognitive impairment may be present.

### Step 3: Matrix 1: ADL with Cognitive Impairment

Cross reference the result from Step 1 (ADL level) with Step 2 (presence of cognitive impairment) to determine High, Medium or Low using the following matrix:

		Step 1: ADL		
		<i>High</i>	<i>Medium</i>	<i>Low</i>
Step 2	<i>Cognitive Impairment</i>	<b>High</b>	<b>High</b>	<b>Medium</b>
	<i>No Cognitive Impairment</i>	<b>High</b>	<b>Medium</b>	<b>Low</b>

### Step 4: Determine High, medium or low Social Support

Refer to the *Psychosocial profile*. If a carer is available please complete the 10 questions under Mental Health and Wellbeing (the K-10 Score) and accord level of social support need:

- High:** Lives alone and has no carer OR  
Carer (resident or non-resident) scores 30+ on the K-10 score (ie not coping)
- Medium:** Carer (resident or non-resident) scores 16-29 on the K-10 Score
- Low:** Carer (resident or non-resident) scores less than 16 on the K-10 Score

### Step 5: Matrix 2: Social Support and Matrix 1

Cross reference Step 3 (combined ADL and Cognition) with Step 4 (Social Support) in the following matrix for a final priority level:

		Step 4: Social Support		
		<i>High</i>	<i>Medium</i>	<i>Low</i>
Step 3: Matrix 1 (Combined ADL & cognition)	<i>High</i>	<b>High</b>	<b>High</b>	<b>Medium</b>
	<i>Medium</i>	<b>High</b>	<b>Medium</b>	<b>Low</b>
	<i>Low</i>	<b>Medium</b>	<b>Low</b>	<b>Low</b>

The level from this final matrix can be used to determine priority of access for Local Government HACC services in the WMR.

## Appendix 2: Table of Indicators used by WMR LGAs and related questions on INI

Indicator	Description of application by WMR	Inclusion in the INI/Functional screens and assessments
Isolation	Isolation is fairly consistently applied by WMR LGAs. A high priority client would tend to have few informal supports. Although living alone with no carer was considered a characteristic of a high priority client, a person could co-reside with a carer who also had limited outside supports/ unable to provide support and be considered a 'high' priority.	<p>The <i>Supplementary Living Arrangements Profile</i> asks whether the consumer:</p> <ol style="list-style-type: none"> <li>1) lives alone</li> <li>2) lives with family</li> <li>3) lives with others.</li> </ol> <p>Comments on living arrangements are requested.</p> <p>The <i>Supplementary Psychosocial Profile</i> asks: During the past 4 weeks...was someone available to help you if you needed and wanted help? For example if you:</p> <ul style="list-style-type: none"> <li>- felt very anxious, lonely or blue</li> <li>- got sick and had to stay in bed</li> <li>- needed someone to talk to</li> <li>- needed help with daily chores</li> <li>- needed help just taking care of yourself.</li> </ul> <p>Options:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, as much as I wanted</li> <li><input type="checkbox"/> Yes, quite a bit</li> <li><input type="checkbox"/> Yes, some</li> <li><input type="checkbox"/> Yes, a little</li> <li><input type="checkbox"/> No, not at all</li> </ul> <p>"Use this question if you feel it is appropriate to the consumer's presenting problems...If the consumer has little social support consider referral and the possibility of completing a Functional Profile".</p>

Indicator	Description of application by WMR	Inclusion in the INI/Functional screens and assessments
Carer Issues	<p>Issues related to the carer's ability to maintain their caring roles are important in determining priority of access for WMR LGAs. While carer burden is generally associated with high priority, there is some variation in the terminology used. For example: "carer not coping", 'unable to meet caree's needs or carer 'is either unable to provide the level of assistance required and/or require time to participate in social, family and community activities. This issue is often considered alongside social isolation and living alone. For instance, living alone/isolated <u>or</u> has a carer not coping is indicative of a high priority. On 2 of the score based tools a separate question relates to the household's ability to cope.</p>	<p>Also refer to comments under "Isolation"</p> <ol style="list-style-type: none"> <li>1) The <i>Supplementary Living Arrangements Profile (Carer profile)</i>. Carer availability: has a carer</li> <li>2) has no carer</li> <li>3) not applicable – consumer is carer,</li> </ol> <p>Carer residency status</p> <ol style="list-style-type: none"> <li>1) yes- co-resident carer</li> <li>2) no- non-resident carer</li> <li>3) not applicable – the consumer has no carer</li> </ol> <p>Relationship of carer to care recipient (12 options including: wife/female partner, husband/male partner etc.</p> <p>If there are carer issues, assessors are instructed to complete a separate INI for the carer.</p>
Supports required / available	<p>This appears highly interconnected with carer issues but is sometimes considered separately, e.g. in relation to formal supports and the ability of other agencies to meet needs. This is not consistent across LGAs. It appears that some only consider the ability of formal supports to provide care while others consider the need for additional support in the context of current provision of support from informal and formal supports.</p>	<p>The <i>INI Summary and Referral Information</i> has space to list services used in the last three months and asks for contact details or any other information as appropriate. Under the table of services is a prompt list to help recall of all services in place.</p> <p>Purpose of identifying these services is to suggest consumer problems and issues that may not have been identified to this point- may inform the need for completing other sections of the supplementary profiles. Also, current services need to be accounted for in an initial action plan and if necessary in developing a service co-ordination plan.</p>

