Right to Information Decision – Public Disclosure Log

Right to Information No.: 201718-034

Date of Application: 19 September 2017
Date of Decision: 9 October 2017

Information Requested

The application made pursuant to the Right to Information Act 2009 (‘the Act’), which was received by the Department of Health and Human Services (DHHS) on 19 September 2017 and accepted on 22 September 2017.

Specifically, the information requested:


Decision

The decision is to disclose the information in full.
ACKNOWLEDGEMENTS

This report was prepared for the Department of Health and Human Services by Ms Janette Collier and Faye Petroulakis of the Australian Institute for Primary Care & Ageing, La Trobe University; and Dr Peter Lucas, Wicking Dementia Education Research, University of Tasmania.

The authors acknowledge the time taken by all staff, consultants and key stakeholders in collecting information for this evaluation. Thanks also go to the following people for their assistance: staff of the Tasmanian Department of Health and Human Services; staff of the Access Point; staff of RDNS; members of the expert group; consumers who participated in the survey; service providers; and other stakeholders interviewed for this project.

Citation

TABLE OF CONTENTS

ACKNOWLEDGEMENTS................................................................................................................. 2
Citation ................................................................................................................................................ 2
TABLE OF CONTENTS ................................................................................................................... 3
LIST OF TABLES AND FIGURES ................................................................................................. 5
GLOSSARY ......................................................................................................................................... 6
EXECUTIVE SUMMARY .................................................................................................................. 7
  Background ....................................................................................................................................... 7
  Aim of the evaluation ....................................................................................................................... 7
  Evaluation methods ......................................................................................................................... 7
  Findings ........................................................................................................................................... 7
  Recommendations ......................................................................................................................... 8
    Facilitate access ......................................................................................................................... 8
    Provide information .................................................................................................................... 8
    Test for eligibility ...................................................................................................................... 8
    Undertake client screening for needs identification ................................................................. 8
    Refer to appropriate services ..................................................................................................... 9
    Staffing ......................................................................................................................................... 9
Conclusions ..................................................................................................................................... 9
INTRODUCTION ............................................................................................................................... 10
  Context of the development and implementation of the Access Point ....................................... 10
  Evaluation of the Access Point Demonstration Project ................................................................. 11
  Other Government Reforms Impacting on HACC Services ......................................................... 11
  Other Access Point Models in Tasmania ....................................................................................... 12
  TasCarepoint ............................................................................................................................... 12
  Specifications for TasCarepoint ................................................................................................. 12
  Implementation .............................................................................................................................. 13
  Communication strategy ............................................................................................................. 13
  Evaluation ...................................................................................................................................... 14
  Evaluation methods ..................................................................................................................... 15
    Data sources ............................................................................................................................... 15
    Procedure ................................................................................................................................... 15
IMPACT OF THE ACCESS POINT ..................................................................................................... 19
  Implementation .............................................................................................................................. 19
  Location ......................................................................................................................................... 20
  Impact on organisations referring to the Access Point ................................................................. 21
  Impact on organisations receiving referrals from the Access Point ............................................. 24
  Impact on key stakeholders ......................................................................................................... 27
  Impact on demand management ................................................................................................. 27
  Comparisons with other gateways and Access Points in other states ....................................... 28
  Comparison with international models....................................................................................... 29
  Cost analysis ................................................................................................................................. 34
    A cost analysis of the Access Point for all clients and for younger HACC clients .................. 34
ACCESS POINT FUNCTIONS ........................................................................................................ 36
  Facilitate access to the service via telephone, fax, email ......................................................... 36
  Information provision .................................................................................................................. 36
  Eligibility testing .......................................................................................................................... 37
  Client screening for needs identification .................................................................................... 37
  Referral to appropriate services ................................................................................................ 38
  Staffing .......................................................................................................................................... 39
  Post-implementation initiatives .................................................................................................. 40
FEEDBACK AND FURTHER RECOMMENDATIONS FOR THE ACCESS POINT MODEL .................. 42
  Recommendations ...................................................................................................................... 42
    Facilitate access .......................................................................................................................... 43
    Provide information .................................................................................................................... 45
    Test for eligibility ....................................................................................................................... 45
    Undertake client screening for needs identification ................................................................. 45
    Refer to appropriate services ................................................................................................... 47
LIST OF TABLES AND FIGURES

Table 1: Coding scheme for quotes ..........................................................17
Table 2: Referral source 2009–2011 ..........................................................22
Table 3: Referral source 2013–2014 ..........................................................22
Table 4: Referral source – numbers and types ...........................................23
Table 5: Quarterly data October–December 2013 .......................................24
Table 6: Referral to service providers across regions ...................................26
Table 7: Service type of referral by age group July 2013–March 2014 ..........26
Table 8: System components .....................................................................33
Table 9: Clients and contacts per month ......................................................34
Table 10: Costs per client and per referral ..................................................35
GLOSSARY

ACAP Aged Care Assessment Program
ACAT Aged Care Assessment Team
ACCNA-R Australian Community Care Needs Assessment-Revised
ASM Active Service Model
ATSI Aboriginal and Torres Strait Islander
CALD Culturally and Linguistically Diverse
CCASS Community Care Access Support System
C Client/carer coding for quotations
COAG Council of Australian Governments
DHHS Department of Health and Human Services (Tasmanian)
DSS Department of Social Services (Australian)
Gov Government department/THO coding for quotations
GW Other gateway staff coding for quotations
HACC Home and Community Care
LMO Local Medical Officer
ONI-N Ongoing Needs Identification – NSW
R Referrer coding for quotations
RAS Regional Assessment Service
RDNS Royal District Nursing Service
R N Northern region referrer coding for quotations
R NW North Western region referrer coding for quotations
R S Southern region referrer coding for quotations
SCTT Service Coordination Tool Template
SP Service provider coding for quotations
SP N Northern region service provider coding for quotations
SP NW North Western region service provider coding for quotations
SP S Southern region service provider coding for quotations
TCP TasCarepoint or RDNS staff coding for quotations
THO Tasmanian Health Organisation
EXECUTIVE SUMMARY

Background
The Tasmanian Access Point is intended to provide a suitable entry point into, simplify the journey through, and improve efficiency and effectiveness of the community care system. The Access Point can be used by clients, carers, hospitals, GPs, service providers and other health professionals to receive information about the services available and provide referrals to basic or comprehensive services depending on need. The Access Point in Tasmania is known as TasCarepoint and has been operating in the Southern region since February 2009. The Access Point was expanded to all regions in July 2010.

Aim of the evaluation
The four requirements of the evaluation were:

• An evaluation of the implementation of the Access Point model
• An evaluation of the Access Point’s effectiveness
• A review of the Access Point’s efficiency
• Feedback and recommendations in relation to the Access Point model.

Evaluation methods
The information that informed this evaluation included the following:

• A review of local and international documents relating to the Access Point specifically or single-point entry systems or models (as well as alternative models)
• Interviews with key stakeholders and Access Point staff
• Interviews with various HACC service providers in each region
• A survey distributed to all HACC service providers across the state
• Telephone surveys with Access Point clients
• Reports and quantitative data from RDNS and TasCarepoint
• Interviews with experts in the fields of aged care, medical services and health systems to consider future possibilities.

Findings
Staff of the Access Point have created a service that is valued by clients and service providers. The uncertainty with funding and reforms has provided a challenging environment but the Access Point has embedded itself within the service system. All people interviewed (including clients) understood the function of the Access Point and its position in the referral process. The Access Point has reduced the amount of time spent by community nurses chasing information relating to referrals; reduced the number of contacts made by acute staff when cancelling and restoring services for inpatients; and provided a central wait-list for client services that reduces duplication of effort and multi-listing of clients for services. The evaluation identified a range of issues for the Access Point, and included:

• Facilitate better access to the service
  • The use of electronic rather than faxed referrals
  • Regionalise the Access Point
  • Mandate the use of the Access Point
  • Market the Access Point to potential clients
  • Seek to include DVA referrals within the Access Point
• Provide information
Enable access to the service availability charter for organisations to update themselves

- **Test for eligibility**
  - Develop a state-wide form for all referrals in and out of the Access Point

- ** Undertake client screening for needs identification**
  - Consider having one organisation for assessment
  - Ensure carers needs are captured
  - Reconsider the hours of operation of the Access Point
  - Consider the benefits of opening for a brief period on a weekend

- **Refer to appropriate services**
  - Consider extending the data collection
  - Work with service providers to determine what is required in a referral
  - Monitor the waiting list

- **Use staff with appropriate qualifications**
  - Incorporate staff professional development within the Access Point.

**Recommendations**

Recommendations arising from the consultancy include the following:

**Facilitate access**

*Recommendation 1*: That DHHS reinvestigate the use of secure email and use this system for referrals in and out of the Access Point.

*Recommendation 2*: That DHHS investigate the use of a secure system by all organisations, including non-government, and use this system for referrals and recording of services provided to clients.

*Recommendation 3*: That DHHS considers regionalising the Access Point to support and assist service providers in their region.

*Recommendation 4*: That DHHS mandates use of the Access Point across the state.

*Recommendation 5*: That DHHS conduct ongoing advertising of the Access Point to potential clients.

*Recommendation 6*: That DHHS negotiates the inclusion of DVA clients within the Access Point model.

**Provide information**

*Recommendation 7*: That DHHS and the Access Point develop a web-based repository for service and service availability information.

**Test for eligibility**

*Recommendation 8*: That DHHS considers the development of a state-wide referral form used for all referrals in and out of the Access Point and all programs.

**Undertake client screening for needs identification**

*Recommendation 9*: That DHHS considers establishing a regionalised assessment service that works closely with or incorporates the Access Point to conduct a standardised, independent needs assessment.

*Recommendation 10*: That the Access Point examines their needs identification process to ensure carers are taken into account when assessing clients.
Recommendation 11: That the Access Point examines its records to determine the value of remaining open until 6pm.

Recommendation 12: That DHHS and the Access Point consider opening the Access Point for a number of hours on Saturday afternoon to process referrals for patients discharged from hospital in the previous 24 hours.

Refer to appropriate services
Recommendation 13: That DHHS consider the adequacy of the current formal data requirements of the Access Point.

Recommendation 14: That the Access Point and DHHS work with different service types to narrow down the requirements of a referral.

Recommendation 15: That the Access Point considers a flexible referral with pages that can be added or deleted depending on the type of service requested.

Recommendation 16: That the Access Point actively monitors the waiting list by ringing clients regularly to ensure they still need a service.

Recommendation 17: That the Access Point works with DHHS to investigate a case management role within the Access Point.

Staffing
Recommendation 18: That the Access Point investigates work experience for CSOs.

Recommendation 19: That DHHS ensure nursing staff employed by the Access Point undergo CPD during their employment.

Conclusions
The Access Point — TasCarepoint — has become a valued part of the HACC service system within Tasmania; a remarkable achievement given the uncertainty of the sector over the time. Much of the recent achievement is due to the Access Point staff who have not only marketed the value of the Access Point to the sector but also listened and responded to concerns and problems.
INTRODUCTION

Context of the development and implementation of the Access Point

In 2002, the Australian Government reviewed all federally-funded community care programs and ascertained that consumers struggled with the complexity of the system. People didn’t know how to locate services or what was available, and often had to undergo multiple assessments. Working together, the Australian Government and state and territory governments identified points of entry into community care that could easily be accessed by consumers. These entry points became known as Access Points.

Across Australia the Australian Government established a series of Access Point Demonstration Projects in all states and territories apart from the Australian Capital Territory. These were conducted across diverse locations including metropolitan, rural, regional and remote areas. The demonstration projects covered a mix of consumer groups including Indigenous Australians and people from culturally and linguistically diverse backgrounds; reflective of the diverse demographic profile of the Australian population.¹

The Demonstration Projects comprised a mix of designs, from single projects operating in single sites to multiple projects operating across multiple sites. Within this mix were different models such as the single access point with central intake that operated in Tasmania and New South Wales. In Queensland the model comprised a network of three access points that adopted a ‘no wrong door’ approach.¹

The policy drivers of these Demonstration Projects included A New Strategy for Community Care: The Way Forward, released in 2004, which sought to create easier access to community care for older people and younger people with a disability. This initiative sought to support people to remain living in their own homes instead of moving into institutional care. This document outlined a plan for state and territory governments to better utilise existing infrastructure to develop entry points so that people could more easily access care services while continuing to live in the community.²

Following this, in 2006 the Council of Australian Governments (COAG) developed an Action Plan as part of the Better Health for All Australians initiative that aimed to improve care and support by simplifying entry, improving eligibility, and streamlining assessment processes for the Home and Community Care (HACC) Program. Subsequent to this, the 2007 Home and Community Care Agreement between the Commonwealth and state governments sought to develop joint arrangements to support the establishment of single access points for people seeking information, referrals and assessment for HACC services.³

At state level the Tasmanian Government’s Tasmania’s Health Plan, released in 2007, provided a framework for improving health services; in relation to the HACC program it aimed to “enhance independence of clients and avoid admission to inappropriate care settings”.⁴ In 2007, the Tasmanian Government established a Tasmanian CarePoint Trial that involved, among a number of other components, the development of a referral form, eligibility screening protocols, and protocols for ascertaining unmet needs.³

Building on the resources developed and lessons learnt from the trial, the Tasmanian Access Point Demonstration Project, *TasCarepoint*, commenced operating in February 2009. This project covered all of southern Tasmania and included rural populations as well as residents in the Greater Hobart area. A total of 12 Local Government Areas were included in the Demonstration Project.\(^3\)

**Evaluation of the Access Point Demonstration Project**

An evaluation of the Access Point Demonstration Project was undertaken by KPMG in mid-2009 as part of the national evaluation. Due to the project having only commenced operation in February that year, this evaluation was not able to provide a comprehensive picture of achievements and issues relating to the project.\(^3\) The KPMG evaluation did, however, identify key strengths and weaknesses in the nascent Tasmanian model.

