COLLABORATIVE ASSESSMENT

Best Practice Guide and Self Assessment Checklist

Table of Contents

Acknowledgements

This best practice guide has been developed in consultation with representatives from the broader health and community services sector.

We would like to acknowledge the time, effort and energy of the Gippsland Assessment Alliance Working Group in contributing to the development of this guide.

Name	Agency	Service Type
Cayte Hoppner (Chair) Director, Mental Health Services	Latrobe Regional Hospital	Clinical Mental Health
Leonie Coleman Executive Officer	Wellington PCP	Primary Health
Claire Davis / Elizabeth Meggetto Executive Officer	Central West Gippsland PCP	Primary Health
Jennifer Doultree Aged Care Team Leader	DH - Gippsland	Aged Care
Beth Fogerty Regional Coordinator, (Baw Baw Shire & Bass Coast)	Mental Illness Fellowship Victoria	Psychiatric Disability Rehabilitation and Social Service.
Kate Graham / Deborah Harvey Manager, Gateway	Latrobe Community Health Service	Aged Care Assessment
Lesley Hammond Team Leader, Aged & Disability Services	Bass Coast Shire Council	HACC
Catherine Hanrahan EI CDM Project Worker	Gippsland Southern Health Service	Primary Health
Tess Holgate Manager, District Nursing	West Gippsland Healthcare Group	Sub Acute/Nursing/PAC HACC
Anne-Maree Kaser / Alison Skeldon Executive Director, Community Support	Latrobe Community Health Service	Community Alcohol & Other Drugs
Rowena Lam Primary Health PASA	DH - Gippsland	Primary Health
Leah Mc Fadzean Executive Manager, Aged Care Services	Gippsland Lakes Community Health Service	HACC
Pam Odgers Practice Support Coordinator	Gippsland Medicare Local	General Practice
Kenna O'Donnell PASA	DH - Gippsland	Aged Care – HACC
Vel Radford HARP Manager	Bairnsdale Regional Health Service	Hospital Admissions Risk Program
Linda Rowley	Project Consultant	
Nicole Tierney Occupational Therapy Manager	Latrobe Regional Hospital	Acute and Sub acute Allied Health

1. Introduction

This Collaborative Assessment Guide provides information and best practice principles for Gippsland sub regional assessment networks.

The goal is to promote integrated assessment services across health sectors that achieve consistent assessment practice, streamlined processes for people with a health issue and eliminate the impact of duplicated effort.

This guide:

- aims to promote a collaborative, coordinated and streamlined approach to assessment.

- has been developed for the mutual benefit of people with a health issue, carers and agencies.

- is intended to be implemented on a local government area basis.

1.1 Definitions

"Sub-regional assessment network" is defined as:

"3 or more agencies/services undertaking assessment within a defined local government area (LGA) rather than Gippsland as a whole".

Assessments may be holistic (e.g. Aged Care Assessment Service assessment, Living At Home Assessment) or service specific (e.g. Drug and Alcohol assessment).

2. Agencies / Services involved in Assessment Networks

Local Council • HACC Assessment Service (HAS) • Koori Access & Support Services	**Community Health Services** • Allied Health • District Nursing Service (DNS) • Chronic Care Disease Coordination • Palliative Care
Hospitals • Community Rehabilitation Service • Health Improvement Program • Sub-Acute Ambulatory Care	**Other Health Services:** • Bush Nursing Services (BNS) • General Practitioners • Aboriginal Community Controlled Health Organisations (ACCHO)
Home Care Package providers	**Mental Health Services** • Clinical Mental Health • Community Support Services
Regional services (attending on a sub-regional basis) e.g. • ACAS • Commonwealth Respite and Carelink Centre / Carer Services, • Gippsland Multicultural Service • Veterans Home Care	**Community Services:** • Family Violence Services • Drug & Alcohol Services

3. What is assessment?

Assessment is a decision-making process that collects and interprets relevant information about the person with a health issue. An investigative process, assessment uses professional and interpersonal skills, with a focus on in-depth enquiry to identify relevant issues that will guide a responsive intervention.

Part of an ongoing process of delivering services, assessment may be holistic and comprehensive, or service specific.

Assessment is usually undertaken face-to-face but may be undertaken in other ways if/as required (e.g. telephone, video conference).

