South Australian Aged Care Assessment Programme

Referral Pathways Protocol

January 2016

Government of South Australia
SA Health

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ACAP Referral Pathway Protocol

1. Objective/ Purpose

This protocol has been established to ensure a uniformed approach to the work of the South Australian Aged Care Assessment Teams (ACAT), their target group, and to implement best practice and consistency across service delivery in the state of South Australia.

The Aged Care Assessment Programme (ACAP) Referral Pathway Protocol is guided by the principles set out in the *Aged Care Assessment Programme Guidelines May 2015 (Guidelines).*

It should be referred to wherever a client fits into one of the target groups (see Section 2) and where a referral needs to be made to a South Australian ACAT, requesting an assessment for aged care services. To achieve this aim the document details a variety of referral pathways for referring clients for an ACAT assessment.

The variety of referral pathways detailed in this document reflect the fact that clients may be referred from a number of sources, including the My Aged Care Contact Centre, hospital or community settings, and may have a range of needs and goals.

By clarifying the referral pathways for a range of clients, from a variety of environments, this document seeks to streamline and standardise the ACAT response to referrals.

Note that these referral pathways do not pre-empt acceptance of the referral by ACAT nor what the outcome of an assessment for each client might be, but do commit the South Australian ACATs to the timely and effective response of all accepted referrals as per standard ACAT practice and timeliness requirements set out in the ACAP Guidelines.

This document and the instructions it contains, apply to the following stakeholders:

- Aged Care Assessment Programme Reform Unit, Office for the Ageing, SA Health
- Country Health SA Local Health Network (CHSALHN)
- Central Adelaide Local Health Network (CALHN)
- Southern Adelaide Local Health Network (SALHN)
- Northern Adelaide Local Health Network (NALHN)
- All third party referrers to South Australian ACATs including:
  - Hospitals (Public and Private)
  - General Practitioners
  - Service Providers
  - South Australian Prisons including the Prison Health Service
  - Department of Communities and Social Inclusion (Disability SA, Domiciliary Care and Exceptional Needs Unit (ENU))
  - Advocacy organisations including Alzheimer's Australia SA

2. Scope/ Audience

2.1 Client Group

This protocol applies to all referrals for clients seeking aged care services that require an ACAT assessment. This includes the following client groups:

- Clients with an existing ACAT approval who need a different type or level of care
- Clients being discharged from hospital or post-acute service
- Clients at the end of a custodial sentence who require supports to be in place upon release
- Clients approved for parole who require supports to be in place upon release
- Clients eligible for support provided by the ENU and may be eligible for admission to Permanent Residential Care provided at Ian George Court (IGC).
- Clients under the age of 65 years; 50 years for Aboriginal and Torres Strait Islanders.

2.2 Aged Care Services

The protocol applies to referrals requesting an ACAT assessment, for the following aged care services:

- Home Care Package Programme (HCP)
- Transition Care Programme (TCP)
- Residential Respite (low/high)
- Permanent Residential Care

Out of Scope

This Protocol does not include referral pathways for the following:

- Commonwealth Home Support Programme (CHSP) services
- Clients requiring a Home Support assessment by a Regional Assessment Service
- Clients with an existing ACAT approval for the services they require
- Multi-Purpose Services
- State funded post-acute services such as the Metropolitan Referral Unit/Country Referral Unit
- Palliative services
- Mental Health services
- Referral to an ACAT in another jurisdiction

3. Principles

The ACAP Referral Pathway Protocol is guided by the principles set out in the Guidelines. The Guidelines outline the principles guiding ACATs in receiving requests or referrals for assessment, the subsequent intake process and the guidelines covering the process of gaining a client's consent to be assessed.

The Guidelines include principles on assessment for people with special needs and the *National Guiding Principles for Referral and Assessment of Younger people with Disability: between state and territory disability services and Aged Care Assessment Teams.*

4. Referral Information

4.1 Referral Information

Any referral to a South Australian ACAT should include the following core pieces of information to ensure the correct and timely processing of the referral:

- Referrer details including contact information.
- Consent for the referral has been obtained from the client or responsible person
- Client's current medical status is clear (if known).
- Information about existing services (if known).
- Identify the services that are required to meet the client needs including if required prior to discharge and why.
- Location of assessment.
- Details of other people who need to be present at the assessment.
- Any additional information that may assist the referral process including:
  - Clinical assessments
  - Wound care details
  - Medical summaries/history
  - Client history which could include psychosocial and any WHS considerations

- For under 65 (50 for Aboriginal and Torres Strait Islander) clients, the referral must also include documented evidence (either an email or a phone call documented in the referral) of all other options that have been explored and why they were deemed not appropriate to best meet the clients care needs.