Indicator	Description of application by WMR	Inclusion in the INI /Functional screens and assessments
Physical capacity	<p>Is addressed by all LGAs. There is no consistent application. Some consider physical health separately from ability to perform Activities of Daily Living, while others link the two, e.g. one scoring method gives a high score for "frailty/debility- medically unstable, mostly dependent, requires significant support to perform essential ADLs". "High level of frailty or disability" is another description of physical capacity.</p>	<p>The INI templates consider physical health and function separately.</p> <p>The <i>Supplementary Health Conditions Profile</i>:</p> <ul style="list-style-type: none"> <li>• SF-36 -self-rated health- 5 point scale from excellent to poor. The SF-36 has been found to be a good predictor of subsequent illness and premature death. Ask if there has been any changes and if there has have they told their medical practitioner.</li> <li>• Bodily pain- during past 4 weeks- 5 point scale from none- very severe. Consider whether someone with significant bodily pain is already under the care of a medical practitioner and whether impacting on ADLs, personal or social relationships.</li> <li>• 4 point rating of how much health interfered with "normal activities (outside and/or inside the home)". If occurring consider completing functional profile.</li> <li>• list all health conditions - report any problems past or present that may relate to present problem- hospital stays, medical interventions/ conditions or disabilities. Suggests asking questions such as "Do you have any health conditions that interfere with your normal activities that are long-standing or recurring"</li> <li>• list current medications. Suggests a medication review if polypharmacy exists but doesn't state how many would be considered polypharmacy.</li> <li>• Comment box to capture anything not already identified.</li> </ul> <p>The <i>Supplementary Functional Profile</i> was developed to determine functional dependency items for HACC services. It is a 9-item scale that asks about what people are currently capable of doing (rather than what they actually do). If a question is not applicable- eg the consumer doesn't take any medications you are asked to rate based on what the person would be capable of doing if the item actually was relevant. "In assessing capability, take into account not only physical function but also cognition...and behaviour. Consumers able to complete a task with verbal prompting should not be rated as independent (i.e. rate as 1).</p> <p>The response categories for IADL and ADL are basically:</p> <ul style="list-style-type: none"> <li>• Can do without help (score 2)</li> <li>• Can do with some help (score 1)</li> <li>• Completely unable to do (score 0)</li> </ul> <p>IADL has five items; housework, getting to places in walking distance, shopping for groceries or clothes, take medicine, handle own money. Possible score range 0-10. If scored less than 2 recommends referral for assessment using modified version of Lawton's IADL measure.</p> <p>ADL measured with 2 items on walking and taking a bath/shower. If scored less than 2 on either item refer for ADL assessment using either the Barthel Index or the Functional Independence Measure (FIM).</p>

Indicator	Description of application by WMR	Inclusion in the INI /Functional screens and assessments
Mobility	Generally overlaps with “physical capacity” above, however, 3 LGAs have a question with a 5 category response list ranging from ambulant/ independent with no aids through to bedridden	As per <i>Supplementary Functional Profile</i> under physical capacity. The use of aids for enabling completion of self-care tasks is included in the Functional Profile. For example, if able to walk without help (except for a cane)- you would score 0 (indicating independence).
Sensory capacities	Two LGAs ask about sensory loss on a 5 point scale, another asks about sensory loss in relation to safety.	The <i>Supplementary Health Conditions Profile</i> has questions about vision and hearing. Hearing: Is your hearing (with your hearing aid) select from excellent, good, fair, or poor. Vision: Is your eyesight for reading (with your glasses): select from excellent, good, fair, or poor; Is your long distance eyesight (with your glasses): select from excellent, good, fair, or poor. These items used in 1999 Older People’s Health Survey.
Cognitive and emotional capacities/perceived memory function	Cognition considered but not always specified. Some consider cognition on its own, others relate it to function, one considers its impact on accepting help. Some LGAs ask about mental health either separately or in conjunction with cognition	The <i>Supplementary Functional Profile</i> considers memory and behaviour problems. If consumer scores less than 2 on item about medication (item 4) or financial management (item 5) recommend referral for cognitive and behavioural assessment after physical disability and English literacy are ruled out as reasons for difficulties in these tasks. Also refer for cognitive assessment if the person has memory problems or gets confused (item 8). Also refer for a behavioural assessment if (using all sources of information except the consumer) the person has behavioural problems such as aggression, wandering or agitation (item 9). <u>Cognitive assessment</u> : Mini-Mental State Examination <u>Behavioural assessment</u> : modified version of the Australian Resident Classification Scale suitable for people living in the community.  Also refer to <i>Supplementary Living Arrangement Profile</i> : “Is the person capable of making own decisions? Yes/No/Not sure. If answered not sure or no, consider the need for assistance, need for cognitive assessment, and implications for consent. This form also asks to indicate whether financial decisions are made by: 1) Self 2) Power of Attorney 3) Administrator 4) Parent or Guardian

