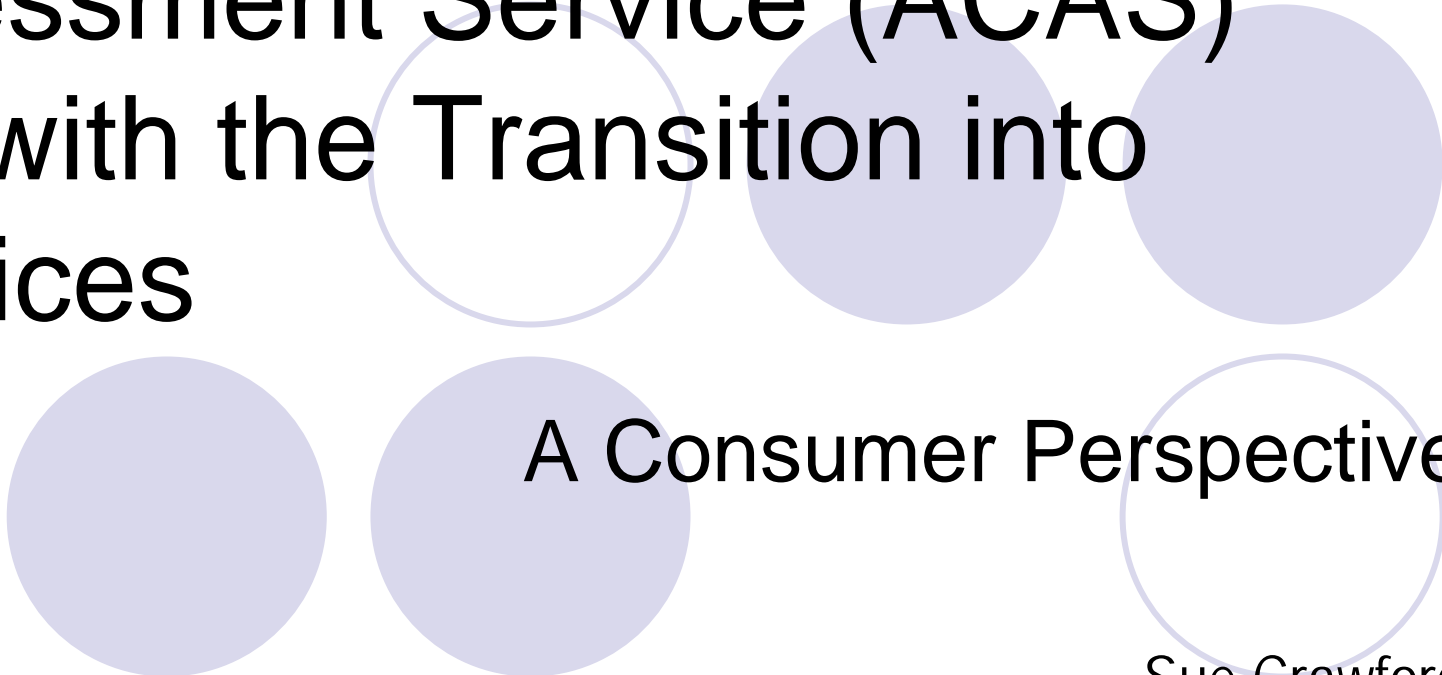


# What is the Aged Care Assessment Service (ACAS) role with the Transition into Services



A Consumer Perspective

Sue Crawford

Community Nurse

North Metro Bundoora ACAS



# The role of an ACAS

- Approval for Commonwealth Government subsidised programs
- Comprehensive, holistic & multidisciplinary assessment
- Development of recommendations into a “care plan”
- Care Co-ordination

# Our ACAS Catchment



- ACAS North Metro Bundoora
- Northern Health - 5 campuses
- 4 LGA catchments – Where Rural meets Metro
- Cohort- 45% from a culturally and linguistically diverse background- including the largest metro ATSI population >55 (8%) of Victorian Population
- Increasing client complexity



# The Aims of the Project

- To examine the client & carer experience and the services that have been recommended
- Identify barriers to care plan uptake
- To review care planning practice

# Selection Criteria & Methodology

## Selection Criteria

- The care plan – minimum 3 recommendations
- Remain in the community
- Ability to give informed consent
- Client Background-50%CALD & 50% Anglo-Saxon

## Methodology

### Client Sample

- File Audit 60
- 20 participants (33%)
- Initial Interview (Face to Face)  
19 client/carer dual interviews  
1 client interview  
12 clients with cognitive impairment
- Questionnaire (Post 6 months after Ax)

# Care Plan Referrals & Uptake

Recommendation	Sample (20)	Uptake
Residential respite	75% (15)	13% (2)
*Packaged Care	45% (9)	66% (6)
Admission to Sub-acute	10% (2)	100% (2)
In-home respite	25% (5)	60% (3)
National respite for carers	10% (2)	100% (2)
* > 6 month waitlist		

# Care Plan referral and uptake

Recommendation	Sample (20)	Uptake
Personal care	15% (3)	66% (2)
Meals-private or MOW	15% (3)	100% (3)
Home Care	15% (3)	66% (2)
Royal District Nursing	5% (1)	100% (1)
Continence service	5% (1)	100% (1)

# Care Plan referral and uptake

Recommendation	Sample (20)	Uptake
*Occupational Therapy	25% (5)	80% (4)
Podiatry	30% (6)	66% (4)
Dietician	10% (2)	100% (2)
Physiotherapy	10% (2)	100% (2)
*Aids and equipment	15% (3)	0% (0)
*Personal Alarm	15% (3)	0% (0)
* >6 month waitlist		

# Care Plan referrals and uptake

Recommendation	Sample (20)	Uptake
Geriatrician's appointment	10% (2)	100% (2)
Counseling	5% (1)	100% (1)
Driving assessment	5% (1)	100% (1)
Dementia consultancy service	5% (1)	100% (1)
*Memory service (CDAMS)	5% (1)	0% (0)
* >6 month waitlist		



# Barriers to Care Plan Uptake

- Availability of HACCC services in certain geographic areas
- Care status change/relevance of referrals
- Cognition
- Fear
- Carer reasons/guilt
- Cultural expectations
- Waiting lists for services

# Care Co-ordination Objectives

- The 'Providing the Right Care in the Right Place' initiative in the Australian Government 2004-05 Budget included \$14.3 million over four years to provide more timely assessment & better case management by ACAT's.
- The allocation of extra funds recognized the increasing complexity of clients referred to an ACAS
- Care coordination is a data collection method, necessary to gain an understanding of the extent of case management activity after an ACAS assessment has finished



# Care Coordination Definitions

- Active responsibility for ensuring the care plan is implemented.
- Follow up referrals
- To bridge the time between when the assessment finishes &:
  - when responsibility for the client is taken on by a carer or;
  - another service provider or;
  - until the client enters residential care



# Where to: Considerations for ACAS Practice

- Contact carer/responsible person prior to assessment
- Post assessment team brochure
- Explore carer issues
- Leave clear information about Access BECC
- Allow more time when working with interpreters
- Provide a written list of referrals and the phone numbers of the agencies/transparency of assessment outcomes
- Contact prior to discharge



Where to:

## Consideration for ACAS practice

- Flexible assessment times to allow access for carers
- Advise clients and carers to book ahead for residential respite
- Review of best practice guidelines for care planning within ACAS Procedure manual
- Team workshop to identify issues & enhance consistency in practice



# Conclusion:

- There lies the tension between meeting targets for assessment numbers in a timely manner or assisting clients to transition into services.

## *The Quandary*

*Do we assist people to transition into the service as opposed to just referring?*