

Victorian HACCC Active Service Model

DISCUSSION PAPER

May 2008

Victorian HACCC Active Service Model

DISCUSSION PAPER

MAY 2008

The Home and Community Care program is jointly funded by the Australian Government and the Victorian Government.

Published by Rural and Regional Health and Aged Care Services Division
Victorian Government Department of Human Services
Melbourne Victoria Australia
May 2008

Design by Lynn Twelftree Art & Design

© Copyright State of Victoria, Department of Human Services, 2008.
This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the Copyright Act 1968.
Also published on www.health.vic.gov.au/hacc
Authorised by the Victorian Government, 50 Lonsdale Street, Melbourne

Contents

Executive Summary	1
1. PURPOSE OF THIS PAPER	3
2. BACKGROUND	4
2.1 What is the Home and Community Care Program?	4
2.2 Reasons for considering a different approach to the way services are delivered	4
2.3 Policy context	6
2.4 Related Developments	7
2.5 Summary	8
3. TOWARDS IMPLEMENTING AN ACTIVE SERVICE MODEL IN VICTORIA	9
3.1 Experience elsewhere influencing the development of the Active Service Model in Victoria	9
3.2 What is the Active Service Model?	10
3.3 Principles of the Active Service Model	10
3.4 Objectives of the Active Service Model	11
3.5 Core components of the Active Service Model	13
3.6 Case studies	14
4. DISCUSSION	17
4.1 The environment	17
4.2 Connections with other professionals and services	17
4.3 Change management	17
4.4 Dealing with demand pressures	17
4.5 Models of service	17
4.6 Workforce	17
4.7 Targeting and Particular Client Groups	18
4.8 The role of carers	18
4.9 Funding and reporting issues	18
4.10 Building partnerships	18

5. STEPS TO IMPLEMENTATION	19
5.1 Direction 1: Strengthen practice within current structures and policy	19
5.2 Direction 2: One or more Demonstration Projects	20
5.3 Direction 3: Further exploration, research and development	20
6. CONSULTATION QUESTIONS	21
6.1 Active Service Model	21
6.2 Implementation priorities	21
APPENDIX 1: What We Have Learned About an Active Service Model Approach	22
7.1 Evidence based models exemplifying an Active Service Model approach	22
7.2 Literature review – summary of findings	28
7.3 The Victorian Active Service Model pilot projects – summary of findings	29
APPENDIX 2: Related Initiatives	31
APPENDIX 3: List of References	39

Executive Summary

In A Fairer Victoria (2005), the Government committed to:

‘reform the way key services, such as Meals on Wheels, are delivered to better meet older people’s nutritional, social and cultural needs. Support could include helping a person cook a meal or providing mobility aids to enable older people to continue their hobbies, walk around their communities or keep up their levels of activity. Services will aim to help people stay involved in everyday activities to maintain or rebuild their confidence and stay active and healthy’.

The short hand term for this approach to service delivery is an ‘Active Service Model’. There has been considerable discussion about an Active Service Model for HACC services in Victoria over the past two years and work has been done to develop its objectives and principles and to define the parameters of its operation.

DHS has funded nine pilot projects; commissioned a literature review to research experience in Australia and in other countries and has hosted the HACC National Forum on Promoting Independence on behalf of all jurisdictions in February 2008. The Forum brought together people from across Australia to engage with those who have been developing and implementing a restorative or re-enabling approach to community based care in Western Australia, England and New Zealand.

This paper is the result of that work and its purpose is to be the basis of consultation with Victorian HACC funded service providers and peak organisations on how an Active Service Model could be implemented in Victoria. Feedback from consultations will contribute to developing an implementation plan that will have short, medium and longer term actions.

The Active Service Model is a quality improvement initiative which explicitly focuses on promoting capacity building and restorative care in service delivery. The core elements of the Active Service Model are:

- capacity building, restorative care and social inclusion to maintain or promote a person’s capacity to live as independently and autonomously as possible;
- a holistic person and family centred approach to care that promotes wellness and active participation in goal setting and decisions about care;
- timely and flexible services that respond to the person’s goals and maximise their independence; and,
- collaborative relationships between providers, for the benefit of people using services.

The principles underpinning the Active Service Model are:

- people want to remain autonomous;
- people have the potential to improve their capacity;
- people’s needs should be viewed in an holistic way;
- HACC services should be organised around the person and carer, the person should not be slotted into existing services; and,
- a person’s needs are best met where there are strong partnerships and collaborative working relationships between the person, their carers and family, support workers and between service providers.

2 HACC ACTIVE SERVICE MODEL • DISCUSSION PAPER MAY 2008

The following five objectives have been identified to act as a focus for implementing these principles across HACC services:

- to build skilled assessment;
- to improve the flexibility, timeliness and responsiveness of HACC services;
- to strengthen HACC services' capacity to deliver services consistent with the principles of an Active Service Model;
- to strengthen, support and further develop the collaborative working arrangements between services; and,
- to implement evidence based models of service delivery that can deliver Active Service Model principles.

The Active Service Model has emerged from a strong evidence base and drivers for change. The evidence base has led us to an understanding of the importance of a wellness or active approach to service delivery.

A key driver for change is the growth in the number of people who are ageing and the reality that a substantial number will have chronic conditions that result in significant levels of disability in the last 10 to 15 years of life. This will inevitably lead to increasing demand for community based services.

Particularly influential in developing Victoria's thinking have been the New Zealand Restorative Care Approach; the UK Enablement Approach and the Western Australian WATCH and HIP programs.

There are also a range of other Victorian policy and program developments that either incorporate elements of this approach or provide opportunities for collaboration and knowledge sharing.

The paper sets out three stages of work to implement the Active Service Model in Victoria.

1. Strengthen practice within current structures and policy through developing resources and training, strengthening assessment practice (already underway with implementation of the Assessment Framework) and further developing partnerships (using the Primary Care Partnerships as a basis).
2. Develop and implement one or more demonstration projects that would operate from the core principles of the Active Service Model and test in Victoria evidence based models of service delivery that are not currently offered in Victoria.
3. Further explore, research and develop areas that will require further action in the longer term to yield the full potential benefits of an Active Service Model.

This discussion paper is the basis for consultations with HACC funded service providers and peak organisations throughout late May and June 2008. The aim of these consultations is to have a dialogue with service providers about:

- barriers and facilitators to the adoption of an Active Service Model;
- examples of current practice that demonstrate this approach;
- feedback on proposed implementation steps; and,
- other ideas for implementation.

Consultations with carers and people using services will also occur on the basis of a paper which addresses the issues from carers' and service recipients' perspectives.

1 • Purpose of this Paper

This paper has been written to structure consultations with HACC funded service providers and peak organisations in Victoria on the development of an implementation plan for an Active Service Model for HACC services in Victoria.

Consultations with carers and people using services will also occur on the basis of a paper which addresses the issues from carers' and service recipients' perspectives. These consultations will occur in July and August this year.

The paper provides an overview of the evidence base and trends that have led to the development of an Active Service Model. It describes the principles, objectives and key components that underpin an Active Service Model. It discusses some of the implementation issues and outlines a range of implementation actions that could be part of an implementation plan, for discussion.

This discussion paper will act as the basis for a series of consultations with HACC funded service providers and peak bodies through late May and June 2008. The aim of these consultations is to have a dialogue with service providers and peak organisations about:

- barriers and facilitators to the adoption of an Active Service Model;
- examples of current practice that demonstrate this approach;
- feedback on proposed implementation steps; and,
- other ideas about implementation.

The outcomes of these consultations and consultations with carers and service recipients will contribute to developing an implementation plan for the Active Service Model for Victoria.

2 • Background

2.1 What is the Home and Community Care Program?

The HACC Program began in 1985 bringing a group of community care programs, variously funded by Commonwealth and State Governments, under one administrative umbrella. The Program is jointly funded by Commonwealth and State/Territory governments and administered by States and Territories. It funds a range of services in the community and in people's homes for frail older people, younger people with disabilities and the carers of both groups. Services are generally provided at a modest level, to people living at home.

The objective of the HACC Program is to support people in their own homes and communities by providing services that maintain and promote independence and help avoid premature admission to long term residential care.

The program has been successful in many respects. Services are generally regarded as efficient and efficacious and, for many frail older adults, result in an overall improvement in the maintenance of a basic standard of living and in delaying inappropriate admission to long term care (Howe, Doyle, & Wells, 2006). HACC is a valued and well utilised set of services, with about 245,000 people in Victoria using at least one HACC service in 2006-07.

In Victoria, about 500 agencies provide in home support (assessment, domestic assistance, personal care, property maintenance respite and delivered meals), health care (nursing at home and allied health) and social support (planned activity groups and volunteer friendly visiting and transport). Local councils throughout the state provide most in home support services, while community health services, Health Services and district nursing services provide health care services. Councils, hospitals and non

government organisations are the major providers of planned activity groups and other social support services.