Assessment may include:
- history-taking,
- examination,
- observation, and
- measurement or testing.

Information may be collected on the person's history of presenting problems, medical, physical, social (such as housing), functional, emotional, lifestyle, cultural, religious, spiritual and psychosocial needs, and risk screening.

Assessment is completed by a qualified service provider to:
- identify the persons strengths, needs, and capacity
- discuss the persons and relevant others' goals
- determine services required
- inform the development of a care/case plan
- determine appropriate referrals required and share information with the persons consent.

3.1 Where does assessment fit into service coordination?

Assessment builds on the information gathered through initial contact with the person, the process of initial needs identification and other relevant sources.

The information can build over time and be gathered from a wide range of sources to develop a comprehensive picture of the persons needs. This is particularly important for people with multiple, complex or unclear needs, or those who require long-term or extensive service provision.

3.2 The benefits of collaborative assessment.

Collaborative working relationships between service providers across the health and community care sector are fundamental to achieving desired outcomes for people with a health condition.

Working together in collaborative assessment can take various forms. At the simplest level, providers consult with each other about the services needed by an individual or family, information is completed on the SCTT and shared via S2S.

In more complex situations, providers work more closely, identifying (together with the individual and family) what services are needed, who will provide them, and how information will be shared to provide a streamlined assessment and reduce duplication.

The number and type of service providers involved depends on the nature of the health issue and the availability of resources. This is a dynamic process that responds to the changing needs.[1] of the person.

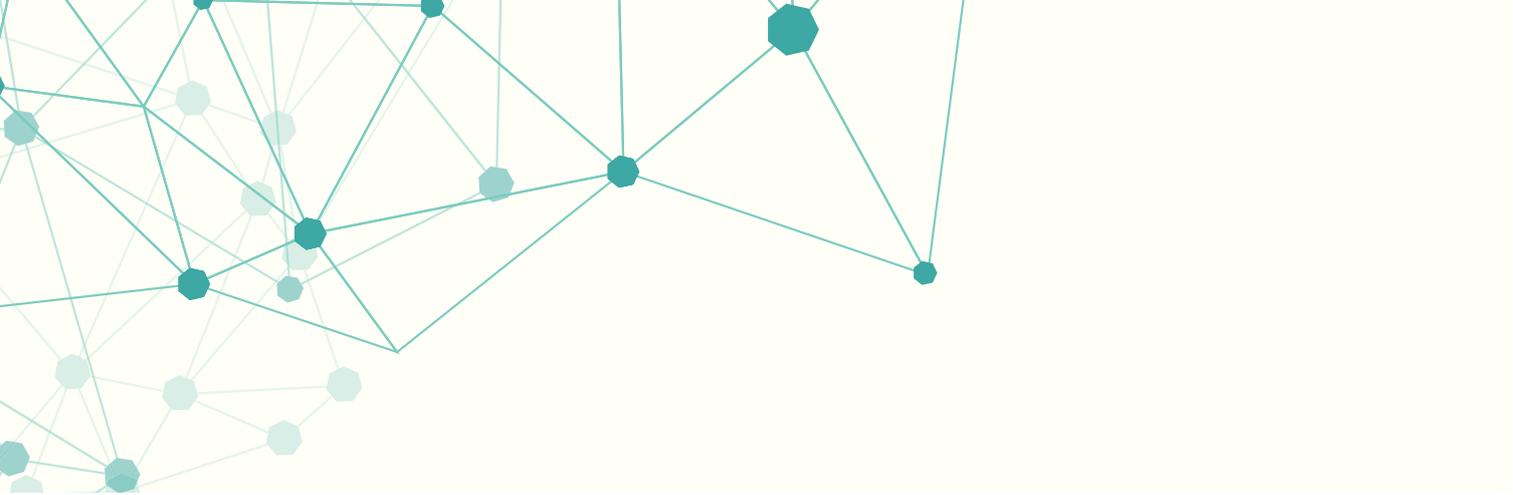The benefits of collaborative assessment approaches include:

- A person's needs are best met where there are strong partnerships and collaborative working relationships between the person, their carers and family, support workers and between service providers[2]'.

- Alliances build trust between organisations, which results in reduced duplication and more timely completion and coordination of assessment, care planning and service delivery[3].