Indicator	Description of application by WMR	Inclusion in the INI/Functional screens and assessments
		Query- does this relate to cognition?
Communication /Impact of Cultural background	Not all LGAs explicitly consider communication. LGAs that do consider it apply it differently. On the score based tool of 2 LGAs people are ranked on a 5-point scale from 'able to communicate effectively' to 'not able to communicate needs'. One LGA considers communication under risk factors. Another LGA considers the impact of cultural background on capacity to organise appropriate help. Apart from this one LGA, most LGAs do not explicitly factor cultural background into priority of access.	<p>The <i>INI Consumer Information</i> form asks for demographic details including:</p> <ul style="list-style-type: none"> <li>• Country of birth,</li> <li>• Indigenous status (4 categories),</li> <li>• Main language spoken at home,</li> <li>• Interpreter required (1 – interpreter not required; 2 – interpreter required)</li> <li>• Preferred language (if not spoken English) including sign language, and any required communication devices or special interpreter needs.</li> </ul> <p>These questions have response items consistent with the HACC MDS (i.e. use Standard Australian Classification of Countries and Languages), with the exception of preferred language that is an open text box.</p> <p>These questions raise potential issues related to language barriers (including sign language etc) however, it doesn't raise "ability to communicate needs" as some WMR LGAs do.</p>
Physical environment	The 4 score based tools considered the physical environment with slightly different focus: accessibility/ safety/ risk/sub-standard housing/health and safety issues	<p>The <i>Supplementary Living Arrangements Profile</i> asks to identify which type of accommodation the consumer resides in from a 14 item checklist (e.g private residence – owned/purchasing, private residence – private rental through to temporary shelter within an Aboriginal community). An open text box follows asking for comments on accommodation.</p> <p>(Living arrangements/ family arrangements are considered under other categories, e.g. social isolation)</p>
Risk abuse / neglect	Usually identified but inconsistently applied by	The <i>INI Consumer Information</i> has an open text box for description of risks, urgency and access issues. The guidelines for completing this text box highlight different types of risk. The consumer may be at risk due to a

Indicator	Description of application by WMR	Inclusion in the INI /Functional screens and assessments
	LGAs. More explicit on score based tools. Some of the	fragile living/social condition, dangerous physical environment, domestic situation where there is risk of physical or emotional abuse or danger, risk of self-harm (deliberate or unintentional). The risk that the consumer presents
Risk abuse / neglect cont.	factors considered include: neglect; abuse by self or others, physical/emotional/financial or sexual abuse, threat to safety, confusion/dementia, inability to verbally communicate.	to other people (e.g. formal or informal carers) is also considered.
Household income / financial situation	Three LGAs specify finances in determining priority. One considers "financially disadvantaged", another considers different income levels and the third ranks from "independent means" through to "pension only"	<p>The <i>INI Consumer Information</i> has a question about government pension/benefit status with a 7 options to select from (including; Aged Pension, Carer payment, no government pension or benefit). Another question has 4 response categories to indicate DVA card status (no card, gold, white, other).</p> <p>The <i>Supplementary Living Arrangements Profile</i> asks to indicate whether financial decisions are made by:</p> <ul style="list-style-type: none"> <li>5) Self</li> <li>6) Power of Attorney</li> <li>7) Administrator</li> <li>8) Parent or Guardian</li> </ul> <p>Another question asks "Because of limited income, during the last month have you made any trade-offs among purchasing any of the following: prescribed medications, necessary medical care, adequate food, home care?" Response categories: yes, no, not sure. This item is from the US MDS-HC. The validity and reliability in an Australian population is unknown although it would appear to have content validity.</p> <p>Question on this profile asks about employment status and provides 8 possible responses (employed/self employed; sheltered, child/student, home duties, unemployed, retired for age, retired for disability, other). An open text box is available for comments on employment.</p>
Willingness to accept current services /	One LGA considers willingness to accept services where willing to accept services results in a	Not considered