2.2 Reasons for considering a different approach to the way services are delivered

There is a growing body of evidence suggesting that being physically active, having a nutritious diet and remaining mentally and socially engaged with friends, family and the broader community can reduce the impact on individuals of conditions associated with ageing.

A common interpretation of what it means to be maintained independent at home in an aged care context involves the provision of services that substitute for a person's own effort, as that person experiences an inevitable decline in function associated with ageing. This interpretation is being challenged by the development of a paradigm referred to as 'Wellness' or 'Active Ageing'. This paradigm emphasises proactive and/or preventative measures that have the potential to reduce older people's dependency levels, or slow their decline, even in the presence of substantial levels of disability as a result of chronic illnesses.

There will be a significant growth in the number of people in older age groups over the next few decades and they will continue to experience significant levels of disability in the last 10 to 15 years of their lives. In the absence of any policy change, this will place increased demand on the current service system.

These are the main reasons to consider:

- ▶ a different approach to underpin the delivery of HACC services; and,
- ▶ promoting a culture of service responsiveness and quality improvement.

2.2.1 Evidence for a wellness or active approach to service delivery

'Wellness' refers to a state of optimal physical and mental health, especially when maintained by proper diet, exercise, and social engagement. It is not only dependent on the actions of a particular individual, but also on the dynamic relationship between people and the quality of their physical and social environment (McMurray, 2007). The concept of 'wellness' reflects a significant shift from 'treatment' to 'prevention' that has gradually occurred in health provision over the last 50 years.

Even when people are elderly and frail, there is increasing evidence that adopting strategies for 'wellness' can make a positive difference to them (Stuck et al., 1999; Peel et al., 2005; Seeman & Crimmins, 2001). These strategies can include exercise (including low level activities such as shopping, cooking and gardening), using aids and equipment, improving nutrition, developing new ways of coping to deal with depressed mood or stress. These strategies often result in an improvement in well-being and morale for the older person and, at least in some cases, may reduce the number of hospital admissions and subsequently delay any need for permanent institutionalisation (McWilliam, Diehl-Jones, Jutai, & Tadrissi, 2000).

In Western Australia, the term 'wellness' has been used to describe a different approach to people using home and community care services. While the emphasis is mainly on older people the approach is applicable to anyone receiving support. 'Wellness' emphasises encouraging independence (in which positive expectations, opportunities for development and positive experiences motivate improvement). It moves away from emphasising illness or dependence (in which there is a focus on difficulties, negative expectations and limited opportunities for development) (O'Connell, 2006).

Developments in understanding 'wellness' are paralleled with more recent shifts in thinking that emphasise 'successful ageing': this focuses on promoting physical activity and active participation in society to maximise the physical and mental well being of people as they age. It contrasts with a view that older adults disengage and withdraw from activities or society as they age (Buys & Miller, 2006).

The World Health Organisation 'Active Ageing' framework (WHO, 2002) has been developed to overcome key criticisms of previous models. The term 'active ageing' was chosen in order to emphasise the valuable contribution older people make to their families, communities and society. It is defined as *"the process of optimising opportunities for physical, social and mental well being throughout the life course, in order to extend healthy life expectancy, productivity and quality of life in older age"* (WHO, 2002, p. 12.). It emphasises the value of continued involvement across six life domains: social, economic, civic, cultural, spiritual and physical. The WHO definition of active ageing comprises three key pillars:

- ▶ Participation: lifelong learning, paid and unpaid work;
- ▶ Health: achieving and maintaining good physical and mental health in later life; and,
- ▶ Safety: ensuring the "protection, safety and dignity of older people by addressing the social, financial and physical security rights and needs of people as they age".

There are some similarities between an Active Service Model and the WHO 'Active Ageing Framework'; they both aim to keep older adults "engaged in life" for as long as possible. They both emphasise a focus on the quality of older people's lives and their engagement in the community (Wistow, Waddington, & Godfrey, 2003). They are

consistent with an ecological approach to wellness, which suggests that well being comes from family, community and social engagement, stepping outside ourselves and becoming enmeshed in a web of reciprocal relationships and interests (McMurray, 2007). From this perspective, improvements in a person's health and functional capacity are necessary but not sufficient. Measures to (re)connect people into community involvement and social relationships are essential.

2.2.2 Increasing Demand for Home and Community Care Services

The other major impetus for change in the way home and community care services are delivered comes from the need to effectively manage demand for services. Demand for services outstrips the availability of services now. Increasing demand for HACC and other community based services as a result of a growing older and disabled population is projected over the next 20 years. Increasing demand is also associated with older peoples' expectation and preference that they will stay at home for as long as possible. There are other factors influencing increasing demand for services such as reduced availability of carer effort because women, particularly women in the 45 to 65 age group are increasingly in the workforce rather than allocating all their time to caring for relatives who need assistance.

Despite overall improvement in health and medical care, there has not, as yet, been any evidence of 'compression of morbidity'. In other words, there have been no indications that the duration of illness and disability has become condensed into a shorter period at the end of the life span. A report from the Australian Institute of Health and Welfare, found that over the 15 year period between 1988 and 2003, gains in life expectancy were accompanied by increases in the expected years with disability associated with significant limitation in activities of daily living (AIHW, 2006).

2.3 Policy context

In 'A Fairer Victoria' (2005), the Victorian Government's overarching social strategy for meeting Victoria's future challenges and improving the lives of all Victorians, emphasizes the provision of accessible and affordable services and targeting support for those in greatest need. It aims to tackle inequality and disadvantage by:

- ▶ emphasising early intervention and prevention;
- ▶ matching local service delivery to individual needs;
- ▶ assisting communities to support individuals to overcome problems; and,
- ▶ making services easier to access, more responsive and more successful.

Services for older people will aim to help people to stay involved in everyday activities to maintain or rebuild their confidence and stay active and healthy.

In A Fairer Victoria (2005), the Government committed to:

'reform the way key services, such as Meals on Wheels, are delivered to better meet older people's nutritional, social and cultural needs. Support could include helping a person cook a meal or providing mobility aids to enable older people to continue their hobbies, walk around their communities or keep up their levels of activity. Services will aim to help people stay involved in everyday activities to maintain or rebuild their confidence and stay active and healthy'.

In 'A Fairer Victoria: Progress and Next Steps' (2006) the Government committed to helping older Victorians stay in their homes by supporting them to maintain independent living in their homes and communities.

In August 2006, the Victorian Government released a policy statement, 'Recognising and Supporting Care Relationships'. This document emphasises

three overarching principles in focusing on care relationships:

- recognising and respecting care relationships;
- supporting people in care relationships; and,
- participation of people in care relationships in decisions and planning regarding their care.

Strategies to support people in care relationships include:

- providing flexible and practical support, service provision and resources;
- accessible, responsive, user friendly and high quality services;
- assisting people to navigate the health and community services system;
- enabling people to make choices about services that meet their needs; and,
- participation of people in care relationships in individual care planning and delivery.

These principles have been incorporated into the development of this discussion paper.

2.4 Related Developments

There are a number of related developments and activities in Victoria that are contributing knowledge and experience and provide opportunities for collaborative service delivery in developing active services. They include:

- Implementation of the HACC Assessment Framework;
- A review of social support services funded by the HACC Program and Victorian Aged Care Services;
- Well for Life projects in public sector residential aged care and planned activity groups, focusing on improving nutrition and promoting physical activity;
- Primary Care Partnerships;
- Chronic disease self management supporting people to maintain themselves in a stable state in the community;

- Municipal Healthy Ageing Plans developed by local councils;
- The Victorian State Disability Plan 2002-2012; and
- Person Centred Active Support (PCAS) Program.

Further information about these developments and activities is in Appendix 2.

The following objectives are common across some or all of these developments:

- person centred care;
- social inclusion;
- working with people's preferences and strengths;
- working collaboratively with the person by increasing choice and control;
- proactively promoting health and capacity building opportunities;
- providing responsive and flexible services tailored to the clients needs and strengths; and,
- building partnerships across agencies and programs to maximise the whole of system service response.

Other initiatives in health care can play a part in the way we develop an active approach to service delivery. They include:

- Enhanced Primary Care Medical Benefit Schedule (MBS) items that are aimed at improving access to allied health for people with chronic conditions and complex care needs and health assessments for those aged over 75;
- The Hospital Admissions Risk Program (HARP) which has developed ways of assisting people with chronic illness who are at risk of or present regularly to hospital, to manage their conditions in a stable state in the community; and,
- Long Stay of Older Persons Program that aims to reduce the deconditioning of older people entering hospital and offer a more rehabilitative or restorative approach.

2.5 Summary

A group of publicly funded services were brought together over 20 years ago to form the HACC program as we now know it. There are indications that the program has been effective in meeting its objectives.

New evidence on ageing and the efficacy of a more health promoting approach has put a greater emphasis on the meaning of independence and the delivery of flexible and timely services. In the light of this evidence, it is timely to consider the nature of service delivery in the HACC Program, the principles that underpin it and opportunities to improve it.