Stakeholder engagement in the development of the Access Point was noted as a major strength of the Tasmanian Demonstration Project and contributed to strong levels of ownership and support for the Access Point by service providers in southern Tasmania.\(^2,3\)

On the other hand, the ACCNA-R screening tool used in the Demonstration Project was deemed by the Department of Health and Human Services (DHHS) to be ‘not fit for purpose’. In the National Evaluation, other states also reported issues with the ACCNA-R screening tool.\(^3\)

**Other Government Reforms Impacting on HACC Services**

In August 2011, COAG agreed to a range of health and aged care reforms, including changes to the HACC program. From 2012–13, this included:

- The Commonwealth having policy, program and funding responsibility for older people (people aged 65 years and over and Aboriginal and Torres Strait Islanders aged 50 years and over); and
- Participating states and territories having policy, program and funding responsibility for younger people.

In April 2012, the Australian Government announced its *Living Longer Living Better* reform package in response to the Productivity Commission’s Inquiry into Aged Care. This model includes a ‘Seniors Gateway’ service, MyAgedCare, which will undertake similar functions to those performed by the existing Access Point in Tasmania. To facilitate transition to the new model DHHS and the Commonwealth have agreed to continue jointly funding the Access Point through the current funding agreement. From July 2015, the MyAgedCare gateway will come into full operation requiring all older clients be diverted through this gateway to access HACC services. Due to these changes, both the older and younger cohorts were considered throughout the evaluation.
Other Access Point Models in Tasmania

In July 2010 a Disability Gateway was established in Tasmania. This was part of a package of reforms in the disability services sector aimed at developing a model that was more responsive to the needs of people accessing specialist disability services. The Disability Gateway operates through regional single points of access aimed at creating a coordinated and integrated service system. Baptcare provides Disability Gateway services in the South West and North of the state and Mission Australia provides these services in the South East and North West. It is this regionally-based model that distinguishes its operations from the Access Point, which operates as a single entity with one entry point state-wide.

TasCarepoint

TasCarepoint has been operating in Tasmania under the management of the Royal District Nursing Service (RDNS) since Demonstration Project commencement in 2009. Upon completion of the Demonstration Project, the Access Point was rolled out on a state-wide basis. The evaluation of the Demonstration Project reported that “CEOs of local hospitals (who also have responsibility for community-based service providers) in regions beyond southern Tasmania … want us to expand there, like, yesterday”.2,3

The Access Point operates as a centralised single point of access (SPA) providing screening, referrals and information to callers. This SPA model is intended to avoid duplication and streamline service delivery so that clients do not have to navigate their way through a confusing maze of service providers. Referrals to the Access Point are received from a variety of sources including hospitals, community organisations, clients, carers, general practitioners, and other primary health services.

At the time of this evaluation 59 non-government organisations and three Tasmanian Health Organisations were providing HACC services across the whole of Tasmania. The non-government organisations include not-for-profit, local government and commercial agencies.

Specifications for TasCarepoint

Specifications for the Tasmanian Access Point Model are set out in an attachment to the Funding Agreement between DHHS and RDNS.6 This Agreement sets out the services to be provided, the means by which the Access Point will facilitate access to the service, the client screening and intake processes to be undertaken, and the roles and qualities of personnel that will staff the Access Point.

A number of services must be provided by the Access Point. These include information provision, eligibility testing, needs identification and referral to appropriate services. To provide these services the Access Point must have suitable arrangements in place for contact via telephone, fax and email. Although a ‘shop front’ was not a requirement, it was intended the organisation have capacity to conduct face-to-face needs screening if necessary. A service register was also required to maintain an up-to-date list of availability of services across all locations.

The agreement specifies that the Aged and Community Care Needs Assessment – Revised (ACCNA-R) will be used to screen clients and determine eligibility. This tool was embedded in the Community Care Assessment Support System (CCASS), which was provided by the Australian Government for use in the Access Point Demonstration Projects. However, from July 2011 the support for CCASS was discontinued. As

stated earlier, DHHS had identified the ACCNA-R as ‘not fit for purpose’ in the evaluation of the Demonstration Project. From November 2011, the Tasmanian Access Point adopted the Service Coordination Tool Template (SCTT) for screening and determining eligibility.\(^7\) SCTT is used throughout Victoria as a standardised referral tool.

The six roles required within the Access Point are listed as:

- Information/intake
- Screening
- Systems/business/training support
- Team leader/manager
- Health care profession to support information provision and screening
- Data collection.

A separate document—the Tasmanian Access Point Report Specification—lays out the requirements for reporting.\(^8\) All reports were to be in Microsoft Excel format and provided daily, weekly, monthly, and quarterly. Currently, only quarterly reports are provided by the Access Point; this frequency is acceptable to DHHS. There was also a requirement for ‘ad hoc’ or ‘as required’ reporting.

The monthly report should contain the following information:

- Service activity
- Variations in resources or management arrangements which may affect the Contractor’s performance of the contract
- Problems encountered by the Contractor in performing any of the required services and recommended solutions
- Complaints or issues received by the Contractor from the Department and others and the rectification action taken, including action taken to avoid recurrence.

**Implementation**

A Victorian organisation, RDNS, was successful in the procurement process to provide the Access Point for the Tasmanian Demonstration Project. The Access Point, known as TasCarepoint, commenced operations in February 2009 and covered all of southern Tasmania, a total of 12 Local Government Areas. In July 2010, the Access Point commenced operating on a state-wide basis.

**Communication strategy**

DHHS employed a business and marketing consultancy, ‘Three Plus’, to assist in developing a Strategic Communications Plan.\(^9\) The objectives of the plan included gaining wide support for and usage of the new service amongst the community and target stakeholders. It was also intended to develop and implement a brand plan for the service, including logo, name, positioning line and style guide.

The target audience for the communication included health professionals, hospital staff, local government, media, politicians, unions, Australian Medical Association, and the Division of GPs. Communication tools to be used were information sessions, media, website, emails, e-newsletters, brochures, flyers and one-on-

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one briefings. Potential and existing HACC clients were to be made aware of the new entry point via brochures, flyers and media, as well as via their existing health professionals.

Evaluation

A partnership between the Australian Institute for Primary Care & Ageing from La Trobe University and the Wicking Dementia Research and Education Centre from the University of Tasmania was engaged to carry out the Tasmanian evaluation of the Access Point model. Elements of the evaluation and their components were:

- An evaluation of the implementation of the Access Point model including:
  - analysis of the Access Point model implemented, compared with the initial Access Point model requirements
  - analysis of the location and accessibility of the Access Point
  - analysis of the staffing structure implemented by the Access Point
  - use of assessment tools and their effectiveness
  - linkages with other health, community and disability sector access and referral agencies
  - review of Access Point intake, screening functions and processes
  - review of ‘waiting list’ functions and processes
  - that any analyses will need to consider the age of clients, with reference to the age split between the Commonwealth and Tasmanian HACC Programs.

- An evaluation of the Access Point’s effectiveness including:
  - the impact the Access Point has made on streamlining client pathways
  - the proportion of service providers and referrers utilising the Access Point service
  - the impact of the introduction of the Access Point on accessibility of HACC services from a client perspective
  - analysis of the implementation process
  - the impact of the Access Point on community care service
  - the impact of the Access Point model on Aged Care Assessment Teams
  - the impact of the Access Point model for intake and referral for key referrers in relation to responsiveness and accessibility of services
  - acceptability of the Access Point to service providers, referrers and other key stakeholders
  - the impact on demand management by service providers or other services
  - analysis of the ‘telephone’ approach and effectiveness of ‘client visit if required’ as opposed to direct client contact approaches for assessment.

- A review of the Access Point’s efficiency including:
  - a comparison of the efficiency and resourcing of the Access Point with the Disability Gateway and, where available, of Access Points in other states and territories
  - a comparative cost analysis of the Access Point for combined older and younger HACC population and the HACC younger target population only
  - recommendations for appropriate resourcing for a point of entry for the younger HACC client group.

- Feedback and recommendations in relation to the Access Point model including:
  - an analysis of the benefits of the state-wide model versus a regionalised approach
  - a review of other existing intake, referral and assessment services within Tasmania with reference to current best practice and literature
- identification of opportunities for improved integration and streamlining of functions.

The evaluation of the Access Point adopted a mixed methods approach to collect data necessary to provide an informed report to DHHS. This included a review of documentation about the establishment and funding of the Access Point, interviews with key stakeholders and analysis of service usage data. The evaluation also involved a comprehensive literature review of models of home and community care service provision that operate in other jurisdictions. Data was gathered from service providers in all three regions via interview or survey. Clients of the service were also offered the opportunity to participate in the evaluation via a telephone interview.

**Evaluation methods**

**Data sources**

Data sources that informed this evaluation included the following:

- A range of DHHS and TasCarepoint documents concerning the Access Point (e.g., funding agreement incorporating the Access Point specifications, communication strategy), previous national evaluation reports, publicly available reports from local and international sources on single-point entry systems or models (as well as alternative models), and any relevant academic literature available on access to community care.
- Interviews with key stakeholders (DHHS representatives, THO representatives, RDNS staff and TasCarepoint staff).
- Interviews with HACC service providers in each region from large and small organisations, covering all service types, were used to gather information on the appropriateness and quality of the Access Point referrals and any issues surrounding implementation of the Access Point.
- A survey distributed to all other HACC service providers across the state to gather information on the appropriateness and quality of the Access Point referrals and any issues surrounding implementation of the Access Point.
- Telephone surveys conducted with TasCarepoint clients to provide information on the effectiveness of the service and gauge satisfaction.
- Reports and quantitative data from RDNS and TasCarepoint.
- Interviews with experts in the fields of aged care, medical services and health systems used to assess the viability of extending the Access Point service to other groups.

**Procedure**

The components used to address the evaluation are described below.

**Review of background documentation and academic literature**

A literature review was conducted using PubMed, MEDLINE, CINAHL and EBSCO databases as well as the Google Scholar and Google search engines. This approach of using several databases was appropriate as the literature on the research topic covers diverse disciplines including social work, gerontology, nursing, allied health and health informatics. Search terms used included “single-point access”, “single-point referral system”, “no wrong door”, “health informatics”, “community-based care”, “aged and community care” and

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“ageing in place”. The searches were limited to items published between 1999 and 2014 as health information and referral systems have evolved rapidly in recent years.11

Peer-reviewed journal articles, “grey” literature and web-based information sources identified through the search process were collated and those deemed relevant to the Access Point model were interrogated in greater detail. In addition, reference lists in the identified relevant literature were scrutinised further to provide a more thorough overview.

**Interviews with key stakeholders**

Key stakeholders interviewed as part of the evaluation included the following:

- DHHS staff responsible for overseeing contractual arrangements with RDNS
- DHHS staff in program areas with clients in the Access Point target group
- THO area management staff
- Staff in organisations that referred clients to, or received referrals from the Access Point
- Staff from Indigenous HACC service provider organisations
- Staff from culturally and linguistically diverse service provider organisations
- TasCarepoint staff
- RDNS Client Service Manager of TasCarepoint
- Access Point service recipients (consumers and/or carers).

The objectives of interviews with DHHS staff were to:

- Obtain the views of key Department staff on aspects of the implementation of the Access Point model, including policy and protocols, relationships with health areas and service providers, staff recruitment and training, adequacy of resources, marketing strategies, information resources, and barriers and facilitators to implementation.
- Obtain the views of the Department on the ongoing operation of the Access Point model, including relationships with service providers, staff training, impacts on staff, impacts on client information and referrals, and any unintended consequences (positive and negative) of which they are aware.

The objectives of interviews with service providers making and/or receiving referrals were to:

- Obtain information from their point of view on the quality and appropriateness of the Access Point referrals.
- Obtain their views on the relationship of their service with the Access Point, and how well the Access Point responds to referrals and the effectiveness of any strategies suggested.

HACC service providers from across Tasmania were recruited by various means. DHHS staff nominated some as potential sources of valuable information and HACC service providers nominated others who they thought would suitably inform the evaluation. These people were initially contacted by telephone or email and a time was made for them to be interviewed by members of the evaluation team. Where possible, the evaluation team intentionally targeted staff involved in direct service delivery, rather than management-level staff, as this approach ensured those involved with the Access Point on a day-to-day basis were able to provide their insights.

The objectives of interviews with TasCarepoint staff were to:

- Obtain the views of TasCarepoint managers/coordinators on aspects of the implementation of the Access Point model, including policy and protocols, relationships with health areas and service providers, staff recruitment and training, adequacy of resources, marketing strategies, information resources, and barriers and facilitators to implementation.
- Obtain the views of staff on the ongoing operation of the Access Point, including relationships with service providers, staff training, impacts on staff, impacts on client information and referrals, and any unintended consequences (positive and negative) of which they are aware.
- Obtain staff views on any enhancements suggested by the KPMG report.

In total, 53 semi-structured interviews were conducted as part of the evaluation, involving 83 participants. Interviews were recorded and transcribed and subjected to a process of thematic analysis that identified recurring themes or issues. Key themes and issues are discussed in the next section of this report. Forty interviews were conducted face-to-face as it was agreed with DHHS that a better response would be achieved this way. The remaining 13 interviews were conducted via telephone, including those held with interstate access point managers.