- A highly networked service system that can function without barriers and promotes partnerships with individuals, families and carers, and general health and community services for the provision of prevention and care[4] is desired.

1 Enhancing Interdisciplinary Collaboration in Primary Health Care, The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care, 2005
2 HACC Active Service Model, Principle 5
3 Victorian Government Department of Human Services 2007, Framework for assessment in the Home and Community Care Program in Victoria, Aged Care Branch, Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne.
4 Victorian Mental Health Reform Strategy, 2009 - 2019

4. Best Practice Principles for Collaborative Assessment

The best practice principles for collaborative assessment are:

- Person Centred Practice
- Informed Decision Making
- Interagency Collaboration
- Trust and Respect
- Continuous Learning
- Quality Assessment Practice

5. Key Indicators

The following table outlines the key indicators that sit against each principle.

These indicators are intended as a guide to enable assessment networks to assess and develop their current practice.

Best Practice Principles

Best Practice Principles	Indicator
1.Person Centred Practice The individual (and family) is the focus of services, with assessment tailored to individual needs.	The Assessment Network understand and use Person Centred thinking and approaches in the collaborative assessment process.
2. Informed Decision Making Practitioners involve the individual in decision-making and respect informed decisions.	The Assessment Network provides relevant, accessible information to the individual regarding the assessment process, enhancing individual choice and control.
3. Interagency Collaboration A collaborative, shared decision-making approach to assessment will produce better outcomes for individuals and services.	The Assessment network has agreed assessment process and protocols in place that: • Facilitate good practice in collaborative assessment and reduce risk • Provide a framework for triage
4. Trust & Respect A collegial environment that supports shared decision-making, creativity and innovation facilitates effective assessment and referral to appropriate services.	The contribution of each profession's knowledge and skills is optimised to achieve the best outcome for the individual.
5. Continuous Learning Practitioners learn from each other and practise in a flexible way to best meet individual and family needs	Practitioners maximise their skills and knowledge and collaborate to share their learnings and ensure currency of practice.
6. Quality Quality practice is integral to continuity and coordination of assessment	The Assessment Network practices in line with the Continuous Improvement Framework 2012 (Criterion 5)

An "Assessment Network Best Practice Self Assessment Checklist" (Attachment 1) has been developed to assist Collaborative Assessment Networks to assess their current level of progress toward best practice in collaborative assessment, and prioritise areas for improvement. The checklist outlines criteria associated with each of the Best Practice Principles and indicators.
The checklist enables Collaborative Assessment Networks to assess their level of progress with each criteria using a 5 point rating scale.

Once Collaborative Assessment Networks have identified their progress against each criterion, identified areas for improvement can be prioritised using the action plan that forms Attachment 2.

Attachment 1

Assessment Network Best Practice Self Assessment Checklist

Name of the Network:...

Member agenices:...

....

....

This checklist has been developed to assist Collaborative Assessment Networks to assess their current level of progress toward best practice in collaborative assessment, and prioritise areas for improvement.

The checklist outlines criteria associated with each of the Best Practice Principles and indicators.

Assessment Networks can assess their level of progress with each criteria using a 5 point rating scale:

1. Processes not in place

2. Starting to think about and discuss the development of processes / protocols (e.g. discussion within network, allocation of tasks).

3. In Progress (e.g. documents being drafted / in draft form)

4. Developed – not being consistently implemented

5. In place and working effectively

Goals and actions toward improvement can be documented in the Action Plan on page 15.

Best Practice Self Assessment Principles and Checklist have been developed from the following source documents:

•   Enhancing Interdisciplinary Collaboration in Primary Health Care, The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care, 2005

•   Victorian Statewide Primary Care Partnerships, Continuous Improvement

•   Framework 2012, A resource of the *Victorian Service Coordination Practice Manual*, HACC Active Service Model, Principle 5

•   Victorian Government Department of Human Services, Framework for assessment in the Home and Community Care, 2007

•   State of Victoria, Department of Health, Strengthening assessment and care planning: A guide for HACC assessment services in Victoria, 2011

Principle 1. Person Centred Practice

The individual (and family) is the focus of services, with assessment tailored to individual needs.

Indicator: The Assessment Network understand and use Person Centred thinking and approaches in the collaborative assessment process.