The HACC program is in a good position to support and promote wellness in older people for a range of reasons:

- ▶ It is often the first point of contact for many people seeking assistance and it delivers services to a large number of people in Victoria (about 245,000 people in 2006-07);
- ▶ It funds a range of services that, if they can work together with a client focus, would result in more positive outcomes for those receiving them; and,
- ▶ It provides an opportunity to engage people at

a point when early intervention and prevention focused strategies could have maximal impact.

Capacity is being developed in HACC services as well as other programs that many people using HACC services access. Implementation of the HACC Assessment Framework with an emphasis on a broad based Living at Home Assessment delivered by skilled practitioners, provides the opportunity to build a more wellness promoting service system.

People's needs are not static and can change slowly or rapidly over time. HACC and related primary care services need to respond in a timely and flexible way that promotes the person's goals and maximises their abilities.

This discussion paper poses the following questions:

- ▶ Is there another way of framing HACC services to support clients and their carers to maximise their independence and remain connected to the community in a way that is meaningful and satisfying to them and receive services that respond to what they need in a timely manner?
- ▶ Is there an alternative ethos of care that can underpin HACC services?

3 • Towards implementing an Active Service Model in Victoria

3.1 Experience elsewhere influencing the development of the Active Service Model in Victoria

Four examples have significantly contributed to and influenced the development of the Active Service Model in Victoria. They are operating in Western Australia, New Zealand and England (refer to Appendix 1 for more information on each example).

The Restorative Home Support Program (New Zealand), the Homecare Re-ablement programs (England) and the Home Independence Program in Western Australia offer service delivery models.

Restorative Home Support has been led by New Zealand's District Health Boards and includes:

- ▶ goal facilitation that builds a support program around the goals and aspirations of the client;
- ▶ functional and repetitive Activities of Daily Living (ADL) exercises to improve people's level of fitness;
- ▶ systematic training for support workers and health professionals;
- ▶ assessment tools that support and inform this approach; and
- ▶ funding and reporting structures designed to complement this approach.

Homecare Re-ablement in the UK has been led by national policy from the Ministry of Health that underpins the design and implementation of models developed by each Council involved. The focus in service delivery is on 'doing with' rather than 'doing for' and time limited interventions. There is flexibility for Councils to implement the policy in a way that suits local requirements and this has led to significant variation.

The Home Independence Program developed by Silver Chain in Western Australia has also demonstrated positive outcomes from this type of approach in an Australian context.

The Wellness Approach to Community Home Care (WATCH) operates in Western Australia. The Wellness approach emphasises a philosophical change in the way we think about and provide HACC services to people. This approach is distinct from a restorative or enablement model, in that it is proposed as an underlying philosophical approach to providing services which reinforces and supports each client's level of independence.

The key features of this approach are: direction from the WA Aged Care Policy Directorate; the need for a culture change across HACC organisations; identifying client abilities as well as difficulties; building capacity; emphasis on psychosocial requirements as well as physical limitations; reconnection with social networks; working in partnership with the client; establishing expectations and support options up front; ability based goal oriented assessment and support plans; working 'with' rather than 'for' all clients; only providing those services which are required by the client (while also recognising that some clients will need ongoing services); potential for time limited support as appropriate; ongoing staff skill development in wellness, assessment support planning and goal setting; and, a commitment by WA Aged Care Policy Directorate towards funding and reporting structures that will complement this approach.

These examples include different strategies and components, although they demonstrate some common features that are consistent with the outcomes of the Victorian Active Service Model pilot projects (detailed in Appendix 1):

- ▶ goal directed person centred care;
- ▶ strength based holistic assessment;
- ▶ interventions focussed on the person's functional and social goals;
- ▶ flexible and timely responses tailored to the individual;

- time limited interventions;
- a planned review process;
- staff that are skilled to work with clients in a capacity building manner; and,
- collaborative partnerships between individuals and providers, and between providers for the benefit of clients.

These common features are also consistent with those identified in successful programs in the literature review commissioned by DHS (Appendix 1 has a summary of findings).

3.2 What is the Active Service Model?

The Active Service Model is a quality improvement initiative which explicitly focuses on promoting capacity building and restorative care in service delivery. HACC 'clients' in this context include both service recipients and their carers.

The core elements of the Active Service Model are:

- capacity building, restorative care and social inclusion to maintain or promote a person's capacity to live as independently and autonomously as possible;
- a holistic person and family centred approach to care that promotes wellness and active participation in goal setting and decisions about care;
- timely and flexible services that respond to the person's goals and maximise their independence; and,
- collaborative relationships between providers. for the benefit of people using services.

In principle, this approach is applicable to all people accessing HACC services and to all HACC service types. The service response will differ according to the person's needs and goals. It takes as its starting point that ageing in itself is not a determinant of functional, social or psychological decline leading to an inevitable need for service.

It is important to note that capacity building in this context does not only relate to physical function but includes social and psychological wellbeing.

3.3 Principles of the Active Service Model

The principles underpinning the Active Service Model are:

Principle 1: People want to remain autonomous

Autonomy is highly valued by people at all stages of life. Autonomy is the experience of personal efficacy in the context of reciprocal and interdependent relationships. Its loss can have a devastating effect on people's emotional and physical health and well being. Maintaining autonomy has a positive effect on both people's quality of life and their ability to manage day to day life. This is core to assessment and service provision from both a philosophical and an operational perspective.

Principle 2: People have the potential to improve their capacity

The starting point is that all HACC clients have the capacity to improve their function and wellbeing across all domains. We are aiming to ensure that every opportunity to involve a person in daily activities and in their connection with their community is actively supported.

Experience has shown that the frailest older people in nursing homes have made gains which have enhanced their quality of life with particular capacity building techniques. Maintaining a person's independence is more than providing a service for something they can no longer do for themselves to help them remain at home.

However, this principle needs to be applied in a way that is sensitive to people's emotional, psychological and physical capacity at particular points in time, and takes account of their expressed desires and needs.

Principle 3: People's needs should be viewed in a holistic way

Holistic refers to an approach that focuses on each client as a whole person. That is, instead of treating an illness or responding to a physical restriction, holistic care looks at an individual's over-all physical, mental, spiritual, and emotional well-being and is respectful of their autonomy or right to self determination. Independence is not limited to physical functioning but extends to social and psychological functioning and choices.

The care relationship is part of an holistic consideration of a person's circumstances. All interactions with the person seeking services need to be undertaken in the context of their care relationship, where it exists.

Principle 4: HACC services should be organised around the person and carer; the person should not be slotted into existing services

Person centred care is a theme running through a range of related Victorian Government initiatives. Person-centred care is 'treatment and care provided by services [that] place the person at the centre of their own care and consider the needs of the older person's carers' (DHS, 2003, p. 18). The focus of service provision is on care that is flexible and responsive and based on the individual goals of a particular client (and his or her carer) in their own environment, as opposed to services that provide a standard program of care for all clients (NARI, 2006).

Principle 5: A person's needs are best met where there are strong partnerships and collaborative working relationships between the person, their carers and family, support workers and between service providers.

Collaboration and partnership with carers, families and the broader community is essential. Strategies and service delivery will be more successful if they are understood and endorsed by those that support the person.

The expertise and options to meet a person's needs and preferences can be located in more than one organisation. Improving the interaction and collaboration between services enables individuals to maximise their opportunities to achieve their goals.

3.4 Objectives of the Active Service Model

The following objectives explore the major areas that need to change to implement these principles.

Objective 1: To build skilled assessment

As specified in the HACC Assessment Framework, assessment for people accessing HACC services should be person centred, capacity focussed and holistic, capturing the person's aspirations and goals, with clear pathways to review and reassessment (if required). Assessment is critical to identifying opportunities to improve individual capacity, to deliver health promotion information and to advise on local formal or informal support or service options.

Major developments are occurring in community care assessment at a State and National level. To achieve the outcomes we are seeking, assessment practice needs to be aligned with the principles outlined above.

The Active Service Model principles set out above also underpin the Victorian HACC Assessment Framework. Implementation of the Assessment Framework provides an avenue to embed the Active Service Model in practice.

Objective 2: To improve the flexibility, timeliness and responsiveness of HACC services

Providing flexible and responsive services has been an aim of the HACC program since its inception. However, there are a range of barriers to achieving this including the pressure of demand for services, resource capacity and service delivery being task focused.

DHS aims to explore the scope, within the current service funding structure, to meet people's needs

through more flexible options that complement a person's abilities, difficulties, needs and care relationship, and are available when needed.

One avenue is to consider how services can be provided in an episodic or short term way as people's needs arise.

Objective 3: To strengthen HACC services' capacity to deliver services consistent with the principles of an Active Service Model

The success of the Active Service Model is contingent on the capacity of staff and the culture of organisations responsible for service delivery. It requires a well supported, skilled and adaptive workforce, engaged with the philosophy of working with people rather than for them. The Active Service Model recognises that independence will be promoted by the way staff relate to clients, their expectations of clients and their capacity to engage clients.