Indicator	Description of application by WMR	Inclusion in the INI /Functional screens and assessments
increased assistance	lower score (i.e. lower priority) and refusing services results in a higher score (i.e. higher priority).	
Commitment to stay at home	Not explicitly considered by most LGAs- one measures on 3 point scale from 'considering other options' (low priority) to 'very committed' (high priority).	Not considered
Health Behaviours		<p>The <i>Supplementary Health Behaviours Profile</i> asks about behaviours including:</p> <ul style="list-style-type: none"> <li>• Smoking (never smoked, has quit smoking – if so when?, currently smokes);</li> <li>• alcohol consumption; how often? (never, monthly, once a week, 2-4 times per week, 5+ per week; how many standard drinks do you have on a typical day when you are drinking?); How often do you have more than 6 standard drinks on one occasion? (never, monthly, once a week, 2-4 times per week, 5+ per week) – consider referral if alcohol consumption is an issue.</li> <li>• breast screening- yes/no – if yes record date</li> <li>• pap smear- yes/no – if yes record date</li> <li>• physical activity/fitness: Would you accumulate 30 minutes or more of moderate intensity physical activity on most days of the week? Yes/no. During the past 4 weeks what was the hardest physical activity you could do for at least 2 minutes? (5 response category from very heavy (eg jog, fast pace, carry a heavy load upstairs or up hill, through to very light (walk, slow pace; wash dishes)</li> <li>• open text box for comments on health behaviours “including other relevant issues (eg, other substance use, safe sex practices)”.</li> </ul>
Falls Risk		The <i>Supplementary Health Conditions Profile</i> asks whether the consumer has had a fall in past 6 months (yes/no) and the number of falls in this time period. This item selected from the DVA D677 form on the basis of its common usage.
Nutritional status	Most LGAs do not consider nutritional status explicitly. One rates it one a 3-point	<i>Health Behaviours Supplementary Profile</i> includes the HACC program’s Nutritional Risk Tool, which is a 10-item checklist. Yes to one or more items means that nutritional risk exists. These questions are selected from the HACC Program Nutritional Risk Tool. The items used are invalidated and some items in the checklist might be

Indicator	Description of application by WMR	Inclusion in the INI /Functional screens and assessments
Nutritional status cont.	scale from adequate and independent to unable to maintain adequate nutrition independently. Another considers the consumer's ability to prepare meals.	given different weights.
Psychological wellbeing	Not referred to specifically.	<p>Psychosocial profile includes the K10 to determine the need for a mental health assessment.</p> <p>10 items are; tired out for no good reason, nervous, so nervous that nothing could calm you down, hopeless, restless or fidgety, so restless you could not sit still, depressed, that everything was an effort, so sad that nothing could cheer you up, worthless. 5 possible responses for each item (all of the time – none of the time).</p> <p>Score range 10-50. Tool has normative data (on Australian population- the characteristics of this normative population are not specified). Scores based on this normative population suggest scores:</p> <p>10-15 – ¼ population risk of meeting criteria for an anxiety or depressive disorder and remote chance of reporting a suicide attempt</p> <p>16-29 – 3 times the population risk for anxiety/depression/suicide attempt. Refer to primary care mental health unit.</p> <p>31-50 – 10 times the risk of anxiety/depression and 20 times the risk of suicide. Refer to specialist mental health assessment.</p>