Where possible, quotes obtained during interviews have been used to support the findings. Anonymity has been maintained but the following coding scheme will be used, where possible, to attribute the quotes to groups of participants.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Coding example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government departments / THO</td>
<td>(Gov)</td>
</tr>
<tr>
<td>TasCarepoint or RDNS staff</td>
<td>(TCP)</td>
</tr>
<tr>
<td>Service Provider</td>
<td>(SP)</td>
</tr>
<tr>
<td>With region</td>
<td>(SP S), (SP N), (SP NW)</td>
</tr>
<tr>
<td>Client/carer</td>
<td>(C)</td>
</tr>
<tr>
<td>Referrer</td>
<td>(R)</td>
</tr>
<tr>
<td>With region</td>
<td>(R S), (R N), (R NW)</td>
</tr>
<tr>
<td>Other gateway staff</td>
<td>(GW)</td>
</tr>
</tbody>
</table>

**Survey of HACC providers**

An online survey was distributed to all HACC providers via an email link. The survey included the same questions as used in the semi-structured interviews with service providers making and/or receiving referrals. Sixty-nine responses were received with between 30–40 responses to each individual question.

**Phone survey of HACC Service Users**

In addition to the interviews, the evaluation team surveyed clients of the Access Point. Over the course of one week TasCarepoint staff invited clients and/or carers at the end of each instance of contact to participate in the evaluation by providing them with information about the project. Those who agreed were asked to provide best contact times and were sent a written explanation. Evaluators then contacted the clients or carers by telephone and conducted a short survey. The Access Point manager estimated that 32 calls were received during the week and 10 clients or carers agreed to be contacted and completed a survey.
Analyses of TasCarepoint data

TasCarepoint provided the evaluation team with de-identified data covering three-quarters of the financial year 2012–2013. This data includes details of the following:

- Inbound activity (calls via 1300 line, internal transfers and faxes in)
- Outbound activity (calls out, faxes out)
- Declined Service Requests (reasons)
- Client activity (new clients by month, total clients, clients activity by region, Under 65 vs Over 65)
- Wait-lists
- Trends identified across reporting periods.

Some historical data has also been captured; this enables the evaluation to look at the change in inbound and outbound activity as well as client numbers. This historical data covers the period between the initial demonstration project in Southern Tasmania and the implementation into the North and North West regions.

The evaluation team also received a copy of the October–December 2013 Quarterly report. In these reports the Access Point includes details of complaints and/or compliments as well as a summary of key activities undertaken as part of their role as a single access point operator. The Access Point team leader provided hardcopy reports showing the variety of services that refer to the Access Point and those services that the Access Point refer to. These paper reports cover October 2013–February 2014.

Finally, the evaluation team requested any raw data that could be used to look at the agency/service types of referrals made by the Access Point. The HACC MDS was also requested for the same period to examine new clients, and therefore new referrals, in the period for comparison.

These data/reports will inform the evaluation of the service; however, it should be noted that changes in data collection and reporting during the operation of the Access Point will impede some of the analysis. Breakdown of data by age will also be difficult as this was only collected from July 2012 onwards.

Analyses of program costs

An analysis of the program costs will be conducted using the total level of funding for the program and the total services to clients funded under the program. This will also take into account the staffing of the Access Point as well as the breakdown, where possible, into clients under and over 65 years old.

Expert interviews

As part of the evaluation, people identified as experts in their field were interviewed to provide additional insights into the complexities of providing a comprehensive single point of access service on a state-wide basis. These experts were also asked to consider the viability of an Access Point covering a range of sectors such as disability, housing, mental health and aged care. The opinion of the experts will be used to develop the overall recommendations about future options for the Access Point.
IMPACT OF THE ACCESS POINT

This section of the report examines the impact of the Access Point on the services around it. The implementation of the Access Point, a comparison with Access Points in other jurisdictions and a cost analysis is also included.

Implementation

Prior to the implementation of an Access Point, there were Tasmanian initiatives such as the Carepoint trial in Hobart. A ‘Final Options’ paper was developed by Australian Healthcare Associates towards the end of 2007, suggested models for the Access Point based on the outcomes of the Carepoint trial. Within this document there is mention of a substantial attitudinal barrier to be considered when implementing the Access Point. The document describes “the ‘parochial’ nature of the population and tendency for people to establish relationships and uptake services within the community in which they live, rather than rely on ‘outside’ services or providers.” By ‘outside’ providers they mean providers from other regions in Tasmania. Another reason for service provider reluctance to use the Access Point was providers had coordinators within their organisations who handled referrals. An Access Point would obviate the need for that position and potentially remove the funding associated with it as well. Changes to the HACC system were also looming, service providers were expecting a one-stop-shop at any time and couldn’t see the point of changing temporarily. However many outside factors facilitated the Access Point implementation. It was part of a national agenda—there was a mandate for the Access Point and funding to initiate it.

However, the implementation in the Southern region also involved a number of challenges. The procurement process to appoint the successful provider had to meet Australian Government as well as local DHHS requirements, and an interstate provider was appointed to conduct the implementation. This stage of the implementation was established in Southern Tasmania only and was treated as a proof of concept.

During the implementation period there was a great deal of uncertainty about the health reforms, the possible future changes to the Aged Care Assessment Program (ACAP), and the possibility of a future ‘one-stop-shop’ to provide access, assessment and referral for aged care services. This uncertainty affected the Access Point funding agreement. The successful tenderers, Royal District Nursing Service (RDNS), were given a 12-month agreement; a funding practice that makes sustainability difficult. A more sustainable funding model may have assisted with a challenging implementation. The current reform context continues the uncertainty for RDNS and the Access Point staff to this day, with no surety for the long term.

To assist implementation, an advertising and marketing strategy was developed with the help of a consulting company. It was decided that engaging the public in the initial stages would be confusing; instead, the Access Point was marketed to GPs and potential referrers. A full marketing campaign may have improved the number of clients accessing the Access Point.

One driving factor of the demonstration project was to break the ‘stop chasing services’ loop. The demonstration phase lasted 17 months before the Access Point was extended into the Northern region. During this time restructures were also taking place within DHHS. Only qualitative data and information collated during the course of this report is available to describe the extension of the Access Point to the North and North West Region. Qualitative data from interviews is all that can be used to inform this section of the report. A working group that involved service providers was established for the

implementation of the Access Point in the Southern region. This strategy was not continued during the extension to the other two regions. Assumptions were made that the successes of the demonstration project would be enough to convince service providers in the North and North West to come on board. There seemed to be much less investment in relationship-building prior to the Access Point being expanded:

*I don’t think we did the consultation and implementation as well in the North/North West. I think there was a lot more energy at the beginning and we probably had more interested providers here. And I think we should have done a bit more work in the North/North West. It wasn’t that it wasn’t well done; I just think that we didn’t put as much into it.* (GOV)

The state-wide implementation was seen as successful by a few key stakeholders but on-the-ground feedback from service providers is mixed. The Access Point provided a consistent level of service outcomes and removed the burden from referrers to know all services available across the state. It was intended that the Access Point would identify service gaps as well as areas of unmet demand.

KPMG conducted a national evaluation of the Access Points Demonstration projects within a few months of the Tasmanian Access Point commencing. The final evaluation report describes the two different approaches used by the Access Points Demonstrations – ‘no wrong door’ and ‘single door’. The ‘no wrong door’ model allows clients to enter into the community care services system through any ‘door’ they can find. The ‘single door’ model provides a central intake for all clients wanting to access community care services. The evaluation report describes the Tasmanian Access Point as being a ‘single door’ model that was “designed to explicitly operate as a centralised intake from the commencement of operations”.

The specification for the Tasmanian Access Point, an attachment to the funding agreement, states that “while people will be encouraged to utilise the Access Point, this will not preclude people contacting their current service provider for information or services.”

Two of the three Tasmanian Health Organisations (THOs), North and South, have chosen to make it their policy to use the Access Point, but both organisations acknowledge there is no re-enforcement of this policy, especially in more remote rural areas. THO North West was considering mandating the use of the Access Point prior to commencement of this evaluation. Decision-makers in this THO will wait to see the results of this review before making a final decision on mandating:

*From our point of view though, we see more positives than challenges. We see a great deal of benefits in the fact that we don’t have to do all that running around after the information because TasCarepoint will do that for us.* (GOV)

Location

In the Southern region, location wasn’t seen to have any impact on the effectiveness of the Access Point. Only two of the people interviewed mentioned that the Access Point was based in Hobart. One agency raised the location as a possible cause when saying that the roll-out of the Access Point didn’t seem as well-implemented beyond the Southern region. The interview participant raised the location of the Access Point stating that rural agencies based in the Southern region felt no impact from the Access Point being based in Hobart. In the North and North West regions, however, approximately half of the providers interviewed felt the location of the Access Point was detrimental to its effectiveness.

In the early days of implementation in the Northern Region, the Access Point’s understanding of the geographic areas covered by services providers was an issue. Clients living in small towns were referred to services outside the area. While this hasn’t been a problem for a number of years, this early difficulty with geographic boundaries was mentioned in almost all of the interviews in this region.
In Tasmania there are strong perceptions that have guided service configuration and service response to change, which is different in different areas. Further investigation into this perception of difference uncovered concerns about the distance between towns, the lack of public transport facilities, the reduced level of service available and the reduced choice of service provider:

*The north west coast is really spread out. It’s not like Hobart. They’re more compact down there, we’re not, we’re spread out. Some services are quite specific to their geographical areas.*

(SP NW)

One service provider in the North West described an incident where they needed additional services for a client. They contacted the Access Point, which couldn’t locate any available services in the area (there was more than one service provider offering services in that area) and so placed the client on the waiting list. The service provider considered the client was quite a high priority and rang the service providers. They located a provider with some hours available, not what was originally requested but enough to tide the client over. Service providers describe this process as ‘calling in favours’ or ‘knowing when to beg’. While this sort of practice may help clients, it hides the need for services in the area.

Relationships between service providers in the North and North West regions seem to be stronger than relationships between service providers and the Access Point. Most of the people interviewed in the North and North West regions had been in their roles for a number of years. The limited number of service providers and the consistency in staffing means these agencies have had the opportunity to build strong relationships with one another. The Access Point is both remote from the region and relatively ‘new’ to the field. The location of the Access Point also means there are no opportunities for face-to-face meetings between all staff of the Access Point and service providers:

*It was kind of [a] shame that we can’t all get to know each other a bit. Because we would see ourselves as, obviously, as professionals doing this every day and yet it doesn’t seem that we’ve built any sort of relationship. I haven’t.* (SP N)

The Access Point has worked hard with the North and North West referrers and service providers to show the value to clients of a single point of access. However, it hasn’t been totally successful in convincing all referrers and service providers to use the Access Point. The North THO has a policy that everyone should use the Access Point but acknowledges this is difficult in rural areas. The major argument against using the Access Point is that the service doesn’t understand the regions as they are ‘different’ from Southern Tasmania. One service provider interviewed referred to localised communities. Because communities are so local to an area, she believed people know which services are available in their area and therefore either contact them directly or ask for the service by name if being referred by someone else. It should be noted that the implementation of the national aged care gateway, MyAgedCare, will mean access to services for people over 65 years will need to be facilitated through a central, national point of access.

Impact on organisations referring to the Access Point

Table 2 shows the referral source for the Access Point between July 2009 and the end of June 2011. This data was provided by the Access Point showing the number of referrals for each week. Totals for each six-month period are displayed. Note that the first week showing referrals coming into the Access Point is 9/2/2009. The Access Point was expanded into the North and North West regions from July 2010. Table 3 shows similar data for 2013–2014. This data was provided by the Access Point showing the number of referrals for each month. Again, totals for each six-month period are displayed.
### Table 2: Referral source 2009–2011

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Service</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Aged Care Assessment Team</td>
<td>17</td>
<td>21</td>
<td>10</td>
<td>53</td>
<td>53</td>
<td>154</td>
</tr>
<tr>
<td>Extended Care/Rehabilitation Facility</td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>Family/Significant Other/Friend</td>
<td>3</td>
<td>21</td>
<td>12</td>
<td>20</td>
<td>22</td>
<td>78</td>
</tr>
<tr>
<td>Hospital</td>
<td>284</td>
<td>629</td>
<td>523</td>
<td>1,100</td>
<td>1,113</td>
<td>3,649</td>
</tr>
<tr>
<td>LMO/Medical Practitioner</td>
<td>29</td>
<td>62</td>
<td>93</td>
<td>265</td>
<td>302</td>
<td>751</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>32</td>
<td>119</td>
<td>177</td>
</tr>
<tr>
<td>Other Community Based Service</td>
<td>73</td>
<td>173</td>
<td>228</td>
<td>317</td>
<td>296</td>
<td>1,087</td>
</tr>
<tr>
<td>Other Health Service</td>
<td>39</td>
<td>114</td>
<td>44</td>
<td>21</td>
<td>50</td>
<td>268</td>
</tr>
<tr>
<td>Palliative Care Facility/Hospice</td>
<td>3</td>
<td>20</td>
<td>5</td>
<td>10</td>
<td>18</td>
<td>56</td>
</tr>
<tr>
<td>Self/Not Referred</td>
<td>40</td>
<td>59</td>
<td>11</td>
<td>65</td>
<td>68</td>
<td>243</td>
</tr>
<tr>
<td>Word of Mouth</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>507</td>
<td>1,111</td>
<td>936</td>
<td>1,887</td>
<td>2,050</td>
<td>6,491</td>
</tr>
</tbody>
</table>

The above data shows the marketing to GPs and hospitals was effective but self-refferrals or family/friend referrals remained similar before and after the expansion.