Its success is also dependent on agencies with complementary skills working collaboratively together for the benefit of clients, so that care planning and interventions are designed around the needs of individuals.

The Active Service Model can build on the strengths and capacity of existing services and initiatives but it may also require the adoption of new tools and techniques, processes, procedures, and collaborative partnerships to achieve this.

Objective 4: To strengthen, support and further develop the collaborative working arrangements between services

Strengthening collaboration between services to deliver care planning and interventions designed around individuals will maximise the benefits to them. Referral to and consultation with allied health professionals is one of the key elements. Better connections with community health, sub acute services and primary care programs such as chronic disease self management will advance the Active Service Model. This requires robust interagency working arrangements such as the practices, protocols, processes and systems that are in Primary Care Partnerships across the State, developed for assessment and care planning.

Objective 5: To implement evidence based models of service delivery that can deliver Active Service Model principles

Victoria has already funded 9 pilot projects that have developed our understanding of how an Active Service Model could be implemented more widely. The Australian Institute for Primary Care literature review and the HACC National Promoting Independence Forum held in February 2008 have highlighted models of service (referred to above and in Appendix 1) that have possibilities for Victorian services.

We will trial aspects of these models in Victoria in the context of implementing the Assessment Framework and through the development of one or more demonstration projects.

3.5 Core components of HACC Active Service Model

This table sets out the core components of an Active Service Model. It is not to suggest that every service will be able to or should meet all components, but gives a sense of the range of approaches needed.

1. Assessment

- Broad based and holistic (as per Assessment Framework)
 - Covers social, functional, and emotional needs
 - Addresses aspirations and goals,
 - Addresses strengths and capacities as well as deficits
 - Looks at opportunities for social participation and connectedness
 - Involves the carer and significant others in the process
 - Has access to and involves multidisciplinary skills as required e.g. support from physiotherapist, occupational therapist or dietician
 - Uses standardised tools and processes embedding this approach
 - Is a point of advice and referral to a range of services and activities within and external to HACC
 - Considers and supports care relationships
 - Is integrated with other assessment services through local assessment alliances
-

2. Care planning

- Collaborative with client and carer and sets goals that are meaningful and important to client and carer
 - Identifies service options, interventions, referrals and connections
 - Identifies steps and stages towards reaching client's goals, with specified, measurable, achievable outcomes that enable client to chart progress.
 - Clear timeframe with entry, exit points and review processes
 - Interagency care planning as necessary
-

3. Intervention or service delivery

Flexibility and responsiveness	<p>“One size does not fit all”</p> <ul style="list-style-type: none"> • Range and diversity of options • Both client and agency have confidence that a HACC response can be provided when needed • Capacity to be client driven rather than agency driven • Supports dynamic problem-solving and creative solutions
Holistic coordinated services	<ul style="list-style-type: none"> • Focus on the range of services that can meet a range of client and carer needs based on dynamic problem solving and creative solutions • Avoid silos
Capacity building	<ul style="list-style-type: none"> • An enabling approach of doing “with” not “for” as much as possible, recognising that people may still need services that do ‘for’. • Driven by client’s goals and aspirations • Functional Activities of Daily Living (ADL) exercises incorporated into everyday activities where appropriate • Promotion of links and referral to capacity building and social connection opportunities based on client interests
Intervention time	<ul style="list-style-type: none"> • More timely episodic and short term approach to interventions to be considered where appropriate • Time limited intervention that leads to agreed, measurable outcomes , based on goals and care plan
Health promoting	<ul style="list-style-type: none"> • Include opportunities for physical activity • Links and referral to nutrition and chronic disease programs and other social support options • Social connectedness
Continuum of care	<ul style="list-style-type: none"> • Early intervention and prevention which relates to client circumstances rather than levels of dependency • Adapting service provision to respond to needs across the continuum of care • Engaging clients in the broader community care, sub acute and primary health service system in a timely manner, as reflected by their needs.
Access to skilled and knowledgeable staff	<ul style="list-style-type: none"> • Continuous professional development and training for staff • Access to the right expertise when needed, regardless of agency where staff are based • Access to multidisciplinary support and use of an interdisciplinary team approach • Time and support for case conferencing and other professional development strategies
Partnerships	<ul style="list-style-type: none"> • Strong partnerships between agencies including referrers based on Primary Care Partnerships • Well established and documented procedures, protocols, practices and systems between agencies
Funding and reporting	<ul style="list-style-type: none"> • Funding and reporting models that support flexibility of response to client needs while maintaining accountability • Focus on outcomes

4. Review and Reassessment

- Regular review of progress towards goals
 - Review can lead to cessation of services or provision of ongoing services and a care plan with further review
 - Reassessment available if care needs change
-

3.6 Case studies

The following case studies have been adapted from the Active Service Model pilot projects that have operated throughout Victoria. They are intended to highlight how some of the Active Service Model core components articulated in section 3.5 can be operationalised.

Mrs Andelucci

After a stroke left her with limited use of her left arm and poor mobility, Mrs Andelucci experienced depression and short term memory loss. She was heavily reliant on social support and home help. She was rarely cooking for herself or taking care of even basic housekeeping tasks.

During the activity and nutritional program offered at the Planned Activity Group she regularly attended Mrs Andelucci identified four goals:

- 1 To improve her stamina and flexibility. A physiotherapist developed a strength training program and her home care worker encouraged her to carry it through;
- 2 To learn to dance;
- 3 Do more cooking. She asked the home care worker to support her to buy ingredients and prepare basic meals in advance; and,
- 4 To get involved in her community as a volunteer.

Mrs Andelucci quickly reaped the benefits of this focus on her own wellbeing. Within three months, she felt she had turned a corner, happily observing her new 'get up and go'. Mrs Andelucci had become more motivated about doing some of her housework, and was thoroughly enjoying cooking with the support staff and having food in the freezer. She felt physically more confident and was enjoying seeing new friends at dance classes she had started attending.

ASM COMPONENTS

Health promoting

Capacity building

Access to skilled staff

Holistic

Social inclusion

Flexible and responsive

The Planned Activity Group staff utilised goal setting and care planning to identify the tasks Mrs Andelucci valued. Access to the most appropriate support was coordinated to provide services that were flexible and tailored to her needs; providing opportunities for health promotion, capacity building and social inclusion.

Mr Fredrickson

Mr Fredrickson is an 83 year old man who was referred for personal care. He had fallen a fortnight ago and although he sustained no specific injuries, he was now lacking in confidence to shower himself independently. He was previously independent and was motivated to regain his independence again. HACC services would usually have provided an ongoing personal care service that would do the personal care tasks for him.

Using an Active Service Model approach a support plan, with goals of care was developed to:

- connect him to physiotherapy to improve his balance and strength and to provide some falls education; and,
- guide direct care staff on how to work with him to build his capacity and confidence to shower on his own again.

After four weeks of a three days a week service, he had regained his independence and the service was withdrawn. He was encouraged to reconnect to the service if he had any future needs or concerns.

ASM COMPONENTS

Capacity building

Skilled staff

Coordinated services

Flexible and responsive

Episodic

Mr Fredrickson was assisted to regain his independence, something he valued highly. The local council coordinated the expertise of the physiotherapist and the assistance from the personal care staff to work with Mr Fredrickson in a collaborative fashion. Mr Fredrickson received the care he needed, when he needed it and for the time he needed it.

Mrs Clarke

Mrs Clarke is an 82 year old widow who lives alone and has assistance with home care. The home care support staff observed that Mrs Clarke may have a continence issue. The home care staff approached Mrs Clarke and she agreed to a nursing assessment. Mrs Clarke said that she manages her life's activities around her continence issue.

The continence assessment nurse and Mrs Clarke identified her goals:

- to attend her granddaughters wedding in the country in 4 months;
- to improve her walking; and,
- to make it easier to go to the toilet at night.

The nurse developed a continence management plan with Mrs Clarke; made referrals to physiotherapy and occupational therapy; and, ensured the home help staff were informed of all the strategies so they could reinforce and support Mrs Clarke.

ASM COMPONENTS

Collaborative

Capacity building

Access to skilled staff

Client centred

Social inclusion

Flexible and responsive

After 12 weeks Mrs Clarke noted a marked improvement in her ability to control her bladder which she attributes to the support from her home care staff. She sleeps better at night with the commode by her bed as she can get in and out quickly without any ‘accidents’. Her mobility has improved with her walking frame and she no longer suffers shoulder pain from using a single stick. She has already booked her accommodation for her granddaughter’s wedding.

Mrs Clarke received a timely and coordinated service to respond to a need that was only evident to the home care staff. The home staff member had been provided with training and support structures to assist him to connect Mrs Clarke to an appropriate service. This had a significant impact on her quality of life and confidence to reconnect to her community and family.