## Appendix 3: Pilot Tool

Name: \_\_\_\_\_

<i>Indicator of need</i>	<i>How to complete</i>	<i>High: Score 2</i>	<i>Medium: Score 1</i>	<i>Low: Score 0</i>	<i>Score</i>
Domestic ADLs	Refer to <b>Functional Screen</b> items 1-5. Count the number of '2's selected and tick appropriate box:	<input type="checkbox"/> 0 items	<input type="checkbox"/> 1-2 items	<input type="checkbox"/> 3-5 items	
Self Care ADLs	Refer to <b>Functional Screen</b> items 6 and 7 Calculate score for these 2 items and tick appropriate score.	<input type="checkbox"/> 0-1	<input type="checkbox"/> 2-3	<input type="checkbox"/> 4	
Cognition	If cognitive impairment has been diagnosed previously tick high. If it hasn't refer to <b>Functional Screen</b> items 4 & 5 on page 1 and item 8 on page 2	<input type="checkbox"/> Scored 0 on item 8 OR <input type="checkbox"/> Scored 0 on Item 4 or 5 (with no physical disabilities or problems with literacy accounting for difficulty)	<input type="checkbox"/> NA	<input type="checkbox"/> scored 2 on item 8 AND no other indication of cognitive impairment	
Behaviour	Refer to <b>Functional Screen</b> item 9 on page 2	<input type="checkbox"/> Scored 0	<input type="checkbox"/> NA	<input type="checkbox"/> Scored 2	
Psychological wellbeing	Refer to <b>Psychosocial Profile</b> : mental health and wellbeing. Client's score on K-10  <b>OR</b> Referral source from <b>Consumer Information</b>	<input type="checkbox"/> 30+ OR <input type="checkbox"/> Referred or managed by a Psychiatric/ mental health service or facility OR <input type="checkbox"/> has diagnosed psychiatric disability	<input type="checkbox"/> 16-29	<input type="checkbox"/> less than 16	
Self rated health	Refer to <b>Health Conditions Profile</b> : In general, how would you say your health is?	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good OR <input type="checkbox"/> Very good OR <input type="checkbox"/> Excellent	
Sensory-Vision	Refer to <b>Health Conditions Profile</b> . Consider responses for reading and long distance eyesight (with glasses)	<input type="checkbox"/> Both responses poor OR <input type="checkbox"/> One poor and one fair	<input type="checkbox"/> Both fair OR <input type="checkbox"/> One fair and one good	<input type="checkbox"/> Both either good or excellent	
Sensory- Hearing	Refer to <b>Health Conditions Profile</b> . Hearing	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Excellent OR <input type="checkbox"/> Good	
Falls Risk	Refer to <b>Health Conditions</b> profile	<input type="checkbox"/> More than 1 fall in past 6 months	<input type="checkbox"/> 1 fall in past 6 months	<input type="checkbox"/> No falls in past 6 months	

<i>Indicator of need</i>	<i>How to complete</i>	<i>High: Score 2</i>	<i>Medium: Score 1</i>	<i>Low: Score 0</i>	<i>Score</i>
Nutrition Status	Refer to <b>Health Behaviours</b> nutrition risk screening tool. How many items were ticked?	<input type="checkbox"/> 4-10 items	<input type="checkbox"/> 1-3 items	<input type="checkbox"/> None	
Communication	Rate the ability to communicate with others based on barriers of: <ul style="list-style-type: none"> <li>• Language*</li> <li>• Literacy</li> <li>• Speech</li> </ul> <i>*(Refer to <b>Consumer Information: interpreter required and preferred language</b>)</i>	<input type="checkbox"/> Not able to communicate needs	<input type="checkbox"/> Able to communicate needs with some difficulty	<input type="checkbox"/> No difficulty communicating needs	
Social Outings	Does the client engage in social activities outside the home?	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> At least once a month	<input type="checkbox"/> At least once a week	
Carer Availability	Is there a carer* available to meet client's personal, household and social care needs? <i>*Carer: resident or non-resident family, friend or neighbour who provides some assistance with personal, household and/or social needs.</i>	<input type="checkbox"/> No carer available	<input type="checkbox"/> Carer available to meet some needs	<input type="checkbox"/> Carer available to meet most needs	
Carer Status	How well is the carer coping? (from the carer's perspective)	<input type="checkbox"/> No available carer OR <input type="checkbox"/> Able to meet needs with major impact on their wellbeing	<input type="checkbox"/> Able to meet needs with impact on their wellbeing	<input type="checkbox"/> Carer able to meet needs with minimal impact on their well-being	
<b>Total Score</b>					<b>Total</b>

If you have identified any other medical, social or emotional issues that are likely to increase risk (eg, incontinence, environmental hazards, hospitalisations, abuse or neglect) add 2 points to the subtotal. State what the issue/s is

**Score:**

- Scores between 21-30= High Priority
- Scores between 11-20= Medium Priority
- Scores between 0-10 = Low Priority

## Appendix 4: Priority of Access Tool

Client's name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Assessment Officer: \_\_\_\_\_