### Table 3: Referral source 2013–2014

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Dec 2013</th>
<th>Jun 2014</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Service</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Aged Care Assessment Team</td>
<td>197</td>
<td>200</td>
<td>397</td>
</tr>
<tr>
<td>Extended Care/Rehabilitation Facility</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family/Significant Other/Friend</td>
<td>200</td>
<td>256</td>
<td>456</td>
</tr>
<tr>
<td>Hospital</td>
<td>2,669</td>
<td>2,906</td>
<td>5,575</td>
</tr>
<tr>
<td>LMO/Medical Practitioner</td>
<td>1,370</td>
<td>1,496</td>
<td>2,866</td>
</tr>
<tr>
<td>Other</td>
<td>182</td>
<td>275</td>
<td>457</td>
</tr>
<tr>
<td>Other Community Based Service</td>
<td>1,081</td>
<td>1,183</td>
<td>2,264</td>
</tr>
<tr>
<td>Other Health Service</td>
<td>135</td>
<td>152</td>
<td>287</td>
</tr>
<tr>
<td>Palliative Care Facility/Hospice</td>
<td>136</td>
<td>259</td>
<td>395</td>
</tr>
<tr>
<td>Self/Not Referred</td>
<td>598</td>
<td>655</td>
<td>1,253</td>
</tr>
<tr>
<td>Word of Mouth</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6,568</td>
<td>7,382</td>
<td>13,950</td>
</tr>
</tbody>
</table>

The data in Table 3 shows the increase in the use of the Access Point across the board.
Data received from the Access Point shows 46 different referrers regularly referred to the Access Point between October 2013 and February 2014. This excludes clients self-referring and referrals that come through family/friends/neighbours as well as interstate hospitals.

The table below shows a breakdown of agency types and the number of referrals including the average percentage of referrals from each agency type. Agency types have been collapsed into broad categories.

Table 4: Referral source – numbers and types

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital</td>
<td>330</td>
<td>298</td>
<td>291</td>
<td>334</td>
<td>294</td>
<td>1,547</td>
<td>309</td>
<td>27.9</td>
</tr>
<tr>
<td>Private hospital</td>
<td>103</td>
<td>88</td>
<td>105</td>
<td>91</td>
<td>85</td>
<td>472</td>
<td>94</td>
<td>8.5</td>
</tr>
<tr>
<td>ACAT</td>
<td>36</td>
<td>34</td>
<td>29</td>
<td>32</td>
<td>28</td>
<td>159</td>
<td>32</td>
<td>2.9</td>
</tr>
<tr>
<td>LMO</td>
<td>251</td>
<td>228</td>
<td>189</td>
<td>217</td>
<td>283</td>
<td>1,168</td>
<td>234</td>
<td>21.1</td>
</tr>
<tr>
<td>Self / family / friend / neighbour</td>
<td>137</td>
<td>141</td>
<td>115</td>
<td>207</td>
<td>141</td>
<td>741</td>
<td>148</td>
<td>13.4</td>
</tr>
<tr>
<td>Palliative care</td>
<td>15</td>
<td>28</td>
<td>29</td>
<td>42</td>
<td>33</td>
<td>147</td>
<td>29</td>
<td>2.6</td>
</tr>
<tr>
<td>Other</td>
<td>257</td>
<td>245</td>
<td>245</td>
<td>274</td>
<td>291</td>
<td>1,312</td>
<td>262</td>
<td>23.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,129</td>
<td>1,062</td>
<td>1,003</td>
<td>1,197</td>
<td>1,155</td>
<td>5,546</td>
<td>1,108</td>
<td>100</td>
</tr>
</tbody>
</table>

Key referrers to the Access Point are hospitals and GPs (see tables 3 and 4). One obvious benefit of using the Access Point is obviating the need for all health professionals to maintain a list of service providers, contact details, the services they provide and the areas they cover. As well, staff don’t spend time ringing around to assess availability:

TasCarepoint’s concept is fantastic, that you’ve got a central point that referrers go to. So you’ve no longer got people that don’t know the system and have to try to work out where to send the referral to. (R S)

[TasCarepoint has] streamlined the whole process and made things a lot easier. Having that central contact has certainly simplified it, I guess, for the ward staff as well. (R S)

However, there are issues for service providers and the acute sector with speed of response and weekend discharges. The model funded at the Access Point calls for that any referrals received by 12 noon to be actioned the same day. Referrals for clients discharged from hospital late on Friday or over the weekend need to be received prior to midday on Friday. Referrals left until shortly before a client leaves hospital negate the advantages of the Access Point. One interviewee told of a situation where a client was discharged on Friday afternoon and a fax was sent off to the Access Point. The client was left alone all weekend with no contact. The GP discovered this on Monday morning. The blame for this situation was seen to be with the Access Point, not with a lack of discharge planning by the hospital.

All discharge planners/coordinators interviewed reported they wouldn’t use the Access Point for services that the client needs immediately, such as nursing services or personal care. However, for non-immediate services such as domestic assistance, the Access Point is well utilised by discharge staff. For nursing or personal care services, discharge staff report back to the client details of who will be coming and on what day and time. The Access Point feeds back the name of the service provider receiving the referral, but doesn’t know at that point of time if the service provider will accept the referral and if so who will be visiting the client and when. Discharge staff would not responsibly allow a client to go home without ensuring that any immediate care of the client has been passed to another organisation.
A small number of acute care staff displayed a concern about passing on responsibility for clients to another service:

Yes there’s clinicians in there [TasCarepoint] but that clinician when you’re handing care over, you cannot do it to a third party. It needs to occur from a clinician in this service who is handing the care over to that service. (SP S)

These staff seem to see the Access Point as a barrier rather than a conduit to services. The Access Point model should not be a barrier to health professionals conferring about clients; rather it should provide a means to share basic information between organisations that then becomes the basis for further consultation if necessary.

Impact on organisations receiving referrals from the Access Point

The TasCarepoint quarterly report for October–December 2013 shows the following data for the Access Point.

Table 5: Quarterly data October–December 2013

<table>
<thead>
<tr>
<th>Period</th>
<th>Clients</th>
<th>No. of Contacts</th>
<th>Number of referrals out</th>
<th>Faxes out</th>
</tr>
</thead>
<tbody>
<tr>
<td>October–December 2013</td>
<td>3,190</td>
<td>7,708</td>
<td>4,505</td>
<td>6,119</td>
</tr>
</tbody>
</table>

The ‘Number of referrals out’ column in Table 5 approximates the number of referrals sent to all service providers. ‘Number of contacts’ is the number of discrete activities undertaken for all clients. As can be seen, clients may require more than one referral if they are going to receive more than one service or the Access Point has to refer to more than one provider to obtain a service for the client. The Access Point may also chase additional information required for the referral which is captured under the ‘No. of Contacts’.

Data received from the Access Points shows referrals made to 104 different service providers over the period between October 2013 and February 2014. These referrals were spread over the three regions with four service providers working state-wide.

The impact on service providers has been mixed. For one group of providers the impact has been positive—they get value that goes beyond the referrals they receive. Another group of providers receive referrals but say the Access Point hasn’t really had any impact. The last group of providers consider the Access Point has had a negative impact and try to bypass it completely. Reasons for the variation include the region, the service type, and the size and location of the agency.

Nursing services perceive the greatest positive impact from the Access Point; they all acknowledged the time saved in chasing up information. Prior to implementation of the Access Point, they were constantly chasing medication or wound charts before they could deliver the service. Other agencies identified a marked decrease in the level of inappropriate referrals they received.

Service providers identified areas where the Access Point has not streamlined pathways; for example, if there is not enough information in a referral from another health organisation. Practice differs, with approximately half of all providers interviewed reporting they would contact the referrer directly. The other half would go back to the Access Point and ask them to follow up if possible. It was acknowledged that this was a fault with the referral, not the Access Point. Therefore in instances where streamlining hasn’t occurred, for a number of reasons, the number of staff contacts hasn’t been reduced.
Of the 53 service providers interviewed, four indicated they bypass the Access Point because of a bad experience during implementation. Service providers, especially the culturally and linguistically diverse day centres, find they don’t use the Access Point because their client group uses word of mouth to discover services that suit them. Based on what they find they then self-refer.

Two service providers reported using the Access Point as the problem-solver (for complaints or for clients who want to change to a different service provider). Others see the benefits of being able to say ‘no’ to a client:

> We get money for HACC so we quite self-resourceful in that way. But if we were having trouble with an issue and it was HACC issue, we would go to TasCarepoint. (SP NW)

> But I really like it because if we say ‘no look, I’m sorry we haven’t got any home help hours to give’ then you just give it back to them and they sort it out. You don’t have to worry about it. (SP NW)

The Access Point has removed the pressure on service providers to take a client. But it has also removed the ability to offer anything—half an hour for example—to keep the client going. Obviously this isn’t enough service but it may make a difference to the client. As described earlier, these practices hide the unmet need in the area.

The most frequently reported complaint, mentioned in 35 of 53 interviews with Service Providers, concerned the referral form they received from the Access Point. There were too many pages, the typeface wasn’t easily legible and they couldn’t easily locate the information they needed. The Access Point has developed a form for people referring in but rely on the SC TT templates when referring to other organisations.

All service providers said there was no difference for clients aged over 65 years and those who were younger, apart from administration of the clients.

Clients also benefit from the Access Point. They can now ring one number if they want a new service, to change existing services or to cancel or postpone services they are currently receiving. TasCarepoint can also provide information about services and determine if the client is eligible for the service. When cancelling or postponing services, most clients will remember the name of the person who delivers the service but won’t know the name of the organisation. TasCarepoint can usually locate the service provider, even if the referral wasn’t arranged through them.

If the service has a wait-list for a service the client knows they have been placed on that list rather than having to ring back regularly. Prior to the introduction of the Access Point, clients would have to locate a service themselves and either wait until that service had availability or ring other services providers to see if they had space. One client reported difficulties in getting the message through when altering service visits for her husband. However, it wasn’t clear if the delay was with the Access Point or the service provider.

The following table shows the disbursement of service providers and the number of referrals for each region.
Table 6: Referral to service providers across regions

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of service providers</th>
<th>Number of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>39</td>
<td>3,867</td>
</tr>
<tr>
<td>North</td>
<td>35</td>
<td>1,545</td>
</tr>
<tr>
<td>North West</td>
<td>26</td>
<td>599</td>
</tr>
<tr>
<td>State-wide</td>
<td>4</td>
<td>244</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>6,255</td>
</tr>
</tbody>
</table>

Table 7 shows the breakdown of service types to which the Access Point has referred. This data was collected as contemporaneous notes made at the time of referral. We have extracted the service type from these notes and then cleaned the resulting dataset. The data cleaning removed any records where:

- The text concerned suspension or stopping of service
- The text concerned follow-up information
- Test messages were involved
- No information was available
- It was impossible to determine the service type.

The data cover the period 1/7/2013 to 31/3/2014; no conclusions should be drawn from this data but it does provide a picture of the referrals made by the Access Point. The highest number of referrals are for domestic assistance (21.96%) followed closely by nursing care (20.25%).

Table 7: Service type of referral by age group July 2013–March 2014

<table>
<thead>
<tr>
<th>Referral Out Service Type</th>
<th>Referrals 65+</th>
<th>Referrals 65+</th>
<th>Referrals &lt; 65</th>
<th>Referrals &lt; 65</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0.00</td>
<td>3</td>
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</table>
### Impact on key stakeholders

Key stakeholders, aside from referrers and service providers, include DHHS staff and THOs. All agree that a single point of access is important and useful. Of the seven groups interviewed, five believed that issues identified as relating to the Access Point are actually to do with the relationship and trust between different organisations.

During interview, a few key stakeholders referred to early discussions when the Access Point was still in development. At that point they were promised electronic referrals and therefore a reduction in paper transactions relating to client referrals. However, the practice of faxing continues.

Key stakeholders were also concerned about how the Access Point works or will work with the acute sector:

> We are part of a THO so we’re linked to the acute setting, we have processes internally around critical handover so if someone’s coming home to community nursing and they want to streamline that care, we'll still expect a clinician to give our staff a call and say ‘there’s a referral on its way’. That’s a part of our critical handovers. We’re still doing a lot of work on that because that’s a national standard and people are getting their head around how to manage that. So I guess that sort of duplicates the process of them having to talk to us and then complete a referral to another service that could go anywhere. (GOV)

> One of the things that the acute guys were not impressed with, when they send the referral if it isn’t – the cut-off is Friday lunchtime I believe – no one’s in over the weekend given that it’s a public holiday. So there’s clients there waiting for care because the acute sent the referral Friday morning. It wasn’t actioned and we were meant to be in there on the weekend and we knew nothing about it. (GOV)

### Impact on demand management

Demand management covers management of the distribution of and access to services on the basis of needs. The Access Point should help this by showing where unmet demand occurs; they are also in the key position to determine unmet need. All interviewees were asked if implementation of the Access Point had an impact on demand management. Three or four services recognised the importance of the central waiting list and how it can capture unmet demand:
This is going to be really good because we used to ring XXXX and they’d probably keep people on a waiting list. If we do it this way, and TasCarepoint keeps the waiting list then that’s going to improve the funding. They’re going to say: listen here there are 350 people waiting for domestic assistance on the north-west coast, there’s obviously not enough. (SP NW)

Comparisons with other gateways and Access Points in other states

The Disability Gateway in Tasmania was established in 2010. It is maintained by two agencies (BaptCare and Mission Australia) that each cover two of the four planning regions used by Disability, Child, Youth and Family Services. Both agencies are located in Hobart and share a common phone number. Based on the caller’s location, the phone call is diverted to the appropriate agency. The Disability Gateway also does more than refer to service providers, they also provide intake, assessment and coordination of services. One other major difference between the Disability Gateway and the Access Point is the DHHS mandate that all referrals go through the Disability Gateway.

