Guiding principles for referrals to ACAS

February 2018

Purpose

This paper articulates the guiding principles for referrals to Aged Care Assessment Services (ACAS) in Victoria. The Guiding Principles aim to ensure that referrals are directed to the most appropriate assessment service based on the client's need for services at the time of referral.

These principles reinforce and complement 'A Guide for ACAS and RAS working together in Victoria' (DHHS, February 2017) and local RAS/ACAS protocols. This document offers further guidance as to the most appropriate referral pathway for clients seeking both Home Support Services and services requiring delegated approvals under the *Aged Care Act 1997* (the Act).

Background

Following successive aged care reforms since March 2016, increased demand for assessments for services under the Act has necessitated a review of ACAS intake and triage business activity so that clients needing services under the Act receive a timely assessment. This includes assessments for Home Care Packages, residential respite, permanent residential care and Flexible Care (e.g. Transition Care and Short Term Restorative Care.) and requests for a review of Home Care priority.

Each ACAS team reviews and prioritises assessments according to Commonwealth guidelines. Referrals for people who are not managing on their current services are prioritised on a needs basis.

Principles for referral

- RAS should only refer people for a Comprehensive Assessment (following a Home Support Assessment) where people are intending to take up services under the Act within the next 6 months. People not intending to take up services should be given information about ACAS and contact details for My Aged Care so they can ask for an assessment when these services are needed.
- People assessed by the RAS should not be referred for comprehensive assessment for future planning or on a "just in case" basis for services such as respite and permanent residential care where it is unclear whether the person would ever use the service. Information can be provided so people can initiate a referral to ACAS via My Aged Care when needed.
- Where a person is vulnerable or within a special needs group and may have difficulty accessing My Aged Care the contact number of the local ACAS can be provided.

Transferring Assessments

- If a referral is sent to either the ACAS or RAS and is deemed not appropriate then it is the responsibility of the receiving assessment service to communicate and transfer. The client should be advised where appropriate.

VICTORIA State Government | Health and Human Services

- Referrals should be transferred **before they are accepted** so that the receiving assessment organisation can assign the appropriate priority with associated timeframes. It also prevents completed home support assessments being tagged as a 'comprehensive assessment'.

Referral pathways

- If a client has an immediate need for entry-level CHSP services - including after post-acute care or hospital discharge - the referral should be made to the RAS (unless the client has complex needs). Once CHSP services are in place, the RAS will use the guiding principles above to determine if an ACAS assessment is needed

- If the client has an urgent need for both CHSP and Residential Respite Care – RAS and ACAS should consider most appropriate assessment based on the need for the CHSP service and/or respite Note that clients that have an urgent need to access residential respite can do so on an emergency care provision, where the facility accepts the client and applies to ACAS for emergency approval within 5 business days of care starting.

- Clients who have not previously had an aged care assessment by RAS or ACAS and are not in receipt of any services should be referred to RAS as an entry level client seeking service. RAS will consider the above guiding principles to ascertain if an ACAS assessment will also be required.

Referrals from Providers

- Where a person is unable to manage on existing services, referrals should include:
  a) Confirmation of informed consent from the client/NOK/representative indicating they are aware a referral has been made for an assessment for HSP or delegable Commonwealth Services.
  b) Referrals need to include the reason/problem that is triggering the need for services. E.g. A recent change in specific function including health issues.
  c) Current services the client is receiving including other CHSP/other funded services and or private services as this assists with determining assessment timeframes.
  d) The name of the referrer and the role, e.g. case manager i.e. who is responsible for the care plan.