<i>Indicator</i>	<i>How to complete</i>	<i>High: Score 2</i>	<i>Medium: Score 1</i>	<i>Low: Score 0</i>	<i>Score</i>
Communication	Rate the ability to communicate with others based on barriers of: <ul style="list-style-type: none"> <li>• Language*</li> <li>• Literacy</li> <li>• Speech</li> </ul> <i>*(Refer to <b>Consumer Information: interpreter required and preferred language</b>)</i>	<input type="checkbox"/> Not able to communicate needs	<input type="checkbox"/> Able to communicate needs with some difficulty	<input type="checkbox"/> No difficulty communicating needs	
Domestic ADLs	Refer to <b>Functional Screen</b> items 1-5. Count the number of '2's selected and tick appropriate box:	<input type="checkbox"/> 0 items	<input type="checkbox"/> 1-2 items	<input type="checkbox"/> 3-5 items	
Self Care ADLs	Refer to <b>Functional Screen</b> items 6 and 7 Calculate score for these 2 items and tick appropriate score.	<input type="checkbox"/> 0-1	<input type="checkbox"/> 2-3	<input type="checkbox"/> 4	
Cognition	If cognitive impairment has been diagnosed previously tick high. If it hasn't refer to <b>Functional Screen</b> items 4 & 5 on page 1 and item 8 on page 2	<input type="checkbox"/> Cognitive Impairment diagnosed <input type="checkbox"/> Scored 0 on item 8 OR <input type="checkbox"/> Scored 0 on Item 4 or 5 (with no physical disabilities or problems with literacy accounting for difficulty)		<input type="checkbox"/> scored 2 on item 8 AND no other indication of cognitive impairment	
Behaviour	Refer to <b>Functional Screen</b> item 9 on page 2	<input type="checkbox"/> Scored 0		<input type="checkbox"/> Scored 2	
Self rated health	Refer to <b>Health Conditions Profile:</b> In general, how would you say your health is?	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good OR <input type="checkbox"/> Very good OR <input type="checkbox"/> Excellent	
Sensory-Vision	Refer to <b>Health Conditions Profile.</b> Consider responses for reading and long distance eyesight (with glasses)	<input type="checkbox"/> Both responses poor OR <input type="checkbox"/> One poor and one fair	<input type="checkbox"/> Both fair OR <input type="checkbox"/> One fair and one good	<input type="checkbox"/> Both either good or excellent	
Sensory-Hearing	Refer to <b>Health Conditions Profile.</b> Hearing	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Excellent OR <input type="checkbox"/> Good	

<i>Indicator</i>	<i>How to complete</i>	<i>High: Score 2</i>	<i>Medium: Score 1</i>	<i>Low: Score 0</i>	<i>Score</i>
Falls Risk	Refer to <b>Health Conditions</b> profile	<input type="checkbox"/> More than 1 fall in past 6 months	<input type="checkbox"/> 1 fall in past 6 months	<input type="checkbox"/> No falls in past 6 months	
Nutrition Status	Refer to <b>Health Behaviours</b> nutrition risk screening tool. How many items were ticked?	<input type="checkbox"/> 4-10 items	<input type="checkbox"/> 1-3 items	<input type="checkbox"/> None	
Social Outings	Does the client engage in social activities outside the home?	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> At least once a month	<input type="checkbox"/> At least once a week	
Carer Availability	Is there a carer* available to meet client's personal, household and social care needs? <i>*Carer: resident or non-resident family, friend or neighbour who provides some assistance with personal, household and/or social needs.</i>	<input type="checkbox"/> No carer available	<input type="checkbox"/> Carer available to meet some needs	<input type="checkbox"/> Carer available to meet most needs	
Carer Status	How well is the carer coping? (from the carer's perspective)	<input type="checkbox"/> No available carer OR <input type="checkbox"/> Able to meet needs with major impact on their wellbeing	<input type="checkbox"/> Able to meet needs with impact on their wellbeing	<input type="checkbox"/> Carer able to meet needs with minimal impact on their well-being	
Environmental Hazards	Does the environment (in and around the person's place of residence) pose a safety risk to the client or impede the client's ability to mobilise and to maintain hygiene. If an environmental hazard exists could this be resolved in the short term, the long term or is not likely to be resolved at all.	<input type="checkbox"/> Can't be resolved	<input type="checkbox"/> Resolvable within 12 months	<input type="checkbox"/> no risk <input type="checkbox"/> Resolvable within four weeks	
<b>Total Score</b>					<b>Total</b>

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

\_\_\_\_\_ Final Score: \_\_\_\_\_

### Score:

- Scores between 19-30= High Priority
- Scores between 11-18= Medium Priority
- Scores between 0-10 = Low Priority

# **GUIDELINES FOR USING THE PRIORITY OF ACCESS TOOL FOR WMR LOCAL GOVERNMENT HACC PROVIDERS**

## **1) WHAT IS THE PRIORITY OF ACCESS TOOL?**

The Priority of Access tool provides a method for HACC assessment staff to determine the priority of access level of clients/potential clients. It has been developed for use in all Local Government HACC services within the Western Metropolitan Region of Victoria. It is intended that this tool will replace current priority of access tools developed by individual Local Governments. The aim of having a consistent tool across the region is to enable equity of access to be examined across the region for informing planning of HACC services in the future.