The Disability Gateway reported mainly positive linkages with the Access Point. The negative linkages relate to confusion about the role of the Access Point that may have developed in the early stages of implementation. One gateway service believes that the Access Point determines and even allocates the number of hours a client can have.

Models of Access Points differ across each of the four other states that retained them. Victoria still maintains two Access Points—one in the Grampians region and one in the Eastern Metropolitan area. New South Wales has an Access Point that originally covered the Hunter region but has since expanded to include the Central Coast. Western Australia has a central referral and assessment service that is linked to regional assessment services across the state. South Australia had two Access Points—one country and one metropolitan. (Note: to date we have been unsuccessful in speaking to relevant staff about the SA model.)

Victoria’s two Access Points, called Direct2Care, follow the ‘no wrong door’ model. Direct2Care is primarily a telephone service but both its sites operate a shop-front. The Access Points were intended to act as part of a system of multiple entry points facilitating access to the service system. They have a moderate number of calls and the biggest change in the last few years is that their marketing has targeted GPs and service providers. They have been marketed as ‘aged care’, so most of their clients are over 65. They conduct screening and partial assessment before referring to assessment agencies if necessary, or directly to services. They are still using the ACCNA-R for screening but the SCTT templates are used for referral. The Access Points took a long time to be accepted but have successfully integrated in the local networks. Knowledge has been captured by the Access Points in local databases. Both Access Points will close on 30 June 2015.

NSW covers only a section of the state and follows the ‘single door’ approach. The Access Point has resulted in more referrals than in other areas and from this believe they have made a difference. This has of course resulted in more funding. The screening conducted in this region is consistent and equitable. Advertising resulted in ‘bulk’ self-referrals. The Access Point also advertised its services to GPs and allied health. NSW uses the Ongoing Needs Identification – NSW (ONI-N), a broad and shallow tool used for screening. Most of their contacts are phone-based, but they have the facility to contract or outsource face-to-face contacts to service providers if necessary. The Access Point sends electronic referrals, which include any supporting information plus the ONI-N. Eighty per cent of their clients are over 65. The district is looking to the future and what will happen with its younger population. The database used by the Access Point is the one used within the Department of Family and Community Services. The Access Point will shut down on 30 June 2015.
WA converted all Commonwealth Carer and Respite Centres into Access Points for the demonstration phase of the project. It also used the ‘no wrong door’ model. They learnt from the demonstration that conducting the needs and partial assessment over the telephone led to clients getting what they asked for but their needs were not necessarily met. The client had a view about what they need before calling, which means they paid no attention to other needs. This has now changed into a central access point that provides information and examines eligibility for new clients only. The screening looks at cultural, language, cognitive and sensory special needs. The Access Point can then refer to non-HACC services (disability and mental health), ACAT if complex, or to a regional assessment service (RAS) if HACC eligible. The RAS then visits the client and conducts a ‘proper’ needs assessment face to face. The assessment identifies whether the client needs a funded service and follows the re-ablement model—the assessor checks to see if the client needs aids and equipment to assist them with a task rather than a service performing the task for them. The assessment also involves looking at the client’s goals, which are considered very important.

Clients are reviewed regularly by the RAS, not but the service provider. The tool used for screening at the Access Point is the Client Needs Identification (CNI). The Access Point also recommends priority for assessment and maintains the service availability register. This register is web-based and updated by the service providers regularly. Once the RAS has finished the assessment they contact the Access Point with a list of services the client needs. The service availability register will display a list prioritising service providers that can offer all services. The referral is sent by the RAS, not the Access Point. The service provider must accept/reject within 48 hours. It is important to note that Nursing is out of the Western Australian Access Point’s scope; the acute sector makes contact with Nursing services directly. Nursing services and the acute sector also refer clients to the Access Point. The Access Point contacts the client to check the referral information; services are usually put in place without an assessment. The acute sector will ring the Access Point to see if the client is known; to suspend and restart services as required.

Comparison with international models

The literature review found a limited corpus of published academic literature pertaining to the formal evaluation of single-access point models in the community care sector, particularly those similar to the Access Point model. However, the review found compelling evidence that integrated care models are effective in reducing unnecessary institutionalisation of elderly people or people with disabilities. The primary identification of relevant services and information related to services similar to the Tasmanian Access Point was via websites. In some instances, an evaluation of particular areas of the service was accessible through the service’s website.

One integrated care system, the Bois-France Integrated Service Delivery (ISD) network, is described below with two other Canadian initiatives, the Community Care Access Centre (CCAC) and the Home Care health service. Two American initiatives, the ‘211’ information and referral service and the Wisconsin, USA Aging and Disability Resource Centers (ADRC) are also detailed with in-depth information and resources for designing, implementing and developing single access points for community care identified via the latter service’s website. All systems are compared in Table 8.
Canada: Quebec Bois-France Integrated Service Delivery (ISD) network

Tourigny, Durand, Bonin, Hebert and Rochette\(^{13}\) describe the establishment and monitoring of an integrated care system, the Bois-Françs ISD network, across one region in Quebec Province in Canada. The region had a population of over 90,000, with nearly 13 per cent aged 65 and over. The services in the region included an acute hospital, a residential facility (RACF), a community service centre, a combined community service centre and RACF, and 45 GPs. The integration occurred by pooling staff from the different sites to establish a group of 10 case managers to create a single point of entry, assessment and referral. All case managers were social workers. There were no nurses in the group.

Participants in the study were those identified as being frail. A control group was established in another region where no ISD existed. Measures were taken of the two groups prior to implementing the network and then every 12 months for a period of three years. They measured participants and carers and examined carer burden, the participant’s functional status and their desire to be institutionalised. The researchers also examined service usage.

At study commencement the desire to be institutionalised was similar (24% cohorts and 25% for the control group). At study end the group with the ISD were less likely to want to be institutionalised; 39% for the cohorts compared to 58% for the control group. There was a declining trend in institutionalisation in the participant group compared to the control group. The ISD network had a positive effect on carer burden, reducing it significantly in the first two years. However, the ISD didn’t have any effect on the use of services.

Canada: Ontario 310-CCAC “Connecting You with Care”

In 1997, the Ontario Government created 43 Community Care Access Centres (CCACs),\(^{14}\) to provide consumers with a single access point for information, services and referrals for community care. The 43 CCACs were subsequently reduced to 14 in 2006, following the revision of geographic boundaries related to Local Health Integrated Networks (LHINs). The mission of CCACs is:

> To deliver a seamless experience through the health system for the people in our diverse communities, providing equitable access, individualised care coordination and quality health care.

CCACs are accessible to consumers via a single phone number and walk-in centres across the province. Their promotional material provides a specified phone number (310-CCAC) and states:

> Wherever you live in Ontario, it is easy to find the in-home community-based health care services for yourself or for a loved one.

In the Central Local Health Integration Network (LHIN), the three CCAC offices are accessible to consumers between 8.30am and 8.30pm every day of the year, and provide around-the-clock service via the 24-hour telephone service. Each local CCAC in Ontario also has its own website, accessible via the main CCAC webpage, to allow a focus on local care options.

CCACs undertake a competitive bidding process to purchase health and support services from home care providers on behalf of clients. Both for-profit and non-profit health care agencies bid on service contracts through a competitive process. CCACs are provided with an annual budget based on historic use of services.


in addition to other factors, including gender distribution within catchment populations and rural status. An evaluation of palliative care home care services, contracted through the Niagara CCAC, highlighted some of the issues relating to the provision of tendered services, particularly when comparing non-profit agencies to for-profit agencies.\textsuperscript{15} A key finding was the importance of conducting ongoing and continuous evaluations of tendered services, in order to make evidence-based decisions regarding contract renewal, and the need for a standardised, province-wide evaluation framework for CCACs.

According to the CCAC main website:\textsuperscript{16}

> When you contact your local CCAC, you will be introduced to a Case Manager (also referred to as a “Care Coordinator”), who will:

- Talk with you about your needs, and answer questions about what CCACs can provide and what’s available in your community
- Conduct a health care assessment
- Develop a customised care plan that meets your specific needs
- Check in regularly with you and adjust your plan if your needs change

Your CCAC Case Manager works on your behalf to make sure you have access to the care and services you need.

Consumers are also able to search the CCAC website for community services and contact service providers directly. While literature on the CCACC service implementation issues and consumer feedback were not found in the current search, a recent performance evaluation\textsuperscript{17} found scale inefficiency to be the primary (cost) driver for most CCACs. More than half of the CCACs in the sample were larger than optimal. However, the challenge of scale inefficiencies was noted, given the need to ensure access to services for target populations within individual CACC catchment areas.

**Canada: Alberta “Home Care” Community Care Access**

A single point of entry to community care was identified in Alberta.\textsuperscript{18} However, operational details and consumer perspectives related to the service were not available on the Alberta Health Services website. The service is not available to everyone, and visitors to the website are prompted to call for further information:

> “Home Care” is a health service that supports your wellness and independence. The goal is to help you remain safe and independent in your own home or care setting for as long as possible.

The home care case manager who conducts the initial needs assessment could be a registered nurse, physical therapist, occupational therapist or social worker.

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\textsuperscript{16} http://www.ccac-ont.ca/Content.aspx?EnterpriseID=15&LanguageID=1&MenuID=45


\textsuperscript{18} http://www.albertahealthservices.ca/services.asp?pid=service&rid=1001464
USA/Canada-wide: “211” Information and Referral Service for community care (Call Centre)

The 211 telephone service provides 24-hour access to “critical health and human services available in their community”. The target population for 211 includes anyone who is having problems and needs assistance to identify options available, and where to go for help:

With the recent addition of Arizona, 211 is now available in all 50 states plus Washington, D.C. In 37 states there is 90 to 100 per cent coverage. A total of 260 million Americans (87 per cent of the population) have access to the service. 211 also exists in Canada, with 19 million Canadians (56 per cent of the population having 211, plus Puerto Rico.19

Based on information provided on the various 211 websites, the 211 service appears to have some similarity to the Carelink service in Australia, though with a wider target population, and no face-to-face capability. Though marketed as a “single access point to a community’s full range of social, health and government services”, access appears to mean information and recommendations/contact details for relevant service providers. In-depth assessment and/or direct referral to service providers are not provided.

USA: Wisconsin ADRCs

Pioneered in Wisconsin, Aging and Disability Resource Centres (ADRCs) are now being developed in 55 states and territories across the USA.20 ADRCs are “the first place to go to get accurate, unbiased information on all aspects of life related to aging or living with a disability”. Individualised services are available to people who are elderly or who have a physical or developmental disability. ADRCs are also available to help families and friends, caregivers, physicians, hospital discharge planners and other professionals who work with older people and people with disabilities.

ADRCs are marketed as “the place for information and assistance.” 20 According to their consumer website:

ADRCs are friendly, welcoming places where anyone – individuals, concerned families or friends, or professionals working with issues related to aging or disabilities – can go for information specifically tailored to their situation. The ADRC provides information on a broad range of programs and services, helps people understand the various long term care options available to them, helps people apply for programs and benefits, and serves as an access point for publicly-funded long term care. These services can be provided at the ADRC, via telephone, or through a home visit, whichever is more convenient to the individual seeking help.

Table 8 shows all systems examined have a single entry point, provide information, and conduct screening and needs identification. The single point of access with a model similar to the current Tasmanian Access Point is recognised as a best practice option for people accessing health services. In Canada, but not the USA, case management is also considered an important component.

20 http://www.dhs.wisconsin.gov/adrc/
Table 8: System components

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>SINGLE POINT OF ACCESS</th>
<th>INFO PROVISION</th>
<th>INTAKE</th>
<th>SCREENING</th>
<th>NEEDS IDENTIFICATION</th>
<th>ASSESSMENT</th>
<th>SERVICE COORDINATION AND REFERRAL</th>
<th>CASE MANAGEMENT</th>
<th>REVIEW</th>
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<td>✓</td>
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<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<td>✓</td>
<td>?</td>
<td>?</td>
<td>✓</td>
<td>?</td>
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<td>✓</td>
<td>✓</td>
<td>?</td>
<td>?</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Other academic articles compared integrated health systems across several countries. Johri, Beland and Bergman\(^\text{21}\) examined models of care projects that aimed to integrate services and had been trialled in OECD countries. They examined the models for cost-effectiveness as well as for impacts such as institutionalisation, hospitalisation and health outcomes. Researchers used the results to identify common features of an effective solution. These were identified as a single entry point (except for the American programs), case management, assessment, multi-disciplinary team and financial incentives for the providers. The single point of entry in America was problematic due to the payment structure underpinning the health care system. In all other programs, however, the single entry point was seen to improve financial sustainability and direct resources toward the area of need.

Clarfield, Bergman and Kane\(^\text{22}\) compared American, Canadian and Israeli health systems in 2001 and the care of their frail older population. They found that although more money was spent per capita in America, the health system was not coordinated or integrated. The Israeli system demonstrated more integration for some sectors; however, the integration did not include long-term institutional care. The Canadian system was considered the best of the three but still had issues about integration. The two features seen to be the most effective in parts of Canada for improving integration were single entry point systems that include case management.