Mr and Mrs Cooper

Mrs. and Mr Cooper were referred to their local council by their general practitioner for a home care service. The assessor found that Mr Cooper used to do most of the house cleaning tasks prior to his recent hospital admission for a fall and other complicated medical issues. Mr Cooper had reduced mobility and was not able to vacuum or wash the floor. Mrs Cooper was on 24 hour oxygen and experienced shortness of breath after minimal exertion during cleaning tasks.

Following assessment, a plan was put in place to increase both their physical capacity as well as strategies to facilitate their ability to resume cleaning tasks. Mr Cooper was referred to physiotherapy for an ongoing exercise group to increase his mobility following hospitalisation and Mrs Cooper was engaged in home care tasks with alternative techniques and equipment.

On review, Mrs. Cooper had purchased her own motorised carpet sweeper and was cleaning a few rooms at a time. She had purchased a microlite mop and was managing washing the floors well. The local council instituted a reduced ongoing service of 0.5 hours per month to vacuum the corners. Mrs.Cooper commented: “There’s a big difference ... the gadgets you’ve recommended have made cleaning a lot easier ... now I can last longer”.

ASM COMPONENTS

Detailed assessment

Capacity building

Skilled staff

Functional exercise

Flexible and responsive

Without a detailed assessment, it is likely that Mr and Mrs Cooper would have received an ongoing fortnightly home care service that would have completed tasks for them. They were motivated to do as many of these tasks themselves and were assisted to simplify the tasks and build their capacity. The council also provided a monthly service to address their unmet need.

4 • Discussion

There are a range of factors to be considered in planning the implementation of an Active Service Model in Victorian HACC services.

4.1 The environment

Home and community care services are a complex environment to implement this quality improvement development in practise and service delivery. There are a large number of service providers, a diverse staffing mix and range of services available to people with different needs and capacities. Geographically, services are spread across regions with different supporting infrastructure.

4.2 Connections with other professionals and services

HACC services do not operate in isolation. They are embedded in a wider range of health and community services. We need to consider how adopting an Active Service Model may impact on relationships between HACC services and other professionals and services such as general practitioners, ACAS, hospital staff and other community programs and how they will need to develop.

4.3 Change management

Implementing the Active Service Model requires a significant shift in practice and culture to achieve systemic change. There are long held consumer, staff and community expectations on the capacities of older people and what HACC services should do. It will therefore be important to communicate effectively with people seeking services, clients, workers who deliver HACC services and those working in other related sectors such as GPs and the broader community about what we are seeking to achieve.

Change will be incremental, building on and improving existing practice as well as introducing some new practices. We aim to better understand current practice and share local strengths and good

practice between agencies as well as work with agencies to support change, where necessary.

4.4 Dealing with demand pressures

Demand for services often outstrips agencies' capacity to supply services. Agencies report that prevention and early intervention have in many cases been sacrificed to focus on high needs clients.

This issue has several dimensions that are separate from the question of whether there are adequate resources in the HACC Program.

One is the scope for incorporating an active service model approach to service delivery, regardless of the client's level of dependency.

A second is that the way resources are allocated across the range of service available to older people and the pathways from one type of service to another (such as from HACC to packaged care) needs to be, and is being, addressed between the Commonwealth and the States and Territories through work being undertaken in 'The Way Forward' and the Commonwealth's Review of its Subsidies and Services Programs.

A third is that the assessment and review capacity is being enhanced through implementation of the Assessment Framework. This is important in ensuring that short term interventions meet their objectives.

4.5 Models of service

Implementation of the Active Service Model requires a balance between refocusing existing services to operate from this perspective and exploring new and different types of intervention.

Any exploration of new or different interventions will be through evaluated trials to ensure that they deliver the intended outcomes. This will occur incrementally.

4.6 Workforce

The success of the Active Service Model relies on the community care workforce. The desire for training has been clear in discussions with the sector

so far. Training is the starting point for achieving a shift in thinking for people who deliver services funded by the HACC Program, including assessment staff, allied health staff, community care staff and volunteers. One option is to introduce an ongoing training program delivered in each funded service (similar to the Western Australian WATCH program) to propagate an understanding and commitment to the wellness approach that underpins the Active Service Model.

As noted above, HACC services do not operate in isolation. Expectations about positive outcomes for older people need to be understood and reinforced by other providers of community care and health professionals such as GPs.

Working in an Active Service Model paradigm has the potential to improve the work satisfaction of assessment and community support staff in Victoria. However achieving this will require rethinking how the roles of people who deliver services are described.

Workforce shortages are a significant issue that will need to be addressed.

4.7 Targeting and Particular Client Groups

There is no clear evidence showing which groups in the HACC target group are most or least likely to benefit from this approach. The approach appears to have broad application across all people receiving HACC services but what this means in practice requires further exploration.

Through consultations we are seeking information about specific issues, for example, for people from CALD or ATSI communities, those experiencing dementia or other mental health issues.

4.8 The role of Carers

The role of carers is integral to the Active Service Model and there is a strong policy commitment to supporting the caring relationship. The goals aspirations and wellbeing of carers are as important

as those of the person who is being cared for and both need to be fully engaged in assessment and care planning.

4.9 Funding and reporting issues

We need to explore to what extent the existing HACC guidelines and funding framework support or inhibit the Active Service Model approach. For example, what is the scope of the current funding framework to enable the flexibility and responsiveness to individual circumstances sought through the Active Service Model approach?

Further consideration is required about how client outcome measures could be included with assessment and care plans to ensure that data collected can be used for accountability, planning and further service development.

4.10 Building partnerships

It is important to build on the strengths of those services that are already working within an Active Service Model or components of it and engage them in broader implementation of the approach. Partnership between agencies engaged in the care and support of older people are important to ensure that the best outcome is achieved with the minimum duplication of time and effort. This necessitates adoption of practices, protocols, processes and systems for effective coordination and communication with other health care providers, particularly a person's GP. Primary Care Partnerships offer a structure that enables partnering and communication about client care between agencies and across sectors.

Another way to achieve these outcomes is the development of "virtual teams" that bring together a variety of expertise from different services to provide a coordinated response for individuals.

Connections need to be made more broadly between service providers and community organisations, social and recreational opportunities.

5 • Steps to Implementation

An implementation plan will be developed for the Active Service Model by December 2008. The plan will be informed by the outcomes of the consultation process to be undertaken in May to August 2008.

This section outlines areas of work that have emerged as furthering the approach to date. They are strategies that are either already in train (e.g. through the implementation of the assessment framework) or have had strong support in the development process to date. An evaluation strategy for the initiative is also being developed.

This section is divided into three parts. Firstly, actions that can be implemented within existing practice and funding frameworks within a fairly short term timeframe. Secondly, options for one or more demonstration projects. Thirdly, areas that need longer term strategic and developmental work.

5.1 Direction 1: Strengthen practice within current structures and policy

Develop Resources and Training

- 5.1.1 Develop a self audit tool to allow services to assess their status and develop an action plan to move them to implementing an active service model approach.
- 5.1.2 Training and workforce development:
- Pilot an adapted version of the WA Wellness program in Victoria
 - Inclusion of Active Service Model approach within the professional development for assessment staff.
- 5.1.3 Develop a communication strategy to explain the Active Service Model approach and assist in managing expectations in the community and among service providers and health professionals:
- develop resources for HACC service providers, clients, carers and family; broader service system and community; and,

- make available existing resources such as those developed by the WA Independent Living Centre Resource.

5.1.4 Share good practice examples among HACC service providers.

5.1.5 Explore scope for greater flexibility in response to client/carer circumstances within current funding and reporting structures.

Strengthen Assessment

5.1.6 Assessment Framework Implementation:

- Designate HACC agencies as HACC Assessment services (completed)
- develop partnering arrangements for assessment (already underway)
- develop Assessment Alliances which include designated HACC services and other key organisations that contribute to the assessment process eg community health; and
- explore assessment and care planning tools for use in Victoria.

5.1.7 Review the resource requirement to provide assessment and review to meet ASM objectives.

Further Developing Partnerships

5.1.8 Strengthen health and community care partnerships and working relationships:

- DHS to produce a statement of principles about the working relationship between assessment agencies and community health and other health services in delivering Living at Home Assessments;
- Partnering working arrangements to be established between assessment agencies and community health and other health services as set out in the HACC Assessment Framework.

- DHS to develop a joint policy position between Primary Health and Aged Care on the priorities for service provision for HACC funded allied health within community health services.

5.1.9 Through Primary Care Partnerships, develop stronger links between HACC providers and other community organisations to generate opportunities for HACC clients in their local community for social inclusion and connectedness.

5.1.10 Build on Local Government Positive Ageing Plans to improve opportunities for access to local activities and events.

5.1.11 Establish a forum for consumer and carer contribution to the development and implementation of the HACC Active Service Model.

5.2 Direction 2: One or more Demonstration Projects

Develop and implement one or more demonstration projects that would operate from the core principles of the HACC Active Service Model and test in Victoria evidence based models of service delivery that are not currently offered in Victoria.