Criterion No.	Criteria	Rating	Evidence to support rating	Proposed action
1.1	Are the cultural, communication and cognitive needs of the individual/family collected and documented in an agreed format?			
1.2	Has the person centred information (e.g. what's important to the person, interests, strengths and qualities, issues and aspirations) been collected and documented in an agreed format?			
1.3	Are persons the individual would like to have involved in the assessment process involved in a meaningful way? Is this information collected and documented in an agreed format?			
1.4	Have the individuals' needs beyond the presenting issue been collected and documented in the agreed format?			
1.5	Does the network have a process for involving the individual in decisions about their assessment and referrals? Does this correspond to the extent they wish to be involved?			
1.6	Does the network use "Progress for Providers" to assess their progress toward person centred practice?			

1 = Not started   2 = Initial discussions   3= Some progress   4 = Developed   5 = Implemented

Principle 2. Informed Decision Making

Practitioners involve the individual in decision making and respect informed decisions.

Indicator: The Assessment Network provides relevant, accessible information to the individual regarding the assessment process, enhancing individual choice and control.

Criterion No.	Criteria	Rating	Evidence to support rating	Proposed action
2.1	Does the Assessment Network provide health literate information on the assessment process to the individual? (e.g. verbal, brochures, script).			
2.2	Does the assessment network enable the individual to appoint a substitute decision maker if desired?			
2.3	Does the Assessment Network have an agreed process for seeking and documenting consent to involve others in the assessment process and share information with relevant other service providers prior to the sharing of information?			
2.4	Does the Assessment Network have a process for respecting and documenting an individuals' informed decision not to involve other service providers in the assessment process? (as required)			
2.5	Does the Assessment Network have a process for documenting why a referral has been made without the individuals' consent (if required)? (e.g. If the situation is urgent or the individual is perceived to be at risk if the referral is not made)			

1 = Not started   2 = Initial discussions   3= Some progress   4 = Developed   5 = Implemented

Gippsland Collaborative Assessment Best Practice Guide

Principle 3. Interagency Collaboration

A collaborative, shared decision making approach to assessment will produce better outcomes for individuals and services.

Indicator: The Assessment Network has agreed systems, processes and protocols in place that
- Facilitate good practice in collaborative assessment and reduce risk
- Provide a framework for triage

Criterion No.	Criteria	Rating	Evidence to support rating	Proposed action
Facilitating good practice				
3.1	At service intake, does the network have systems/processes to identify the need for collaborative assessment?			
3.2	Are there clear, documented protocols in place to identify the level of collaboration required? e.g.: • information sharing / transfer • case discussion • secondary consultation • organising and facilitating joint assessments			
3.3	Are there protocols to decide roles and responsibilities of practitioners involved in assessment (e.g. process for deciding who should take the lead role in conducting the assessment)?			
3.4	Does the Assessment Network have documented protocols and processes for case discussion / Assessment Network meetings?			
3.5	Does the documentation and processes meet the requirements of the *Health Records Act* and other privacy legislation?			
3.6	Does the Assessment Network have processes to provide feedback loops to other service providers and the individual?			
3.7	Does the Assessment Network have systems and processes to manage conflict effectively?			
Provide a framework for Triage				
3.8	Does the Assessment Network have a shared understanding and agreement of situations / circumstances deemed "urgent" or "at risk"?			
3.9	Does the Assessment Network have a documented framework for prioritisation/ triage of individuals based on perceived risk / urgency who cannot wait for a formal assessment process to be completed?			
3.10	Does the Assessment Network have documented procedures in the event there is an urgent need for assessment and only one agency has an assessor available?			

1 = Not started   2 = Initial discussions   3= Some progress   4 = Developed   5 = Implemented

Principle 4. Trust & Respect

A collegial environment that supports shared decision-making, creativity and innovation facilitates effective assessment and referral to appropriate services.

Indicator: The contribution of each profession's knowledge and skills is optimised to achieve the best outcome for the individual.

Criterion No.	Criteria	Rating	Evidence to support rating	Proposed action
4.1	Does the Assessment Network have processes in place for identifying the relevant skills / disciplines necessary for assessment on a case by case basis?			
4.2	Do practitioners use agreed discipline specific evidence based tools to complete the assessment? Are there processes in place for the sharing of this information?			
4.3	Does the Assessment Network have an agreed set of principles that acknowledges and respects the professional judgement of practitioners involved in the assessment process?			
4.4	Do practitioners complete relevant SCTT in accordance with their qualifications, discipline and role (relevant to the level of assessment)?			