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

The introduction of the Priority of Access tool coincides with the introduction of the Initial Needs Identification (INI) tools being introduced through the Primary Care Partnership (PCP) initiative. It is recommended that use of the Priority of Access tool is not introduced until the INI tools are routinely used in your agency. While the INI tools consider many of the characteristics that are used to determine priority, the INI tools do not summarise the information to determine whether someone has a high, medium or low priority for access to services. The guidelines that accompany the INI tools however, suggest that the following set of codes could be used:

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

To maintain consistency with current practice in the WMR Local Government HACC services the terms high, medium and low have been retained. However, definitions recommended in the INI guidelines, as shown above, are consistent with the categories of high, medium and low.

## **2) DEVELOPMENT OF THE TOOL**

The Priority of Access tool was developed by the National Ageing Research Institute with input from a working party consisting of representation from the Department of Human Services (WMR) and each of the seven Local Government HACC services in the WMR. For further information on the pilot and feedback processes please refer to the full report: "Development of Priority of Access Tool for WMR Local Government HACC Providers" (NARI, 2002).

### 3) WHAT THE TOOL DOES NOT DO

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

- Define client need or identify the client's perception of need
- Specify levels or types of service provision for clients
- Provide a comprehensive assessment tool

### 4) WHO USES THE PRIORITY OF ACCESS TOOL

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

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

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

### 5) WHEN TO COMPLETE THE PRIORITY OF ACCESS TOOL

The Priority of Access tool can be completed during the assessment or after the assessment back in the office.

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

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

### 6) HOW TO COMPLETE THE PRIORITY OF ACCESS TOOL

This tool is designed as a two-sided single-page instrument with fourteen indicators to be completed. The indicators have been selected based on a combination of factors including current tools used in the region, objectives for HACC services and literature regarding factors that predict service use in the community. The first 10 indicators are completed by referring to information completed on the profiles in the Initial Needs Identification (INI) suite of tools. The first four indicators are drawn from the *Profile:*

*Functional Screen.* Completion of this profile is compulsory for all HACC services. The next six questions are based on information from other profiles that are not compulsory for HACC services to complete but have been determined as important for determining priority of access to HACC services. The final 4 indicators are not drawn directly from the INI but have been developed specifically for determining priority of access.

The tool is read from left to right. There are six columns, the first column identifies the element being considered, the second contains directions for the assessor and the remaining three are labelled high, medium or low. The final column leaves room to record the score for each indicator. The 14 indicators require the assessor to place a tick in the box which reflects their interpretation of the situation/need of the client. The layout of the tool is shown below for the first question on the Priority of Access tool: 'Domestic ADL's'.

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

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

### **COMMUNICATION**

This indicator relates to ability to communicate with others and considers issues of language, literacy and ability to produce speech. These factors are not always indicated on the INI with the exception of language where the need for an interpreter and preferred language is recorded on the second page of the *Consumer Information*. Things to consider when determining level is how much communication barriers prevent people communicating their needs in everyday situations, for example, in social relationships and for purchasing goods and services. If someone speaks a language other than English and does not communicate in English they are likely to need an interpreter during assessments and to have a formal carer who speaks the same language. If they have strong networks with their ethnic community they may have many social outings with people who speak their language and be able to purchase goods in particular shops. In circumstances similar to these the assessor would select the "able to communicate needs with some difficulty (medium)". If the person was not linked with their ethnic community, lived alone and felt isolated due to language barriers, the "not able to communicate needs (high)" would be considered a more appropriate response for this indicator.

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

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### DOMESTIC ADLS

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To complete the first question the assessor must refer to the INI *Profile: Functional Screen* items 1-5. These items refer to domestic activities of daily living (ADLs). The assessor counts the number of '2's (indicating independence on specific ADL task). If there are no '2s'- i.e. the person is unable to complete any Domestic ADLs independently, the column under "high" is ticked and a score of 2 is placed in the far right column. If there are one or two '2s' the medium box is ticked and a score of 1 is entered in the far right column. If there are 3, 4 or 5 "2s" the low box is ticked and a score of 0 is placed in the far right column

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### SELF CARE ADLS

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The question on self-care ADLs is completed by referring to the *Profile: Functional Screen*, items 6 and 7. The scores from the two items are added. Possible scores range between 0 (unable to independently walk or complete bath/shower) to 4 (able to independently walk, bath and shower without assistance). This score is translated into the high, medium or low categories according to scores indicated. Tick the appropriate box and then record a 2, 1 or 0 in the far left column according to which box was ticked.