A demonstration project would draw from the experience outlined to date and the outcomes of the consultation process.

It could bring together a range of components of the Active Service model and could include:

- goal focussed assessment
- flexible funding packages
- short term intervention approaches, with access to multidisciplinary support.

A demonstration project would contribute to understanding the practical implications of the following areas of work:

- effectiveness and efficiency of approach;
- funding framework impact;
- outcome measurement;
- quality standards;
- service transformation; and
- workforce training and development.

5.3 Direction 3: Further exploration, research and development

Areas that will require further development in the longer term include:

- development of models for social support that support this approach. This is central to the Review of HACC Social Support currently underway;
- targeting – determining whether there is evidence to define the characteristics of a group among HACC service recipients who would benefit from this approach;
- embedding Active Service Model practice in formal training systems;
- clarifying career pathways for community care staff;
- integration into HACC quality standards;
- revision of funding and reporting frameworks and development of outcome measurement tools;
- how the Active Service Model approach applies to particular target groups such as people from ATSI and CALD backgrounds, and people with dementia.

Victoria would need to undertake a number of these longer term development strategies in partnership with the other jurisdictions.

6 • Consultation Questions

6.1 Active Service Model

- ▶ Do you have any feedback on the principles and objectives of the model?
- ▶ What strengths does your organisation and community have to implement this approach?
- ▶ What barriers will need to be addressed for your organisation and community to implement this approach?
- ▶ Can you describe existing practice occurring in your agency which is a good example of this approach or could become so with more support?
- ▶ Should the Active Service Model approach be used for all HACC clients? If not which categories/client characteristics should be excluded and why?

6.2 Implementation priorities

- ▶ What are the best elements of the models you have seen so far?
(eg NZ Restorative Care; UK Enablement; the Active Service Model pilot projects; WATCH project, HIP Project)
- ▶ What would be worth pursuing in Victoria and why?
- ▶ Should the implementation steps outlined to date (in section 5) form part of the Active Service Model implementation plan?
- ▶ What additional areas should be included in short term, medium term and long term?
- ▶ What should the priority order be?
- ▶ What change management support will your organisation need to put the Active Service Model into place?

APPENDIX 1: What We Have Learned About an Active Service Model Approach

This section provides more detail on work that has significantly contributed to the development of the Active Service Model.

7.1 Evidence based models exemplifying an Active Service Model approach

There are four significant models that exemplify the Active Service Model approach and offer key elements that could strengthen implementation in Victoria.

7.1.1 Restorative Home Support, New Zealand

The recognition that old age is often associated with poor fitness and deconditioning forms the basis of restorative home support. There is a strong belief that older people have considerable ongoing potential to recover fitness and therefore restorative home support invariably involves the integration of physical activity into the day-to-day delivery of services. Restorative home support has several key elements as demonstrated in Table 1.

CASE STUDY (Parsons and Parsons, 2005, p. 7)

Traditional home care: Mrs Sheila Rogers is 78 years old and lives on her own in a two bedroom house in South Auckland. Her husband died seven years and although she has a large and close family (two daughters and two sons) only two of them live in Auckland and she feels quite lonely. Her weekends are especially long as her family are always very busy at weekends and she doesn't tend to hear from them much during this period. A year previous, she fell over and fractured her neck of femur and although she has made a good recovery she is very afraid of falling again. She can't drive and needs help with her grocery shopping. Over the previous two years she has been noticing that she gets more tired and breathless when walking and has found that two years ago she was able to walk to and from her GP surgery (2km), though now she needs a taxi to come back.

Her house is immaculate and she prides herself on her appearance, but since her accident, she has been receiving home care two hours a week for housework and shopping assistance. Her support workers tend to move on quite quickly, though she enjoys their visit as she values the company. In the two hour period, the two of them spend around 20mins sitting down and chatting. The support worker has received minimal training and works 10hrs per week. She last spent time with her RN coordinator seven months ago and that was for a performance appraisal.

Restorative home support: A restorative home support approach provides a very different scenario and follows several stages aligned to those key characteristics described in Table 1. On the initial visit, the Registered Nurse coordinator assesses Mrs Rogers with the interRAI MDS-HC and uses the tool to highlight possible risk factors and in this case significant falls risk, social isolation and low mood. The coordinator uses the TARGET goal facilitation process to allow

Mrs Rogers to identify her goal as attending her grand-daughters first holy communion at the local church which was arranged for 12 weeks time. A goal support ladder is developed with steps to reach the goal being attending Tai Chi classes weekly, walking to and from GP surgery by 8 weeks time, carrying the shopping around shops and carrying home using trolley. The coordinator returns to Mrs Rogers with the updated support plan and her visit coincides with a visit from the support worker who had just finished the accredited six month training programme delivered internally by a designated service trainer. The coordinator takes the time to sign off on the support worker's competency and provides supervision in relation to the ADL based exercise programme.

The coordinator provides information about a Tai Chi class, provides Mrs Rogers with a pedometer and instructions that she needs to increase her total

Table 1: Restorative home support, key concepts (Parsons and Parsons, 2005, p. 4)

Goal facilitation aspirations process	A key concept of the service is to base a support program around the goals and of the older person. The process of goal-setting should be considered as an important mechanism. The goal development and delivery process utilised has been developed by Parsons, Martin and Parsons (2005).
Functional and repetitive ADL exercises	Functional exercises concern working on muscle groups used in every day activities. Restorative home support incorporates this approach into all programmes and the support worker motivates the older person to undertake such exercise.
Support worker training and enhanced supervision	Restorative home support relies on support workers to support older people to maximise their independence, which is a shift from the current home care model which focuses on providing care. Such a philosophical shift requires training and supervision, both up-front and on an ongoing basis. Support workers utilise an extensive experientially based adult learning program (FITS programme) which was developed by The University of Auckland with underpinning evidence (Smith et al, 2004, NZMJ). Of equal significance is the enhanced health professional integrated supervision that restorative home support adopts. Regular contact in both a team environment and one-on-one in the presence of a client occurs at a minimum two weekly.
Health professional training	The role and competencies of the coordinator changes greatly with the evolution of restorative home support. Roles and duties may include: delegation and supervision of non-regulated staff; comprehensive assessment; care management; goal activity analysis and grading, expertise surrounding community integration for older people. Given the clinical and academic expectations of these positions, post graduate education is recommended.
Care management	The intensity of care management differs according to the level of service input; specifically a higher level of care management is present when the service focuses on older people at risk of residential care.
Assessment	Assessment is completed by regionally based multidisciplinary teams that sit outside of the service delivery organisations and complete all aged care assessments including those equivalent to ACAS. Older people with more complex needs require a more comprehensive assessment (such as interRAI MDS-HC) as opposed to those older people with less needs may require a less extensive assessment such as the interRAI MDS contact assessment.
Funding	Funding systems are required to incentivise providers to deliver services that encourage independence and are aimed to reduce in intensity over time. Some organisations are utilising funding systems that utilise bulk funding with a gain sharing arrangement.

weekly steps by 10% a week. As Mrs Rogers can not drive to the Tai Chi class by herself, she arranges for the support worker to take her, visit another client and then pick her up for the trip home. However, the coordinator also made longer term arrangements for a local neighbour, also a recipient of services to provide transport to and from the Tai Chi classes.

The coordinator makes arrangements for a telephone contact in three months time to review progress. At three months, Mrs Rogers is now walking to and from the doctor's surgery, is attending Tai Chi weekly and has a close friendship with her neighbour. The two of them now make a day of the Tai Chi class and have lunch afterwards together. On assessment with the MDS-HC (CHA) or reduced MDS-HC, Mrs Rogers no longer comes up as significant falls risk, nor is presenting with low mood. In fact, she is now undertaking weekly shopping herself using a trolley and the MDS-HC (CHA) assessment triggers the CAP (Clinical Assessment Protocol) of reduced services as she no longer requires the service. A referral is sent to the service provider requesting a reduction or cessation of services.

7.1.2 Homecare Re-ablement, England

Homecare Re-ablement work seeks to improve choice and quality of life for adults who need care. Through the use of timely and focused intensive interventions, it will maximise long-term independence by appropriately minimising ongoing support required thereby minimising the whole life cost of care. This approach focuses on re-abling people so that they achieve their potential in terms of a stable level of independence with the lowest appropriate level of ongoing support or care (CSED, 2007).

Some form of Homecare Re-ablement is operating or in the implementation phase for 87% of services responsible for delivery home care services in England. There is no one single model of Home Care Re-ablement with a number of different structures

in existence and these range from virtually a stand-alone service to those that form part of a package of services.

Common principles and features across all Homecare Re-ablement schemes are:

- ▶ helping people 'to do' rather than 'doing to or for' people;
- ▶ outcome focused with defined maximum duration; and,
- ▶ assessment for ongoing care packages cannot be defined by a one-off assessment but requires observation over a defined period (CSED, 2007, p. 10).