Across the studies and systems described in this section a single point of access to all services, including acute and long-term care, provides optimum outcomes for people accessing the system and those providing the services. This includes the acute and community sectors and also incorporates short- and long-term care. Case management of clients is also seen to provide a benefit for clients and their health professionals.

Cost analysis

**A cost analysis of the Access Point for all clients and for younger HACC clients**

The Access Point received 5546 referrals between October 2013 and February 2014. During the same period it made approximately 6,255 referrals to other organisations. This means on average 1,110 referrals are received in a month and 1,250 referrals are made to other organisations.

The following table shows the number of clients and contacts over the last quarter of 2013.

<table>
<thead>
<tr>
<th>Client group</th>
<th>Clients assisted</th>
<th>Avg clients / mth</th>
<th>Clients/mth %</th>
<th>No of Contacts</th>
<th>Avg no of contacts / mth</th>
<th>Contacts/mth %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>840</td>
<td>280</td>
<td>26.4</td>
<td>1457</td>
<td>486</td>
<td>25.7</td>
</tr>
<tr>
<td>65 and over</td>
<td>2345</td>
<td>782</td>
<td>73.6</td>
<td>4211</td>
<td>1404</td>
<td>74.3</td>
</tr>
<tr>
<td>All clients</td>
<td>3185</td>
<td>1062</td>
<td>100</td>
<td>5668</td>
<td>1889</td>
<td>100</td>
</tr>
</tbody>
</table>


Total funding received for the Access Point in 2012–2013 was $1,546,840. This breaks down into $464,529 funding for younger people and $1,082,311 for clients over 65 years of age. Table 10 uses this data to show costs per client, contact, referrals received and referrals made.

### Table 10: Costs per client and per referral

<table>
<thead>
<tr>
<th>Client group</th>
<th>Avg referrals received / mth</th>
<th>Avg referrals made / mth</th>
<th>Avg clients assisted / mth</th>
<th>Avg no of contacts / mth</th>
<th>Funding / mth $</th>
<th>Cost / referral received $</th>
<th>Cost / referral made $</th>
<th>Cost / client assisted $</th>
<th>Cost / contact $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>280</td>
<td>486</td>
<td></td>
<td></td>
<td>38,711</td>
<td>138</td>
<td>80</td>
<td></td>
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<tr>
<td>65 and over</td>
<td>782</td>
<td>1,404</td>
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<td></td>
<td>90,193</td>
<td>115</td>
<td>64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All clients</td>
<td>1,110</td>
<td>1,250</td>
<td>1,062</td>
<td>1,889</td>
<td>128,903</td>
<td>116</td>
<td>103</td>
<td>121</td>
<td>68</td>
</tr>
</tbody>
</table>

This workload is handled by 13 staff (excluding the team leader) most of whom are part time (8 EFT). Each full-time equivalent position on average per month receives 139 referrals, makes 156 referrals, assists 133 clients and has 236 contacts.
ACCESS POINT FUNCTIONS

As described earlier, the initial requirements of the Access Point model were to:

- Facilitate access to the service via telephone, fax, email
- Provide information
- Test for eligibility
- Undertake client screening for needs identification
- Refer to appropriate services
- Use staff with appropriate qualifications.

Facilitate access to the service via telephone, fax, email

The Access Point has provided access via telephone, fax and email. Any call overflow (due to a busy signal on all lines) or after-hours calls are picked up the RDNS Rally service in Melbourne. The Access Point operates from 8am until 6pm Monday to Friday. Two shifts, 8am – 4.30pm and 9.30am – 6pm, are coordinated to provide these extended hours of business. Referrals received before midday are actioned the same day. Faxes are processed depending on who has sent the fax; that is, health professional referrals are dealt with by nurses. Referrers will often ring first, then send through a fax. Calls from hospital staff, nurses and GPs are prioritised as it is often difficult to reach them if calling back is required.

At the inception of the Access Point, service providers were informed that referrals would initially be faxed but they would soon be transmitted electronically. Faxing is still used today. Larger organisations have policies preventing the use of email for health information. It is common practice that health information must be shared via fax as this is a safer means of communication.

Information provision

Provision of information requires maintenance of service provider and service type data. The Access Point uses a service availability charter—an Excel spreadsheet—that contains state-wide service information including service types provided, areas where services are delivered, and service availability. This is updated regularly by the Access Point Team Leader and another staff member. Availability of services is obtained by phone calls made and received by service providers. However, a provider having not received any referrals in the past three or four months worried that their details were missing. Two service providers in the North West region were concerned that the information held by the Access Point was either incomplete or incorrect. This was deduced from a low number of referrals or none at all.

One organisation in the Southern region that described its relationship with the Access Point as ‘excellent’ had received a limited number of referrals through this channel. The person interviewed thought the onus should be on their own organisation to contact the Access Point:

"It would probably be more appropriate for us to approach them and say ‘Hey, we exist, do you feel familiar with what we do or do you need a bit more information?’" (SP S)

This lack of referrals leading to a concern about organisational information held by the Access Point was not identified as a problem in the Northern region.

The Access Point Team Leader or a representative also attends the regional monthly HACC forums. This allows networking with service provider staff as well as an opportunity to gather information about new funding or new agencies.
Eligibility testing

The eligibility criteria for HACC services are deliberately broad; this can create challenges for some service providers. The Tasmanian HACC Program Manual from 2012 states that to be eligible for a program a person must:

- Live in the community
- Have difficulty performing everyday tasks without help due to functional limitations
- Be at risk of admission to long-term residential care without assistance from Tasmanian HACC program services.

Eligibility is based on both age and level of difficulty in carrying out activities of daily living without help or supervision.23 Carers of people eligible for HACC services may also receive support through the HACC program. Clients who approach the Access Point directly for services receive a functional screening to determine eligibility. Functional screening is conducted using the SCTT template, which is then included in the referral information passed on to the service provider. The majority of agencies were pleased that the Access Point is conducting eligibility testing:

_Previously we accepted referrals from basically any source and we had to determine eligibility. So TasCarepoint determining eligibility certainly is an advantage._ (SP S)

The Access Point assumes that a client referred for services by a health organisation will be eligible for those services. An organisation referring a client to the Access Point for HACC services may have completed a functional screening but no evidence of it is attached to the referral. To prevent burdening the client with additional and unnecessary questions, any contact with them by the Access Point will not include a functional screening. This lack of evidence of functional capacity may cause the organisation receiving the referral to question the client’s eligibility. The number of eligibility issues was low and usually resolved with input from DHHS.

Client screening for needs identification

The funding agreement specifies that the Aged and Community Care Needs Assessment – Revised (ACCNA-R) will be used to screen clients and determine eligibility. As stated earlier, DHHS had identified the ACCNA-R as ‘not fit for purpose’ in the evaluation of the Demonstration Project. On the basis of this finding and given the Australian Government was discontinuing support for the Community Care Assessment Support System beyond July 2011, the Tasmanian Access Point adopted the Service Coordination Tool Template (SCTT) for screening and determining eligibility.24 SCTT is used throughout Victoria as a standardised screening and referral tool.

Clients who approach the Access Point directly for services receive screening via the SCTT. The templates used are:

- Consumer information
- Summary and referral information
- Functional assessment summary (not used for nursing)
- Living arrangements (if required).

The Functional Assessment template covers the standard activities of daily living (feeding, toileting, bathing, continence, dressing, walking and transfers) and the instrumental activities of daily living (managing finances, transport, shopping, meal preparation, using the telephone, housework and managing medications). This assessment is conducted mainly to determine eligibility but some service providers will use this information as part of their assessment process. This assessment is conducted via telephone, which is a risk as:

> We already know there’s major under-reporting on telephone – hysterical family or client who say ‘no, I’m fine.’ (SP NW)

Studies have shown that the way data is collected affects the quality of the information gathered. Phone-based data collection is more burdensome for the client than face to face as the auditory demands are greater. A face-to-face assessment also allows a more comprehensive assessment to be undertaken.

Any referrals made by the Access Point to a service provider will be followed up by a service provider face-to-face assessment, so any needs missed by the Access Point or under-reported by the client should be identified at the assessment. Further assessment by the Access Point was considered unnecessary by service providers. Any service provider organisation will require their staff to do a risk, safety or OHS assessment before and during the visit to the client.

Referrals that come via another organisation are usually passed on directly using the information provided by the referrer. This does not always include a functional assessment of any sort so the agency referred to will complete this assessment. If these organisations don’t complete all the information on the referral form then the Access Point does not follow this up with the client.

**Referral to appropriate services**

In the early days of implementation in the North and North West regions there was confusion in the Access Point about service provider boundaries which are not mandated by the HACC Program. Although this problem has been resolved, one or two agencies gave this as the reason they were bypassing the Access Point and referring directly to service providers.

All service providers said the quality of the information sent by the Access Point was good. However, the service requirements and needs identification information was difficult to locate in the referrals sent by the Access Point. Two-thirds of the service provider organisations interviewed struggled with the referral documents sent by the Access Point. The problems included the location of the information they needed and the provision of more information than necessary. The SCTT templates contain some coded questions such as living arrangements, income status and carer availability. Responses to these questions often are numbered. The SCTT templates include a coding sheet that provides a definition of the numbers. One organisation struggled with the use of the SCTT templates and the coding used for some items:

> [...] it’s coded so there’s numbers and it’s very difficult for us as service providers to understand what it is they’re wanting. So we still have to go through and ask ‘what’s your pension number?’ all of those sorts of questions. (SP S)

Only two organisations focussed solely on support for carers and only one was interviewed as part of this review. Concern was expressed that carers were being ignored by the Access Point:

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The carer thing is an issue. ... The primary focus is to look after care recipients and the carers are forgotten and hidden again. (SP S)

One ACAT highlighted a similar issue relating to carers, that the Access Point staff are not using their initiative when referring clients who then end up on the wait-list:

Particularly if you’ve got a comprehensive assessment here feeding back to them that’s saying this is what we’ve done and these are the issues and highlighting carer burden. So surely why doesn’t it trigger for them?

In this example, the ACAT expected that, having identified a carer struggling to manage, the Access Point would do more than place the client on a waiting list, no matter how short the list. Implementing some support for the carer in this situation may assist while waiting for services. Although this was the only example mentioned, it demonstrates an expectation that the Access Point take responsibility for clients referred to them. It also shows that the Access Point is considered part of the health service.

All service providers interviewed talked about the early stages of implementation when a lot of inappropriate referrals came through for clients who were out of their area or for services the provider didn’t offer. All agreed this had been resolved.

Staffing

The six roles required within the Access Point are listed as:

- Information/intake
- Screening
- Systems/business/training support
- Team leader/manager
- Health care profession to support information provision and screening
- Data collection.

The Access Point has 14 staff (9 FTE); all part-time except for the team leader. The Team Leader has a background in call centre management and customer service but no health background. When this Team Leader was appointed, RDNS arranged for clinical support to be available in Melbourne if required. At this time the Access Point also appointed a clinical lead, who is second in charge. This person is a grade two registered nurse. There are six grade one nurses (registered and enrolled) and six customer service operators (CSOs; non-health). Previously the Access Point had clinical staff as Team Leaders.

The supporting position in Melbourne is also utilised when the Team Leader takes annual leave. There are two casual staff, one nurse and one CSO who fill in at times of unanticipated leave. A nurse is always on staff and nurses usually take phone referrals from health professionals. The Access Point uses telephone calling software that allows the Team Leader to monitor calls and provide call coaching if necessary.

The combination of CSOs and nurses taking referrals is appreciated by those referrers using the Access Point:

... and as a health professional I felt really reassured when she said to me there are 6 registered nurses and 6 registered client officers [customer service officers] sitting in the one room. Prior to that all the staff really had a problem with the fact they were probably non-health professionals down there. (ACAT)

Nurses can take referrals from health professionals and speak to them using the same clinical language. This model saves time in interpretation and prevents misunderstanding of clinical information. A nurse will understand which situations will require a medication chart or wound chart to accompany the referral. One
nursing organisation recognised that having nurses employed at the Access Point allowed the filtering out of those referrals not requiring a registered nurse:

A lot of times referrals are going to them [the Access Point] rather than us because it’s not appropriate. It’s just basic maintenance hygiene; you don’t need a nurse to do that. So that’s where TasCarepoint has actually sifted a lot. So we’re not getting those routine, mundane, low care referrals. You don’t need a registered nurse for that. (SP NW)

Access Point staff require excellent communication/networking skills. It is these skills that have improved the uptake of the Access Point over time. When recruiting new staff the Access Point looks for face-to-face assessment experience or customer experience and administration.

Post-implementation initiatives

Since implementation, the Access Point has introduced several key initiatives in response to feedback from stakeholders. These were a wait-list service and a referral feedback loop, both introduced in 2013. The wait-list service was one of the biggest changes to the operation of the Access Point since its commencement and was recommended by the Access Point in response to feedback from stakeholders. The intention was to improve access to services when demand exceeded availability. The wait-list was also intended to reduce “an inefficient cyclical process of repeated phone calls between referrers and TasCarepoint”. Prior to implementation of the central waiting list, a list of clients waiting for services was maintained by each provider. Clients were potentially waiting across many lists, which resulted in no central record of unmet demand across the state being kept. Clients may have remained on a waiting list with one provider while another provider in the same area may have had appropriate services available. Implementation of the wait-list service should improve waiting time for clients to access services. However, one provider thought they should maintain their own list:

[When asked if they had a waiting-list] No. We try to meet the need at the time. And sometimes we’re frightened about that because we’re scared that we don’t have a waiting list that we’ll be seen not to be doing our job properly. (SP NW)

Removing the need for service providers to have their own waiting lists reduces the amount of time and resources required to manage them. Although not all service providers use this feature, it is recognised as an improvement or ‘value-adding’ to the Access Point service. A central wait-list also allows DHHS to see a genuine display of unmet demand.