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

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### COGNITION

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If a cognitive impairment such as Alzheimer's Disease or another dementia-related condition has previously been diagnosed by someone with the expertise to diagnose dementia (e.g. neurologist, physician), automatically put a tick in the high column and score 2. If no diagnosis made refer to Functional Screen Items 4, 5, 8. If there is no indication of memory problems or getting confused, and the client's ability to take medicine or handle money is not influenced by confusion or memory difficulties, tick the 'low' box and score zero. If there are some difficulties associated with memory and confusion, tick one of the boxes in the high category and score a '2'. Please note that the score will remain 2 regardless of whether one or two of the boxes in the high column have been ticked.

Completion of the *Functional Screen* alone is not able to determine whether dementia is present. If there are issues related to memory please refer for a cognitive assessment. After a cognitive assessment has been completed, you may need to alter the Priority of Access tool to reflect the results of the cognitive assessment.

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

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## BEHAVIOUR

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

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

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## SELF-RATED HEALTH; SENSORY-VISION; SENSORY-HEARING; FALLS RISK

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These four indicators can be completed after completion of the corresponding questions on the *Health Conditions Profile*. The self-rated health question relates to the first question on the *Health Conditions Profile*: “In general, how would you say your health is?” The two questions on eyesight for reading and for long distance are combined for the indicator of vision. The hearing indicator refers to hearing with the use of a hearing aid if applicable. The falls risk considers whether there has been no falls, one fall or more than one fall in the previous 6 months.

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## NUTRITION STATUS

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This indicator refers to the number of items ticked in the nutrition risk screening tool on the *Health Behaviours Screen*.

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## SOCIAL OUTINGS

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Being able to go out for social outings provides an indication of social support for the person requesting services. High, medium or low is selected based on the frequency of social outings. A social outing could be considered any outing where the person has some meaningful social interaction with others. For some people a trip to the local shopping centre may be solely a means of purchasing goods, however, for others this may provide an opportunity to socialise with friends and acquaintances. Employment, volunteer work, schooling, and senior citizens centres all provide opportunities for socialising with others.

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## CARER AVAILABILITY

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This question is specifically about the availability of someone to provide assistance or to provide social contact for the person needing assistance. A carer may be resident or non-resident, a family member, friend or neighbour. This may refer to more than one carer. Availability includes being physically present and able to assist with tasks as well

as being willing to complete tasks or provide meaningful social contact. Availability is recorded in relation to the level of care required. Perhaps a client needs assistance with only one or two domestic tasks. If there is no carer available select 'high', if a carer is available to provide assistance with some of these tasks select 'medium', and if a carer is available to complete all or most of these tasks select 'low'. If a client needs assistance with numerous tasks such as personal care, housework, gardening, shopping and transport, select high if there no carer available, medium if a carer/carers can fulfil some of these needs or low if a carer/carers can meet most of these needs.

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

If the person being assessed is a carer, consider whether they have any supports or back-up if they are sick, unable to provide a particular type of assistance for the person they care for or they need a break.

**Please note:** if there is no carer it is important to select the "high" category and score the corresponding 2 points.

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### CARER STATUS

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

**Please note:** if there is no carer it is important to select the "high" category and score the corresponding 2 points.

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### ENVIRONMENTAL HAZARDS

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

To complete this indicator consider whether the hazard can be resolved and by when. A risk may pose an extreme danger to the client but if it can be easily resolved the low

category is selected. For example, an exposed electrical wire is extremely dangerous but can be resolved quickly by an electrician\*. This would therefore fall into the low priority for a HACC service. The medium category in the POA tool would be selected if there were hazards/issues that could be resolved in the longer term-within a year. These issues could be resolved through significant renovations or through regular assistance with a home care service. Select the high category where there are issues which cannot be overcome other than by leaving the environment altogether. For example; issues relating to the location of the residence; being on a floor above ground level; and the structure, layout and size of the residence.

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

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### **'OTHER' (SEPARATE BOX)**

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

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

## **7) HOW TO USE THE SCORE**

Once all 14 indicators have been completed and the "other" category completed, a total score can be calculated using the far right column on the tool. Scores will range between 0-30 which is then used to determine a high, medium or low priority using the following score ranges:

**Scores between 19-30= High Priority**

**Scores between 11-18= Medium Priority**

**Scores between 0-11= Low Priority**

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

Although people assessed as a low priority may be placed on a waiting list or not offered HACC services, it should be recognised that literature suggests that some contact with a service may have benefits for the person requiring assistance. It is recommended that

clients placed on a waiting list are routinely contacted to determine whether other services may be required or whether their priority level has increased. It is also important that assessors also consider other services outside the Local Government HACC services and referrals are made as appropriate.