The two main forms of homecare re-ablement are those that operate as intake teams and those that operate as discharge support. With the intake model it is common that all people assessed as needing and being eligible for homecare are passed to the intake team. They apply a 'de-selection' criteria, in that all people undergo time limited re-ablement unless they:

- ▶ are not receptive to the approach i.e. they want to be looked after;
- ▶ have severe mental health or learning difficulty needs;
- ▶ are not suitable because of their care needs: e.g. terminal care; and,
- ▶ are not old enough (commonly to be > 19yrs) (CSED, 2007).

Thus, everyone is assumed to be able to benefit from re-ablement unless they are positively deselected or deselect themselves. Intake team models tend to be staffed by carers, more commonly known as enablers, who have access to therapy staff as required.

Discharge support services tend to focus more on those who are judged to have the capacity to benefit from time limited homecare re-ablement.

Thus, people are positively selected onto the service, albeit that their criteria are commonly very similar to those outlined above. Services focused on hospital discharge support tend to be staffed by teams that include therapy and care staff (CSED, 2007).

All Homecare Re-ablement programs are time limited with the maximum time in the program being generally set at 12 weeks. Data from the South Gloucestershire program showed that 66% had reached their potential within 4 weeks, almost 80% within 6 weeks, 85% within 8 weeks and 93% within 10 weeks (CSED, 2007, p. 19).

**CASE STUDY – the Woodlands team
(CSED, 2007, p. 62)**

Initially a member of the therapy staff visits the users within their home completes an assessment. Goals are set and agreed with the user and re-ablement is then provided by staff from the external provider. Reviews are completed weekly by the Manager with the Rehabilitation Assistant at which time input can be received from therapists and nursing staff. As progress against goals is achieved, the re-ablement package is stepped down.

Discharge from the service is approved by a member of the therapy staff and the need for any ongoing care package is gauged by any unmet goals. People referred from hospital have their assessment completed by hospital based therapy staff and so they are fast tracked. Ongoing care packages are arranged through a central brokerage service.

7.1.3 Home Independence Program, Western Australia

Silver Chain, Western Australia’s largest home care provider has developed, implemented and evaluated a home care program focused on promoting people’s independence: the Home Independence Program (HIP). HIP is an early intervention program directed at optimising functioning, preventing or delaying

further functional decline, promoting healthy ageing and encouraging the self-management of chronic diseases. It is designed to target older individuals (over 65 years of age) when they are first referred for home care services or at a point when their needs have increased and additional services are being requested. The effectiveness of HIP has been examined in a pilot study, a two-year operational trial and a randomised-controlled trial.

The HIP program streams people into a time limited program before making decisions about ongoing service needs. The service model consists of a number of key components:

- ▶ an inter-disciplinary team consisting of multi-disciplinary staff;
- ▶ comprehensive assessment;
- ▶ goal oriented care planning;
- ▶ time limited and targeted interventions;
- ▶ telephone support and follow up;
- ▶ education about principles of self-management, healthy ageing;
- ▶ use of medications and illness/accident prevention strategies;
- ▶ family involvement;
- ▶ social inclusion; and,
- ▶ use of local resources (Lewin et al, 2006).

CASE STUDY (Silver Chain Nursing Association, p. 33)

Mrs O is an 89 year old lady with arthritis, stroke 5 years previous, multiple falls, urinary tract infections and bronchiectasis. She resides with her daughter and her partner who are having difficulty managing her care. She was referred to Silver Chain for assistance with personal care, domestic assistance and respite.

At initial assessment it was identified that Mrs O:

- ▶ required assistance with most transfers;

- walked using a walking frame;
- required moderate assistance with personal care;
- had some difficulty with urinary incontinence;
- fully dependent for shopping, cooking, laundry and transport; and,
- had an unstable knee which meant that at times she could not weight bear and her daughter was lifting her as the hoist they had was not suitable.

Goals were set with Mrs O to:

- be independent with personal care within 12 weeks;
- improve her transfers;
- improve leg strength and mobility; and,
- improve respite and social support opportunities.

Interventions provided for Mrs O included:

- OT and physiotherapy input to improve transfers, ensure appropriate equipment was in place and an individualised exercise program;
- training by personal care assistant for showering and dressing;
- training in improved transfers;
- information on support groups and respite services; and,
- chronic disease self management.

Mrs O improved her leg strength and thus improved her transfers and mobility. She was able to manage all her personal care and accessed respite more regularly.

7.1.4 The Wellness Approach to Community Home Care (WATCH), Western Australia

WA HACC has recently adopted the concept of a Wellness Approach as its policy position. CommunityWest a non profit making organisation in WA has been working since 2006 in partnership with WA HACC to develop and implement wellness. To date the Wellness Team at CommunityWest has supported over 50 HACC funded agencies to

commence implementation of a wellness approach.

The Wellness Approach is a philosophical change in the way we think about and provide services to HACC eligible clients with poor physical or mental health. The approach where possible assists people to accommodate their functional disability by learning or relearning the skills necessary for daily living. For those individuals where this is not appropriate then the approach is about providing support that ensures that every opportunity is taken to involve a person in daily activities and in retention of social connections

The approach needs to occur throughout an organisation and with all those involved whether it is the care recipient, or someone involved with them that refer or come into contact with potential users (O’Connell, 2007, p.6).

As this is seen as a philosophical way of working with individuals, it is an approach that is applicable to all people seeking HACC services. It is based on the assumption that maintaining a person’s independence is more than providing a service which tends to substitute for a person’s own effort to look after themselves to help them remain at home. The following have been identified as the key strategies that have assisted agencies currently implementing wellness to develop the approach:

- Change of mind set for all in the way people are viewed as regards their capacity to improve their overall functioning;
- Ability based assessments and support plans;
- Goal planning in partnership with client;
- Where possible, doing with not doing for the client
- Time limited interventions/services (where appropriate);
- Looking at the reason behind a request for assistance or change in function instead of just providing or increasing service;

- ▶ Staff training in the principles of a Wellness Approach and assessment and support plan training;
- ▶ Client and carer education in principles of optimising function and well being;
- ▶ Regular reviews and changes to support plans to accommodate progress, including ongoing appropriateness of service;
- ▶ Building staff awareness, skills and confidence to promote the approach;
- ▶ Emphasis on social networks/community connections to optimise the success of the model and link client back into the community; and,
- ▶ End of service review where appropriate and reconnection with community (O'Connell, 2007, p.14).

HACC service provision that focuses on wellness, capacity building and promoting independence with clients can have far reaching benefits both to clients, their carers and staff. It has the potential to enable clients to remain in their own homes for longer than if we continue to provide services in the current model. Over time it is anticipated that wellness will be the accepted way in which HACC services are delivered in WA.

CASE STUDY (O'Connell, 2008 HACC Forum)

72 year old lady, obese walks with a frame

- ▶ Receive shopping services. Manages own personal care. Hasn't left the home for 3 years except for hospital/GP appointments.
- ▶ Support worker visited weekly. 1.30hrs shopping service. Checked cupboards, wrote list, shopped, returned, unpacked.
- ▶ Review from wellness perspective, identified that she can check in cupboards and select own shopping requirements write list and on support worker return unpack own bags

- ▶ Client agreed to change in way support was delivered and did all that she identified that she was able to do. Over time. client has identified that she would like to actually get to the shops. Not able to walk around the supermarket but now goes out weekly and interacts. NB remember she had not left the home for many years.
- ▶ Service likely to remain. But client is now more active has increased social interaction , handles money, works out own shopping needs, knows the cost of items and is keen to look at further ways of increasing her ability and involvement.
- ▶ She identified that she had got into a routine, had become fearful of going out and had become reliant on the support worker visit for company.

CASE STUDY (O'Connell: HACC Forum)

82 year old Italian lady living at home alone

Diagnosis: Diabetes arthritis. Historically receiving fortnightly 2 hours domestic assistance.

- ▶ This lady was looking after both of her dogs; she also maintained a vegetable patch in her back yard.
- ▶ Wellness review completed, identified that client had no functional limitations and could clean her own home independently. She had informed the assessor that she mopped, vacuumed and dusted her home in between services and before the support worker was due, to allow the support worker time to sit down in her busy day and chat with her.
- ▶ It was very evident however this lady was socially isolated. She had explained the only friend she had who spoke Italian had passed away and that this lady had often taken her to the local Italian club which she now missed
- ▶ The assessment identified the real need, which was for social support and to provide a link back into her community

- Alternative service provided. Domestic Assistance withdrawn and social support provided with goal to link client back to Italian club. Support staff facilitated her to do this over a three month period. Now no longer receives a service that she did not need and is much happier with the outcome.

7.2 Literature review – summary of findings

The Australian Institute for Primary Care was engaged by DHS to undertake a review of the international and national literature to:

- develop a comprehensive knowledge base that supports the case for change to an approach that includes person centred capacity building or restorative care, that will maximise the client capacity to live independently in the community; and
- identify models of service delivery that are applicable in Victoria.