  Please note: A formal letter from Disability SA staff is **not** required and will not be issued.

- For ENU clients, the referral must also clearly identify the client as ENU eligible and include information about appropriate available services, such as IGC, that may best meet the clients care needs.

<u>Where the referral does not contain enough information</u>
Where the referral does not contain enough information as set out above for the My Aged Care Contact Centre, or ACAT to process the referral, the referral may be rejected back to the referrer seeking additional information. This may cause delays in the processing of the referral through to ACAT Triage.

4.2 My Aged Care Contact Centre

Referrals can be made to the My Aged Care Contact Centre in three ways:

Faxed Referral	1800 728 174
Web Based Referral Form	www.myagedcare.gov.au/referral
Phone	1800 200 422
MONDAY TO FRIDAY *(exc public holidays)*	*8am to 8pm (local time)*
SATURDAY	*10am to 2pm (local time)*

5. Referral Pathways

5.1 Enquiries

All enquires on behalf of clients who need to be referred or have been referred through the My Aged Care Contact Centre must be made through the My Aged Care Contact Centre. This includes enquiries about:

- existing services/approvals the client may have in place and/or
- the progress of a referral to ACAT.

Historical information is not being transitioned to the My Aged Care System and it is only when a client has a record created in the My Aged Care System that any current approvals will be viewable. Aged Care Online Claiming can still be used by Service Providers to view current approval information.

Enquiries on behalf of a client may need to occur under 'implied consent' if the client cannot give verbal consent over the phone to the My Aged Care Contact Centre. In this instance, the enquirer will need the client's full name, date of birth and Medicare Number.

5.2 Clients with an existing ACAT approval and no change in care needs

If the client has an existing ACAT approval, and the type and level of care required has not changed from that existing approval level, a referral to ACAT is **not** required. In this instance, follow the pathways below depending on the client's situation:

- If the client has previously been in receipt of services but has had a break in care (including hospitalisation), contact the existing service provider directly to arrange the recommencement of services. This includes a return to Permanent Residential Care.
- If the client has not been in receipt of services, a referral should be made directly to an appropriate services provider using the existing referral pathways.

Please see Fact Sheet #4 – Existing Clients for further information.

5.3 Metropolitan ACAT Referral Pathway

5.3.1 Community Assessments

From 1 July 2015, all community referrals to a metropolitan ACAT for clients over 65 (50 for Aboriginal and Torres Strait Islanders) requesting an ACAT assessment, must be made directly to the My Aged Care Contact Centre. This includes enquiries about current services/approvals and referrals for services set out in Section 2.2.

This applies to all assessments being conducted by a metropolitan ACAT in the community or residential care setting.

5.3.2 Hospital Assessments

From 1 July 2015, all hospital referrals, including for Private and Public hospitals and from Local Health Networks (LHN), must be made directly to the local metropolitan ACAT.

These referrals must be made directly to the local ACAT, using the South Australian Hospital Referral Form.

5.4 Country ACAT Referral Pathway

From 1 July 2015, all referrals to a country ACAT for clients over 65 (50 for Aboriginal and Torres Strait Islanders) requesting an ACAT assessment, must be made through the My Aged Care Contact Centre. This includes enquiries about current services/approvals and referrals for services set out in Section 2.2.

This applies to all assessments being conducted by a country ACAT in the community, residential care and in-patient settings such as hospital (both Public and Private). This includes referrals for clients in a metropolitan hospital whose assessment will be undertaken by a country ACAT upon discharge.

For country ACAT assessments, all referrals from South Australian LHNs and hospitals (both Public and Private) must be made to the My Aged Care Contact Centre using the South Australian Hospital Referral Form.

5.5 Prison Referral Pathway

From 1 July 2015, all referrals to a South Australian ACAT requesting an ACAT assessment for clients over 65 (50 for Aboriginal and Torres Strait Islanders), must be made through the My Aged Care Contact Centre. This includes referrals for:

- A client at the end of a custodial sentence who requires supports to be in place upon release.
- A client approved for parole who requires supports to be in place upon release.

An ACAT assessment is **not** appropriate to support a parole application or for a prisoner still serving a custodial sentence.

5.6 Exceptional Needs Unit Referral Pathway

From 1 July 2015, all referrals from the ENU to a South Australian ACAT, requesting an ACAT assessment, must be made through the My Aged Care Contact Centre.

ENU clients undergo an extensive eligibility screening process in order to be accepted by the ENU. Given the vulnerability and complexity of this client group, see Section 2.1, it is not appropriate for the phone based screening to occur directly with the client.

