About HACC
(Home & Community Care)
and **Home Care Packages**

Aims of this session:

- Learn **about HACC** services
- Learn **how to refer** to HACC services
- **Improve engagement** between GP clinics, HACC services and Home Care Packages
- Promote use of **HACC brochure**

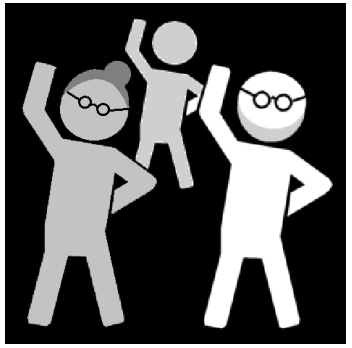
This information was developed by HealthWest Partnership. This initiative is supported by funding from the Victorian and Commonwealth Governments. Pictograms modified from originals sourced at www.sclera.be

What is the purpose of HACC?

HACC services support people to:

- stay **active**
- **independent**
- living **at home**

Focus on **strengths**, capacity building, **goals** and **person-centred** care.

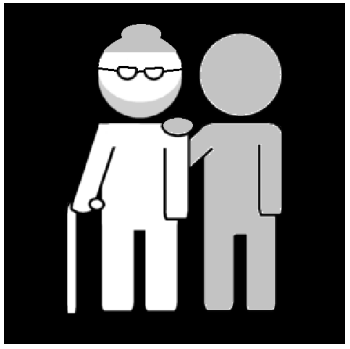


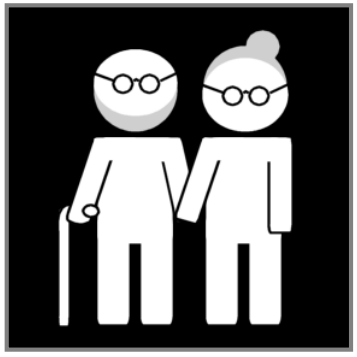
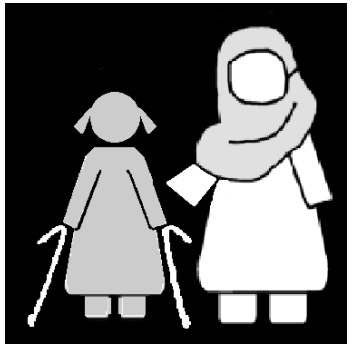
Who is eligible for HACC?

Patients who are eligible for an **assessment***:

- **Older people**
- **Younger people with disabilities** who do not qualify for Disability Care (NDIS)
- **Carers**

*****Patients may be eligible for assessment but not entitled to service.*



What services are available?

- HACC nursing in the home
- Allied health services
- Home and personal care
- Planned activity groups (PAGs)
- Meal preparation (in the home)/ Meals on Wheels
- Respite services
- Community transport services
- Shopping Assistance
- Home and property maintenance
- Friendly visiting and Telelink

Services are tailored, not one size fits all.

Who provides HACC services?

- Local Councils
- Nursing services (e.g. RDNS)
- Community health centres
- Other community organisations

Refer to service directories:

www.connectingcare.com

www.humanservicesdirectory.vic.gov.au

What do HACC services cost?

- **Assessment is free.**
- Costs for services will be advised during assessment.
- Patients will be assessed for their ability to contribute to the cost of services.
- Some equipment, aids and dressings may not be covered.
- If needed, patients will be assisted to access subsidy programs (e.g. State Wide Equipment Program).

No patient will be denied a service due to inability to pay. Fees may be negotiated.

What happens when you refer to HACC?

- Patients will be contacted by an **Intake** Officer.
- An Assessment Officer will then visit them at home to conduct a **comprehensive assessment**.
- The Assessment Officer:
  - Initiates a **support plan** (if eligible)
  - Refers them to other services (as needed)
- Wait times may apply.

What do information and feedback do you want to receive from HACC services?

About Home Care Packages*

Home Care Packages* are designed for **older people** who need a coordinated package of care.

- **Four levels of support** available (basic to high level).
- Packages will be **consumer-directed**.
- Patients will be asked to contribute to the cost.
- Eligibility determined through a comprehensive assessment by an **Aged Care Assessment Service** (ACAS).

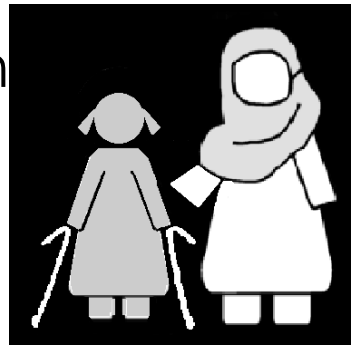
*****Replaces Community Aged Care Packages (CACPs) & Extended Aged Care in the Home (EACH) packages.*

Access & Support Workers

Purpose: Form a bridge between clients and mainstream service providers.