Managing this list is a very manual and labour-intensive process. Client information is captured on an Excel spreadsheet and includes the client’s postcode and the date the client was placed on the waiting list. The client is told how many people are ahead of them on the list. When the service provider has availability they ring and say what hours they have availability in, for which services, and the area (could be ‘regional’ or more specific). List is sorted in date order so clients will get the service on a first-come first-served basis unless the provider can only service someone in a particular area. In smaller areas, staff at the Access Point will ring around for providers. Clients with a greater need will be prioritised for a service.

The waitlist service is greatly appreciated by service providers and is an excellent initiative. The second initiative was a ‘Referral Feedback Loop’, introduced on a trial basis in late 2013. This was intended to “improve communication and shared knowledge of client care planning” and involved the

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Access Point advising the referring agency of referral outcomes, thereby providing reassurance to those agencies that referrals to the Access Point had been actioned.27

FEEDBACK AND FURTHER RECOMMENDATIONS FOR THE ACCESS POINT MODEL

A single point of access is an effective way to improve the general public’s access to services. The Access Point model should continue beyond June 2015 to make navigation of the HACC system easier for people under 65 and their carers. During an analysis of international integrated care systems, Johri et al. found a single point of entry helps to ‘ensure society’s resources are targeted on the basis of medical need’. An advantage of maintaining an Access Point would be the ability to easily transfer callers over 65 to the MyAgedCare system.

Recommendations

There are elements of the existing model that work well and others that could be improved. These are listed together in this section with recommendations for improvement included throughout. It is acknowledged that some recommendations may be impossible to implement before transition to the MyAgedCare system in July 2015. However, it is important these recommendations be considered for any future iteration of the Access Point. Some recommendations will help service providers and referrers transition to the MyAgedCare system.

The sections here are consistent with functions of the Access Point and so the recommendations can be grouped into the following categories:

- **Facilitate better access to the service**
  - The use of electronic rather than faxed referrals
  - Regionalise the Access Point
  - Mandate the use of the Access Point
  - Market the Access Point to potential clients
  - Seek to include DVA referrals within the Access Point

- **Provide information**
  - Enable access to the service availability charter for organisations to update themselves

- **Test for eligibility**
  - Develop a state-wide form for all referrals in and out of the Access Point

- **Undertake client screening for needs identification**
  - Consider having one organisation for assessment
  - Ensure carers needs are captured
  - Reconsider the hours of operation of the Access Point
  - Consider the benefits of opening for a brief period on a weekend

- **Refer to appropriate services**
  - Consider extending the data collection
  - Work with service providers to determine what is required in a referral
  - Monitor the waiting list

- **Use staff with appropriate qualifications**
  - Incorporate staff professional development within the Access Point

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Facilitate access

The Access Point model allows access via telephone, fax and email. However, referrals are only taken via telephone and fax. While the telephone systems used by the current Access Point work well, using fax as the major method of referral may need reconsideration. With the gradual introduction of VoIP phone systems throughout government and non-government organisations in Tasmania, fax machines are being phased out. Service providers are finding fax machines are being removed completely or shared within the organisation. Email is an alternative but would need to be made secure.

An alternative to secure email would be the use of the existing iPM system, which would provide a secure method of sharing information between organisations. Email could be used to notify service providers of referrals sent through iPM.

The Access Point is located in Hobart, which is seen as a problem for services in other regions, particularly the North West. Walk-in clients are possible in the current location but not obviously for clients in other locations.

The Access Point is not currently mandated so clients and referrers can bypass the Access Point and refer directly. Therefore, data held by the Access Point about clients and services is not complete. A telephone call from the acute sector to cancel services for a client may require some intensive investigative work by the Access Point to locate the correct service provider.

Marketing of the Access Point was successful with service providers and referrers. Much of this is due to the continuous work of the Team Leader. However, clients have never been targeted.

DVA clients can access HACC servicers if those services are not provided by DVA. However if the service is offered by DVA, these clients sit outside the scope of the Access Point. Benefits of the Access Point are unavailable to these clients and DVA service providers, resulting in the need for acute and community referrers to maintain a list of available DVA services across the state.

Electronic referrals

The encryption of emails would remove the need for fax machines. Encryption could happen between organisations or through the establishment of an online secure portal. A secure portal could also incorporate the web-based service charted described below.

Recommendation 1: That DHHS reinvestigate the use of secure email and use this system for referrals in and out of the Access Point.

iPM

The Access Point, as an external provider in the Tasmanian health system, has no access to the state-wide patient management system iPM. This also applies to the non-government service providers. This means the Access Point maintains a separate client record that contains information about services the client has received or is receiving. This key information should be retained in the central client record within iPM. iPM also has an electronic referral system that could be easily utilised, thus obviating the need to fax information between services. Email could be used to notify the service provider of a referral within the system.

It is understood that access to iPM has been restricted. This decision should be reinvestigated as the value to the client, the state, the services and the Access Point would be considerable. Information technology is a tool and as such should enhance business, not direct it. It should be possible within a large health system to restrict areas of client information so that only the required information can be accessed.
**Web portal**

An alternative to iPM would be the establishment of a separate web-based system that is used by the Access Point and all service providers state-wide. This web-based system would provide a portal for all users of the system and allow referrals to be made within the system to providers and to the Access Point. Emails could notify organisations of waiting referrals requiring attention. The web portal could also hold the service availability charter; see recommendation 7 below.

**Recommendation 2:** That DHHS investigate the use of a secure system by all organisations, including non-government, and use this system for referrals and recording of services provided to clients.

**Location of Access Point**

The location of the Access Point in Hobart seems to be an issue mainly with the North West region. It has been difficult for service providers to trust an organisation outside their region. Locating Access Point staff across the state would encourage relationship-building and trust. Both would assist with take-up of the Access Point service. It is therefore recommended that DHHS regionalise the Access Point, either locating one agency or a number of smaller sub-agencies in each region. Co-locating the Access Point with a HACC service provider may also assist take-up of the Access Point. Each Access Point should also offer a shop-front for walk-in clients. Many people, especially those in rural or regional areas, prefer to discuss their situation face to face, not over the phone. A shop-front would allow face-to-face contact and also assist in raising awareness of the Access Point. One phone number used across the state should be possible and work in a way similar to the Disability Gateway. If someone inadvertently calls into the wrong regional office then a warm transfer should be used to connect the client to the correct office.

Consideration should be given to selecting staff for the regional offices from the current staff of service providers in the region. These people have the local knowledge and will aid in settling the new model into the service system.

**Recommendation 3:** That DHHS considers regionalising the Access Point to support and assist service providers in their region.

**Mandating**

As mentioned earlier in this report, use of the Access Point was never mandated by DHHS. July 2015 will be a difficult transition for some service providers and referrers; mandating use of the existing Access Point now may aid that transition. It will also enhance the data gathered by the Access Point.

**Recommendation 4:** That DHHS mandates use of the Access Point across the state.

**Marketing**

Advertising the Access Point could be done in a number of ways, but it must be ongoing. People will only pay attention to information they need at the time. Marketing to potential clients will also reach service providers and referrers. Creative consideration should be given to where the marketing occurs:

*Any amount of marketing in the media, if I don’t think I need that then I’m not listening. It’s not until I want it today, where do I go? How do I find out? You can do a lot of marketing but people are not necessarily going to remember.* (SP S)

*One place we could do a lot more work is hairdressers. They’re pseudo councillors and they could have a number they could give and say ‘you might be able to get some help for that.’ Word of mouth is your best marketing.* (SP S)
Recommendation 5: That DHHS conduct ongoing advertising of the Access Point to potential clients.

**DVA**
Including DVA clients would eliminate the need for referrers to treat DVA referrals in a separate way.

Recommendation 6: That DHHS negotiates the inclusion of DVA clients within the Access Point model.

**Provide information**
The service availability charter, while working in its current form, relies on phone calls to and from service providers to keep it up to date. It is retained within the Access Point with no visibility outside the organisation. One or two service providers in each region mentioned they hadn’t had many referrals, if any, and wondered if the Access Point had up-to-date information about their service.

**Service availability charter**
Although the Excel spreadsheet used by the Access Point is only edited by two staff, Excel is not the most robust software to use in this situation. A more robust service could be developed that put the responsibility back on the service providers to update their information and availability more frequently.

Recommendation 7: That DHHS and the Access Point develop a web-based repository for service and service availability information.

**Test for eligibility**
This process works well within the Access Point with only a few exceptions. The exceptions occur for clients referred from other health organisations where the Access Point does not conduct a functional assessment as part of eligibility testing. The exceptions could be removed completely by changing the referral form. A number of different referral forms (of varying lengths) are used across Tasmania. Establishing consistency in referral practice would assist with electronic referrals in the future.

**Referral form**
The establishment and use of a state-wide referral form that included a functional screening component would improve referrals coming into the Access Point and help to avoid eligibility concerns. All clients would receive the same screening without duplication at either the Access Point or—if referred by another health organisation—the agency providing the service. The same referral form could then be used to refer people from the Access Point to other service providers.

Service Providers struggle with the layout of the documents currently used by the Access Point to refer clients for services. A recent trial of referral information from the MyAgedCare system was highly praised by those in the sector who saw the documents. The layout of this documentation should be considered when further development takes place.

Recommendations 14 and 15 below also involve the referral form, looking at requirements for a referral and flexibility in form use.

**Recommendation 8**: That DHHS considers the development of a state-wide referral form used for all referrals in and out of the Access Point and all programs.

**Undertake client screening for needs identification**
As with eligibility testing, client screening occurs only if the client is not referred directly from another health organisation.
Any referrals made by the Access Point to a service provider will be followed up by a face-to-face assessment by the service provider. If clients have more than one service provider for different services they will receive multiple assessments asking similar questions. One of the aims of an Access Point is to prevent clients from having to answer the same question many times. While each provider must conduct an assessment for its service, the needs assessment could be removed from individual providers.

One organisation that offers direct services to carers mentioned they get few referrals from the Access Point. One ACAT also gave an example where carer burden wasn’t picked up in a referral.

The Access Point is open between 8am and 6pm. A number of staff reported that they rarely received referrals after 5pm and most service providers have left by that time so no referrals could be passed on.

Referrals from the acute sector are often last-minute for patients being discharged the same day. It was never intended for the Access Point to manage last-minute referrals. Timely planning needs to occur for all discharges but especially those that take place on Friday afternoon or over the weekend. Patients discharged from hospital on the weekend may need to be seen by Community Nursing on Monday or earlier. Knowing that the Access Point doesn’t open on the weekend, some acute staff will send the referral directly to the Service Provider. Other staff will send the referral to the Access Point expecting it to be dealt with first thing on Monday.

**One assessment**

Any service provider organisation will require their staff to do a risk, safety or OHS assessment before and during the visit to the client. A central agency could conduct a standardised independent needs assessment face to face with the client. This would enhance the focus in the HACC sector on wellness and re-ablement. This assessment would also commence the risk assessment for service providers. Johri et al. 21 identified geriatric assessment as an effective component of an integrated care system.

This model could not be used with clients requiring nursing care. Rather, the community nurse could conduct the standard assessment during their visit.

**Recommendation 9:** That DHHS considers establishing a regionalised assessment service that works closely with or incorporates the Access Point to conduct a standardised, independent needs assessment.

**Carers**

The Access Point should examine their needs identification process to ensure relevant questions are asked relating to the carer. Consultation with a carer organisation could assist this process by suggesting questions if required.

**Recommendation 10:** That the Access Point examines their needs identification process to ensure carers are taken into account when assessing clients.

**Hours of operation**

**Recommendation 11:** That the Access Point examines its records to determine the value of remaining open until 6pm.

**Weekend opening**

Changing the process within the acute sector to plan referrals for weekend discharges will take time. It may be worth considering opening the Access Point for a few hours over the weekend to assist with nursing and personal care referrals that must be actioned on Monday morning. For THO Community Nursing to be able to include new patients in their schedule, they must have details of any new patients first thing in the
morning. Referrals sent to the Access Point over the weekend will not be processed by them until Monday morning, by which time the service provider’s schedule has already been arranged. This creates a great deal of pressure to process the referrals quickly to ensure the client receives a service. There was agreement among Community nurses that any referral received over the weekend with an accompanying message on the answering machine could be processed on Monday morning. Service providers with a weekend service may process the referrals sooner than this.

**Recommendation 12:** That DHHS and the Access Point consider opening the Access Point for a number of hours on Saturday afternoon to process referrals for patients discharged from hospital in the previous 24 hours.

**Refer to appropriate services**
At present it is difficult to extract the service type of the referral from the data collection system used by the Access Point. A cross-tabulation of referral service type by referral source would show if the acute sector is using the Access Point for referrals to all or only some HACC service types. With the current data set it is also difficult to distinguish between a contact that is providing follow-up information, a contact that is a referral for a client, or a contact that is a modification to existing services.

At present there is no distinguishing between a referral for one service, a referral to one organisation for multiple services and a referral to multiple organisations for different services for the same client.

THO Community Nursing find the Access Point saves the organisation time by chasing up additional information they require to provide their services. Other types of service providers said they would contact the referrer directly if there isn’t enough information in the referral passed on by the Access Point.