1 = Not started   2 = Initial discussions   3= Some progress   4 = Developed   5 = Implemented

Principle 5. Continuous Learning

Practitioners learn from each other and practise in a flexible way to best meet individual and family needs.

Indicator: Practitioners maximise their skills and knowledge and collaborate to share their learnings and ensure currency of practice.

Criterion No.	Criteria	Rating	Evidence to support rating	Proposed action
5.1	Does the Assessment Network have a process to identify and prioritise the assessment training needs and professional development opportunities of its members?			
5.2	Is time allocated at each meeting to support network members to develop their assessment skills (e.g. sharing best practice, problem solving, and sharing knowledge)?			
5.3	Does the Assessment Network have a documented process in place for sharing professional information (e.g. Drop Box, distribution of information at meetings)?			
5.4	Does the Assessment Network have a process in place to access secondary consultation as required?			

1 = Not started   2 = Initial discussions   3= Some progress   4 = Developed   5 = Implemented
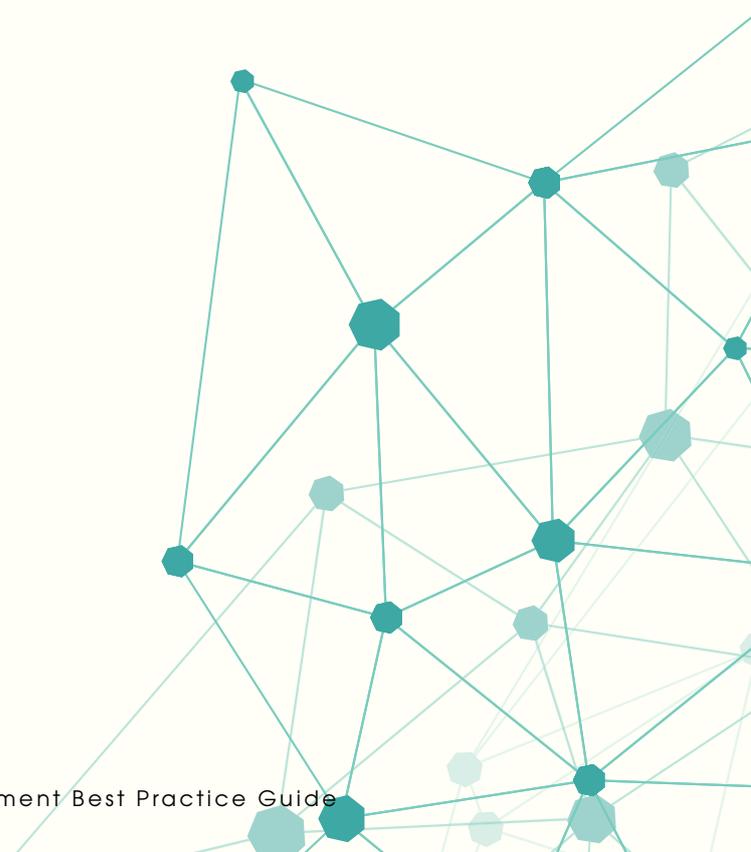
Principle 6. Quality

Quality practice is integral to continuity and coordination of assessment.

Indicator: The Assessment Network practices in line with the Continuous Improvement Framework 2012 (Criterion 5)

Criterion No.	Criteria	Rating	Evidence to support rating	Proposed action
6.1	Does the Assessment Network have a documented quality process that meets the Victorian Continuous Improvement Framework 2012 Criterion 5?			
6.2	Is practice reviewed against the Continuous Improvement Framework 2012 and other relevant accreditation standards e.g. Aged Care Accreditation, National Safety and Quality in Healthcare Service Standards?			
6.3	Is there a documented grievance procedure to manage assessment related complaints from any entry point?			

1 = Not started   2 = Initial discussions   3= Some progress   4 = Developed   5 = Implemented

Attachment 2

Action Plan

Identify the areas you, as an Assessment Network prioritise for improvement, and document in the Action Plan below.

Criterion No.	Goal	Priority Action	Strategies for Improvement	Person/s responsible	Planned completion date	Actual completion date