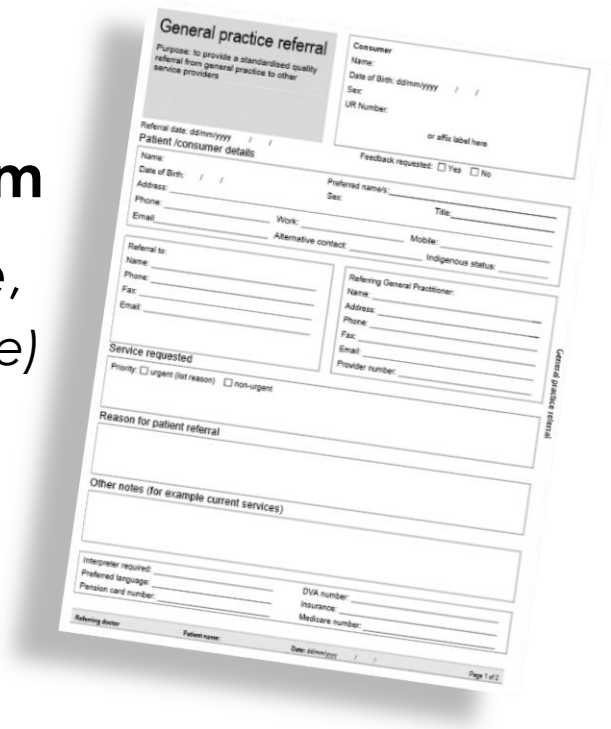
Eligibility: Must be eligible for HACC services and have access barriers due to diversity.

- Face-to-face initial assessments.
- Ability to attend joint assessments.
- Assist clients who are experiencing barriers in accessing services.
- Provide episodic support at key stages of the care pathway.



How to make a referral

- Use the **GP Referral Tool**
  - Replaces Victorian Statewide Referral Tool (VSRT)
- Provide **comprehensive information**
- Complete **all sections**
- Available online or as a **'supplied' form**
- Send securely using **Connecting Care**, **Argus**, or via post. *(Fax/ email is not secure)*


General practice referral

Purpose: to provide a standardised quality referral from general practice to other service providers

Consumer
Name:
Date of Birth: dd/mm/yyyy
Sex:
UR Number:
or affix label here

Referral date: dd/mm/yyyy
Patient /consumer details
Feedback requested: Yes No
Name:
Date of Birth:
Address:
Preferred name/s:
Sex:
Title:
Phone:
Email:
Work:
Alternative contact:
Mobile:
Indigenous status:

Referral to:
Name:
Phone:
Fax:
Email:

Referring General Practitioner:
Name:
Address:
Phone:
Fax:
Email:
Provider number:

Service requested
Priority: urgent (list reason) non-urgent

Reason for patient referral

Other notes (for example current services)

Interpreter required:
Preferred language:
Pension card number:
DVA number:
Insurance:
Medicare number:

Referring doctor:
Patient name:
Date: dd/mm/yyyy
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General practice referral

Incomplete referrals may be returned
could delay services

Comprehensive referrals ***avoid the patient having to repeat their story.***

HACC Client pathway

Clients visits GP
Medicare item - Over 75 health assessment

Client **needs support** in home or community and is:
- **65 or over**
- living with a **disability**
- OR a **carer**

Support needs are **high** and **ongoing** and require **case management**

GP refers client to Aged Care Assessment Service (**ACAS)** for assessment for **Home Care Package** or residential care

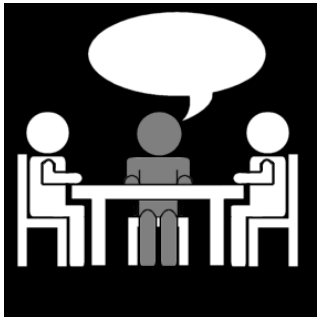
Support needs are **low** or **time-limited**

GP refers client to **HACC** for assessment

GP sends **GP referral Tool** securely via **Argus/ Connecting Care**

Intake Officer calls client to discuss and arrange assessment

Assessment Officer visits client in home



Support Plan commences, if eligible.

Medicare items - Care planning/ Team Care/ Case Conf.

Assessment Officer provides **feedback to GP**

Use of the HACC brochure

- Designed using **health literacy** principles.
- Use when talking with **all** clients, particularly those from **culturally of linguistically diverse** backgrounds or with **low literacy**.
- Use as a **communication tool**.
- Use in conjunction with the **Teach Back method**.

Close & thank you

- Any questions?
- Please complete **evaluation survey**. We love feedback!
- More info:

  Projects Manager, Home & Community Care
  HealthWest Partnership
  Ph: 8379 9950

Thank you!

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