The referral pathway for ENU eligible clients is as follows:

- ENU forward the referral to the My Aged Care Contact Centre on behalf of the client. The referral **must** contain the information identified as required (see Section 4) for a timely referral to be processed through to the appropriate ACAT for triage.
- Where the referral clearly identifies that the client is an ENU client, and includes all mandatory information, it should be processed by the My Aged Care Contact Centre directly to the appropriate ACAT for triage.

5.7 Clients aged under 65 (50 for Aboriginal and Torres Strait Islander) Referral Pathway

From 1 July 2015, all referrals to a South Australian ACAT for a client who is under 65 (50 for Aboriginal and Torres Strait Islanders) must be made following the pathways below. This ensures that younger people are appropriately screened and that all appropriate options have been explored before a referral is made for an ACAT assessment to determine eligibility for aged care services.

5.7.1 Determining eligibility for disability services or other appropriate care options

All clients under 65 (50 for Aboriginal and Torres Strait Islanders) must go through this process **prior** to referral to ACAT unless already undertaken at a previous time and their situation has not changed.

1. The referrer contacts Disability Services to determine the client's eligibility.

- Confirmation of eligibility can be obtained via the Duty Officer for the *Disability SA Intake team* (8372 1434) or fax to 8115 1267. Alternatively, call *Disability SA Information and Referrals* (1300 786 117).

- Where the client **is** eligible for disability services, or is an existing disability client, then the client will follow the disability service pathway to commence/recommence receipt of services to meet their needs.
- If there are waitlists for appropriate disability services then referral to ACAT for assessment for age care services is not appropriate.

2. The referrer investigates all other appropriate options to best meet the care needs of the client.

- Where the client **is not** eligible for disability services, but can access other services more appropriate to meet their care needs then the client will follow the service pathway to commence receipt of these services including but not limited to:
  - South Australian Home and Community Care (Under 65/50)
  - Alternative accommodation options
  - Palliative care and hospices
  - Mental Health services such as Individual Psychosocial Rehabilitation Support Service (IPRSS)
  - Supported Residential Facilities
  - ENU
  - Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse (CALD) specific supports
- If there are waitlists for appropriate services to meet the clients care needs then referral to ACAT for an assessment for age care services is not appropriate.

** Once a client has been through the **two step** process outlined above, and it is deemed that aged care services are still the most appropriate option to meet the clients care needs, then there are two referral pathways available depending on the client's situation.*

5.7.2 Where the client is not eligible for disability services and residential aged care has been deemed the most appropriate care option for the client.

This referral pathway is relevant for clients for whom an ACAT assessment is appropriate as there are no other appropriate options available to the client and permanent residential aged care is the most appropriate option to meet the client's care needs. This includes cases where disability services have been explored and the client is deemed **not** eligible.

To access an ACAT assessment, a referral to the My Aged Care Contact Centre **is** required and **must** include the information contained in Section 4 in order to proceed through to ACAT for triage.

The referral **must also** include the following in writing:

- details of a documented phone call or email from the *Disability SA Information and Referrals* or *Intake and Assessment* staff stating that the client does not meet their disability eligibility criteria.

Suggested wording: *Disability SA Information and Referrals or Intake and Assessment staff confirmed on <insert date> that <client's name> is not eligible for services through Disability Services due to <insert reason/s>*

and

- documented that all other options for care have been explored.

Suggested wording: *Other care options including <list all that are relevant> were explored and determined not appropriate to best meet <client name> needs due to <inset reason/s>.*

Please note: A formal letter from Disability SA staff is **not** required and will not be issued.

5.7.3 Where the client is eligible for disability services and seeking Permanent Residential Care

This referral pathway is relevant where the client is an existing disability client or is eligible for disability services, but it is deemed that the client needs to access Permanent Residential Aged Care to best meet their care needs. To receive this service the client requires an ACAT assessment.

The referral **must** include the following in writing:

- documented that all other options for care have been explored

Suggested wording: *Other care options including <list all that are relevant> were explored and determined not appropriate to best meet <client name> needs due to <inset reason/s>*

and

the approval from the Accommodation Placement Panel (APP) including an **attached** copy of the APP Outcome Letter.

Please note that for eligible disability clients, community services and residential respite should be provided through disability services.

5.8 Respite and Transition Care Program Extension Requests

Requests for extensions for both Residential Respite and the Transition Care Programme are to be made directly to the ACAT that covers the region that the Residential Respite or TCP services are being provided. This may not be the ACAT that did the original care approval.

6. Evaluation

The number of referrals made to the South Australian ACATs using the appropriate referral pathway for the client's situation and care needs, will serve as an accurate evaluation of the efficiency and effectiveness of this document, and any changes made accordingly.