Almost all service providers complained about the number of pages that comprise the Access Point’s referral documentation. The information contained in the referral was required in some cases but the service provider found the referral difficult to read and key information—client’s address and the service required—were buried somewhere around page 5. At present the same referral is sent regardless of the type of service; for example, a personal care service provider will receive the same information as a provider doing an annual spring clean.

One major change the Access Point has implemented in the past 12 months is the maintenance of a central waiting list. This not only provides a more accurate picture of unmet demand across the state but also removes the burden of each provider maintaining their own waiting list. At the end of May approximately 100 people were on the largest list (for domestic assistance).

Discharge planners in three of the hospitals interviewed tend not to use the Access Point for immediate services because a guaranteed service (personal care or nursing mainly) must be in place before their patient leaves the hospital. The Access Point will send a referral to a service provider but doesn’t follow through to ensure the service will be provided, and when. This is more of a case management role but it is important for hospital discharge staff. The client must be notified before leaving hospital which service will visit and when. This information, if gathered, could provide more feedback than that given currently.

**Data collection**
Modifications to the data items collected and definitions of terms could resolve these difficulties and allow both the Access Point and DHHS to interrogate the data further. This may require the development of data items such as referral service type, contact type, contact outcome and referral reason. This will also require a definition of a referral.
**Recommendation 13:** That DHHS consider the adequacy of the current formal data requirements of the Access Point.

**Components of a referral and flexibility of referral form**

Consultations should be held with service providers to determine their exact information requirements for a referral. If these are known, the Access Point could chase the information required, as they do for Community Nursing. This would also encourage referrers to provide a better quality referral.

**Recommendation 14:** That the Access Point and DHHS work with different service types to determine the exact requirements of a referral.

**Recommendation 15:** That the Access Point considers a flexible referral with pages that can be added or deleted depending on the type of service requested.

**Waiting list**

There is a concurrent evaluation of the TasCarepoint wait list functionality underway. The findings of this additional evaluation will provide evidence to make improvements to the current wait list function. The waiting list functionality could be improved. There is currently no active management of the list; clients are placed on the list, told where they are positioned and then not contacted again until a service provider offers a service. Recently a large service provider requested 100 clients from the waiting list. The Access Point created 100 referrals to the provider who then contacted the clients. A number of clients no longer needed the service. The Access Point then had to generate more referrals to fill the spaces:

> The other function the gateways do in that space is called ‘active monitoring’. And it’s exactly that: they work with the client on the waiting list. If there is a crisis point being reached then they might access brokerage or one-off funding or get them something short term, even though we know the end game is an ongoing package. They’re not just sitting on the waiting list with nothing. So the idea is we ask them how often they want to be contacted, because some people say ‘don’t contact me until you’ve got something to offer me’ and others want to be talked to every couple of weeks/six weeks. And even just that might help a family stay coping vs ‘I feel like I’m completely on my own and I don’t know what’s going to happen’. So that’s the other role they do: they quite actively manage that needs register. (GOV)

**Recommendation 16:** That the Access Point actively monitors the waiting list by ringing clients regularly to ensure they still need a service.

**Case Management**

Johri et al. 21 recognised case management as being of pivotal importance when coordinating services and also for maintaining clinical responsibility. This lack of clinical continuity was mentioned in a number of interviews. A case manager within the Access Point could actively monitor the waiting list and possibly negotiate some interim level of service if required for clients on the waiting list. Case management would not be ongoing for clients but relate only to the current referral. Clients with ongoing case management needs should be referred to the Community Options Service.

**Recommendation 17:** That the Access Point works with DHHS to investigate a case management role within the Access Point.
Staffing
The use of nurses and CSOs within the Access Point has improved the filtering of referrals, the information gathered and the information referred. The use of nurses as the only staff in the Access Point may not be cost effective if most referrals relate to domestic assistance or other non-clinical services. The current combination of customer service operators and nurses is the most cost effective approach.

Staff professional development
Many service providers reported they had conducted information sessions for the Access Point to explain their services. It would be interesting for staff to experience a service provider organisation.

The nurses employed in the Access Point must undertake continuing professional development (CPD) to maintain their registration. At present this is organised on an ad hoc basis by the clinical lead.

Recommendation 18: That the Access Point investigates work experience for CSOs.

Recommendation 19: That DHHS ensure nursing staff employed by the Access Point undergo CPD during their employment.
CONCLUSIONS

The Tasmanian Access Point is intended to provide a suitable entry point into, simplify the journey through, and improve efficiency and effectiveness of the community care system. The Access Point can be used by clients, carers, hospitals, GPs, service providers and other health professionals to receive information about the range of services available, and provide referrals to basic or comprehensive services depending on need.

The evaluation of the Tasmanian Access Point had the following requirements:

- An evaluation of the implementation of the Access Point model
- An evaluation of the Access Point’s effectiveness
- A review of the Access Point’s efficiency
- Feedback and recommendations in relation to the Access Point model.

The evaluation was conducted using tools such as interviews, surveys, data analyses and a document and literature review.

It was known prior to the evaluation commencing that the Access Point model had been implemented well in the Southern region but less well in the North and North West. Interviews occurred with service providers in all regions, with additional focus on the North and North West regions. The Access Point has developed and adapted over time to meet the needs of referrers, service providers and clients. This responsiveness has seen the implementation of new improvements within the Access Point, a feedback loop and waiting list functionality. During the last 12 months, staff of the Access Point have had more engagement with the sector, actively meeting agency staff and key stakeholders.

This evaluation has highlighted a few areas that could improve the Access Point service. Some items are internal to the Access Point, such as monitoring the waiting list, an examination of working hours and professional development for staff. Other recommendations involve systems around the Access Point such as a state-wide referral form and mandating all referrals through the Access Point. Another group of suggestions encourage consideration of major changes such as regionalising the service and incorporating assessment and case management into the model. Finally, changes were suggested for tools such as the IT used to capture data and an updating of the service availability charter.

The evaluation also found aspects of the service that are valued and should be mentioned here:

- All clients surveyed agreed that they were listened to and were satisfied with the service they received from the Access Point
- Time-saving associated with not chasing information
- Independence of the Access Point from service providers
- Use of nurses to communicate with health professionals
- Concerted efforts by the Access Point staff members to promote the service to referrers and service providers, resulting in improvement over time to call volume and referral rates.

Everyone involved in the evaluation agreed that a single point of access was the most equitable model for referrers, clients and service providers. The evaluation found that, overall, the Access Point is a valued part of the HACC service system within Tasmania. Given the uncertainty of the sector over the time, this is a remarkable achievement by everyone involved. Much of the recent achievement is due to the Access Point staff who have not only marketed the value of the Access Point to the sector but also listened and responded to concerns and problems.
APPENDIX 1: INTERVIEW QUESTIONS

Questions for Key Department of Health & Human Services/Tasmanian Health Organisation staff

- At what stage of development was TasCarepoint at when you became involved?
- What was your role in the development and implementation of TasCarepoint?
- What do you think were the challenges in implementing TasCarepoint?
- What do you think were the main achievements in implementing TasCarepoint?
- Can you comment on the advertising and marketing strategy for TasCarepoint?
- Can you identify any factors that facilitated the implementation of TasCarepoint?
- Can you identify any barriers that impeded the implementation of TasCarepoint?
- What could have been done better in the implementation of TasCarepoint?
- What do you see are the main challenges in monitoring the impact of TasCarepoint?
- What do you think has improved since TasCarepoint was implemented?
- What aspects of the operation of TasCarepoint could be improved?
- Can you identify any unanticipated consequences (positive or negative) from the implementation of TasCarepoint?
- Do you believe there has been any change to relationships in the sector because of the implementation of TasCarepoint?
- Do you think that a single point of access to services works? Why/why not?
- How do you think the intake tool is working?
- Do you believe the policies/protocols regarding TasCarepoint are sufficient to operate the service successfully?
- If the policies/protocols are lacking – which area is this in?
- Do you believe that the resources allocated to TasCarepoint are adequate?
- Is there any other area where TasCarepoint could be improved?

Questions for Service providers receiving referrals

- What is the relationship between your agency and TasCarepoint?
- Have you received any referrals from TasCarepoint?
- What impact has TasCarepoint had in terms of the number of referrals to you?
- Were the referrals you received from TasCarepoint appropriate? If not, why not?
- Have you sent any inappropriate referrals back to TasCarepoint?
- Were you happy with their response?
- Are you happy with the quality of referrals that you receive from TasCarepoint?
- What level of information did you receive in the referral? E.g. basic details or comprehensive information about the client?
- Was this an appropriate level of information for your service?
- Do you believe that TasCarepoint has had an impact on your resources?
- What would you like to see changed about the way that TasCarepoint operates?

Questions for Service Providers referring in

- Have you ever referred a client to TasCarepoint?
- If yes, what was your experience?
• If no, why not?
• How well do you believe the referral form works in transferring client information?
• Do you believe that TasCarepoint is impacting on demand management?
• What is the relationship between your agency and TasCarepoint?
• Do you think that TasCarepoint has improved your client’s ability to access services in a timely fashion? How?
• What do you think would improve the service delivered by TasCarepoint?

**Questions for Access Point staff**

• How long have you been involved with TasCarepoint?
• What were you doing prior to joining TasCarepoint?
• What is your current role?
• Do you believe that you have been given adequate training for your role?
• At what stage of development was TasCarepoint at when you became involved?
• What do you think are the strengths of TasCarepoint?
• What do you think has improved since TasCarepoint was implemented?
• What aspects of the operation of TasCarepoint could be improved?
• What do you think are the advantages of TasCarepoint for clients?
• Do you think that a single point of access to services works? Why/why not?
• How do you think the intake tool is working?
• How do you believe the ‘telephone’ approach is working?
• Do you believe that you are sending the appropriate level of information when you make a referral?
• Are your information sources suitable to make high quality referrals?
• Do you believe there are any difficulties for the client when contacting TasCarepoint?
• Are you aware of any unintended consequences (positive or negative) arising from the implementation of TasCarepoint?

**Interview questions TasCarepoint team leader**

• How long have you been involved with TasCarepoint?
• What were you doing prior to joining TasCarepoint?
• At what stage of development was TasCarepoint at when you became involved?
• What do you think were the challenges in developing TasCarepoint?
• What do you think are the key strengths of TasCarepoint?
• Can you comment on the advertising and marketing strategy for TasCarepoint?
• Can you identify any factors that facilitated the implementation of TasCarepoint?
• Can you identify any barriers that impeded the implementation of TasCarepoint?
• What could have been done better in the implementation of TasCarepoint?
• What do you think has improved since TasCarepoint was implemented?
• What aspects of the operation of TasCarepoint could be improved?
• Do you think that a single point of access to services works? Why/why not?
• How do you think the intake tool is working?
• Can you explain how the ‘wait list’ for clients works?
• Do you believe the policies/protocols regarding TasCarepoint are sufficient to operate the service successfully?
• If the policies/protocols are lacking – which area is this in?
• Is there any other area where they could be improved?
• Do you have sufficient resources to employ adequately skilled staff to TasCarepoint?
• How many staff do you employ and what is your staffing structure i.e. clinical vs non-clinical?
• What roles do these staff undertake (intake, referral, assessment)? E.g. Service facilitator, Intake worker
• Are health professionals used for assessments?
• How do you believe the ‘telephone’ approach is working?
• Has there been a change in staff roles since the initial implementation of TasCarepoint?
• Do you believe that these roles work well?
• What competencies/qualifications do you ask for these roles?
• Do you have any problems in attracting skilled staff to TasCarepoint?
• Do you have sufficient resources to ensure adequate staff training?
• Are the other resources required to operate TasCarepoint sufficient?
• Do the resources available make the operation of TasCarepoint sustainable?
• What database do you use to make referrals?
• Are your information sources suitable to make high quality referrals?
APPENDIX 2: EVALUATION CLIENT TELEPHONE SURVEY

Firstly some general questions about you:

What gender are you?

Male □ Female □

How old are you?

Less than 20 □ 20 – 24 □ 25 – 29 □
30 - 34 □ 35 – 39 □ 40 – 44 □
45 - 49 □ 50 – 54 □ 55 – 59 □
60 – 64 □ 65 – 69 □ 70 – 74 □
75 – 79 □ 80 – 84 □ 85 – 89 □
90 – 94 □ 95 – 99 □ 100 or older □

Now some questions about TasCarepoint

Could you tell me how you heard about TasCarepoint? ____________________________________________________________

Did you contact TasCarepoint directly or did an agency do it for you?

If agency, which one? ____________________________________________________________

If directly, was it for yourself or someone else? ______________________________________

The following questions use a scale from 1 to 6 with 1 meaning you don’t agree and 6 meaning you do agree

1) The person explained to me what TasCarepoint do:

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly disagree</th>
<th>Slightly agree</th>
<th>Agree</th>
<th>Strongly agree</th>
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Why or why not?
2) The person explained to me what TasCarepoint would do for me:

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<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly disagree</th>
<th>Slightly agree</th>
<th>Agree</th>
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Why or why not?

3) The information they gave me was useful:

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<th>Strongly disagree</th>
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<th>Slightly agree</th>
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Why or why not?

4) I understood the information they gave me:

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Why or why not?

5) The person listened to me:

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<th>Slightly agree</th>
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Why or why not?
6) I was satisfied with what TasCarepoint did:

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<th>Strongly disagree</th>
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<th>Slightly disagree</th>
<th>Slightly agree</th>
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Why or why not?

7) Did TasCarepoint refer you to other services?

a. If yes then were those services suitable:

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<th>Slightly agree</th>
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Why or why not?

Is there anything else you would like to tell us about your experience of TasCarepoint?

Thank you for your time today.