7. Definitions

In the context of this document:

Aged Care Assessment Team (ACAT) – ACATs comprehensively assess the needs of frail older people and facilitate access to available commonwealth subsidised services appropriate to the client's care needs.

Aged Care Assessment Program (ACAP) – The ACAP is a Commonwealth Government funded program to provide assessment, information, advice and assistance to frail older people who want to remain at home with support or who are considering living in an aged care home. The Commonwealth fund the state/territory governments to manage the program on their behalf in the jurisdictions.

Aged Care Act 1997 ('the Act') – The principal legislation that regulates the aged care programme. The Act covers residential care, flexible care and home care. The Act does not cover Commonwealth Home Support Programme (CHSP) services, Carers Allowance and aged care services that are administered under State/Territory legislation (such as Retirement Villages).

Client – a person who is a recipient of a professional service. At a minimum, all clients must be medically stable to receive a service or be accepted for an ACAT assessment.

Commonwealth Home Support Programme (CHSP) – The CHSP is the entry level of Australia's aged care system for older people who need assistance with daily living to remain living independently at home. The CHSP consolidates four Commonwealth funded home support programmes into one streamlined and simplified programme:

- Home and Community Care (HACC)
- National Respite for Carers (NRCP)
- Day Therapy Centres (DTC)
- Assistance with Care and Housing for the Aged (ACHA).

Consent – The referrer must obtain written or verbal consent from the client or the client's representative prior to making the referral to ACAT for an assessment. This must be documented as part of the referral to ACAT.

Discharge – This includes discharge from a hospital (Private and Public) as well as discharge from other Local Health Network coordinated programs including post-acute/hospital avoidance programs such as Healthcare at Home, Rehab in the Home, TCP.

Exceptional Needs Unit (ENU) – Eligibility for the ENU includes:

- Not a Disability SA client
- Not a client of Mental Health and receiving support
- They are typically current rough sleepers
- They experience social and functional impairment and have challenging behaviours.

Flexible Care – Under the Act, Flexible care relates to Transition Care.

Home Care Package (HCP) – A HCP provides a co-ordinated package of services to meet client needs.

Ian Georg Court (IGC) – An Anglicare SA 40-bed ageing-in-place facility which provides support for disadvantaged frail aged residents who were homeless or at risk of homelessness.

Medically stable – reaching a point in medical treatment where life-threatening injuries and disease have been brought under control.

My Aged Care Contact Centre – My Aged Care assists older people, their families and carers to access aged care information and services as the Central Gateway to access Commonwealth subsidised aged care services including:

- Commonwealth Home Support Programmer
- Home Care Packages Programme
- Transition Care Programme
- Residential Respite
- Permanent Residential Care

Older Person – Under the Act, there is no definition of an older person or an aged person. However, an older person may be regarded as someone who is 65 years or older, or if they are Aboriginal and Torres Strait Islander, 50 years or older.

Regional Assessment Service (RAS) – The My Aged Care Regional Assessment Service assesses the needs of people for a lower intensity of care provided by the CHSP. The RAS will operate in all jurisdictions other than Western Australia and Victoria where current state operated approaches will be maintained for the present time.

Respite Care – Care given as an alternative care arrangement with the primary purpose of giving the carer or care recipient a short term break from their usual care arrangement.

Responsible Person - includes any person, such as a family member, friend or neighbour, who is giving regular, ongoing assistance to another person without payment for the care given. A Responsible Person does not have to be a formally appointed Guardian.

Specific Needs – clients identified with specific needs to meet their care needs. Examples include, but are not limited to, clients:

- with a Mental Health illness and diagnosis
- who identify as Aboriginal and/or Torres Strait Islander.
- who require Palliative Care
- with a Chronic illness

- with a disability

Target Group - The *Aged Care Act, 1997* and the Principles and Guidelines that stem from it, do not define what an 'aged', 'non-aged' or 'younger' person is, the target group for the ACAP is defined as 'frail older people'. The ACAT role is to provide assessment, information, advice and assistance to frail older people who want to remain at home with support or who are considering living in an aged care home.

Transition Care Programme (TCP) – Transition care is a form of flexible care that is legislated by the Act and the Principles. Transition care is provided at the conclusion of an in-patient hospital episode. It provides a range of services that includes low intensity therapy and either nursing support and/or personal care.

Younger People - Clients under the age of 65 years (50 years for Aboriginal and Torres Strait Islander).

8. References, Resources and Related Documents

The below documents should be considered if more information is required.

- *Aged Care Assessment Program Guidelines*, May 2015
- *Aged Care Act 1997*
- *National Health Reform Agreement,* 2011 Section F Aged Care and Disability Services
- *National Guiding Principles for Referral and Assessment of Younger People with a Disability,* 2006