The literature review focussed on older adults, who constitute approximately 70% of total HACC clients.

A growing body of research literature was identified that demonstrates it is often possible to re-able occupational and social functions in frail older adults with chronic illness. A variety of the specific elements of an active service model such as exercise and balance programs, health promotion and programs involving the provision of aides and equipment have been trialled, with largely positive outcomes to date. The majority of such studies have been trialled as separate programs, as single components outside of existing HACC type services (i.e., typically not undertaken by HACC staff), and are not directly compared to “standard” services currently being delivered in the HACC program.

To date, there is only a small body of published and grey literature that has investigated the efficacy of multi-component programs within the context of

existing home and community care services. Among all of the relevant literature, the three programs which have received the most thorough attention as well as the most robust evaluations include the Silver Chain ‘Home Independence Program’ in Western Australia (Lewin et al., 2006), the ‘Leicestershire Home Assessment and Re-enablement Team’ in the UK (Kent et al., 2000) and the ‘Restorative Home Care Agency’ based in Connecticut, US (Tinetti et al., 2002). Each program involved the input of a multi-disciplinary team delivering multi-component interventions that are time-limited in duration, and based within home and community care services. Each of these three programs was able to demonstrate a significantly reduced need for home and community care services following intervention. They were also able to demonstrate improvements in self care and activities of daily living in the Australian and US programs and delayed residential placement and reduced hospital visits in the US program.

Overall when integrating outcomes from the literature from both single component and multi-component intervention programs, the strongest evidence is in relation to improvements in the domains of:

- functional status; and
- decreased use of community services.

There is also evidence, albeit as yet less consistent, to suggest that interventions utilising an active service type approach may result in improvement in:

- quality of life;
- mortality;
- caregiver burden;
- admission to residential care; and,
- hospital admissions.

At this stage, it is not yet clear which subgroups from the existing HACC client group are likely to receive maximal benefit from access to an active service model, or the point at which provision of this type of model is no longer viable. The majority

of programs developed to date have focused on functional improvements and targeted relatively low dependency HACC clients. Findings from these studies suggest that the low dependency group is likely to possess relatively high levels of health and fitness, which may make them somewhat better candidates for more active interventions such as provision and training in use of aids and equipment, retraining in domestic activities of daily living and physical therapy for strength and balance. On the other hand, it is also likely that a client's level of motivation and degree of social integration may impact on their capacity to benefit from the model. Hence, minor improvement in function in a relatively dependent client may be sufficient to bolster self-confidence and allow informal supports to continue.

The three key examples of multi-component programs implemented within home and community care services with highly successful outcomes highlighted earlier shared some important components:

- ▶ a multidisciplinary team;
- ▶ a relatively comprehensive assessment (face-to-face and in the person's home) – there are some suggestions that a strength-based assessment may be most appropriate (O'Connell, 2006);
- ▶ a combination of interventions incorporating both functional and social goals; and,
- ▶ time-limited in duration.

7.3 The Victorian Active Service Model pilot projects – summary of findings

In mid 2005, one of the first steps in developing the Active Service Model strategy was to seek proposals from HACC service providers to undertake pilot projects. The aim was to further clarify how the Active Service Model objectives could be realised. They provided a promising start to exploring the implications of implementing possible active service model approaches.

The HACC Active Service Model pilot projects demonstrated an improved approach to working with clients. They generated exploratory and descriptive information and further clarified that there is no single active service model. Rather, a range of interventions, reflecting the philosophy of the active service approach, should be made available within the service system.

A variety of topics and approaches have been undertaken by the 9 pilots including:

- ▶ Assisting people to maximise their independence with home care through interventions that addressed the physical, environmental and technical aspects, whilst assisting the client to participate in capacity building activities. They also used a more flexible suite of services that were tailored for the client;
- ▶ Assisting people to better manage their continence through the collaborative support of a specialist nursing organisation and local government, and the use of direct care staff in referring and supporting clients with continence needs;
- ▶ Reviewing of current assessment practices and identification of areas that provide opportunities for enhancement of assessment practices;
- ▶ Working with clients to make their gardens safer and more accessible;
- ▶ Utilising community care staff to facilitate client involvement in physical activity;
- ▶ Group work where clients are engaged in physical activity, nutrition and other strategies to improve social engagement and independence; and
- ▶ Auditing current practices from client intake to exit to identify opportunities to improve practice to a more capacity building practice.

Some of the outcomes from the pilots included

- ▶ Client focussed interventions that were often set by the client. For example the reallocation of

home care hours to assist with cooking as the client had learnt and become motivated to cook for herself;

- ▶ Timely and flexible service delivery including access to allied health. This allowed the intervention to occur when the client was requesting it and/or when they were motivated to engage with it. Some projects were able to deliver a different service response than the usual (quarterly or monthly home care service or, assistance to learn alternative ways of doing things);
- ▶ Development of client skills, confidence, motivation and social connectedness;

- ▶ Greater job satisfaction particularly for the community care staff;
- ▶ Increased referral and connectivity;
- ▶ Increased use of adaptive strategies;
- ▶ Increased advocacy for involvement in prevention, health promotion, social and/or recreational activities; and,
- ▶ Identification of opportunities within and between organisations where practice or systems could change to maximise the application of the Active Service Model.

Further informations about the pilot projects can be obtained from http://www.health.vic.gov.au/hacc/projects/asm_pilot.htm

APPENDIX 2: Related Initiatives

Assessment framework

DHS released a framework for Assessment in the Victorian HACC Program (DHS, 2007) that is being implemented from the end of 2007. The goal of the HACC Assessment Framework is to support and build good practice in delivering Living at Home assessments and to support designated HACC Assessment Services to build alliances with other key providers of assessment. These alliances will ensure a more coordinated and streamlined assessment based on a person centred approach.

Good assessment in the HACC program and strong links with key health and community care organisations are critical if the HACC program is to efficiently manage client pathways, provide well targeted service responses and refocus the model of service delivery towards a more active model that aims to maintain client independence wherever possible.

The Framework articulates a set of principles that underpin HACC assessment:

- ▶ client centred;
- ▶ carer focussed;
- ▶ promote independence;
- ▶ partnership approach;
- ▶ care planning and service delivery; and
- ▶ system focussed.

Within this framework it is proposed that a Living at Home Assessment including both a broad, holistic assessment of client and carer need for both HACC and non-HACC services, and a service-specific assessment for those services provided by the assessing organisation are delivered. A key feature of a Living at Home assessment will be that the assessment builds on clients' and carers' strengths and abilities, with a focus on improving their quality of life and social participation as well as functional capacity.

A second feature of the Framework is consolidating funding to conduct Living at Home Assessments to those organisations with the resources and professional expertise to undertake and develop this role. Assessment will be undertaken by staff dedicated to this role that will have appropriate support and training. This will be supported by the development of partnerships between organisations that could contribute professional or sectoral expertise to maximise the assessment process.

Further information can be obtained from:

<http://www.health.vic.gov.au/hacc/assessment.htm>

Social support review

Social support programs have been a part of HACC since its inception and have remained largely unchanged. Given the changing demographics, community expectations and the significant development of other social support and carer programs, it is timely to review the provision of social support funded by the HACC Program. A further consideration informing this review is the relationship between services provided by the HACC Program and similar services funded through Aged Care, Disability Services and through the Commonwealth's National Respite for Carers Program.

Social support includes respite, planned activity groups and volunteer coordination, which includes friendly visiting and transport provided by volunteers. The review commenced in late 2007 and is to undertake a research and development project over 18 months, leading to directions for social support that will guide program developments in subsequent years.

Well for Life

Well for Life is an innovative program that aims to improve nutrition and physical activity for frail older people by focusing on change in policies and practices in providers of Home and Community Care

Planned Activity Groups (PAGs) and among Public Sector Residential Aged Care (PSRAC) agencies. Well for Life brings together health promotion approaches, a strong evidence base and opportunities for partnership between aged care and other areas of the primary care sector.

Well for Life seeks to address and encourage a health promoting culture by focusing on provider policy and practice. Through its emphasis on nutrition and physical activity Well for Life upholds the principles of the 'Go for your life' campaign.

Well for Life is ground-breaking, in that it challenges established systems, attitudes, and practices with the aim of improving the health and well-being of frail older people in aged care settings. A fundamental assumption underpinning Well for Life is the need for multi-level action across organisations, the aged care workforce and with older people and their families and carers. It is also premised on the notions of capacity building and evidence-based practice, although paradoxically the evidence base on practice change in aged care is relatively limited. Over time, Well for Life could be expected to contribute to that evidence base.

Evaluation of the projects suggests that Well for Life also has intangible benefits that are not easy to document. These benefits are around challenging prevailing stereotypes of what frail older people can do, and what improvements might be achieved in old age in health and enjoyment of daily life. This challenging of stereotypes is embedded in Well for Life principles and is expressed through simple changes in staff practices, and participation by residents and participants in physical activity and better nutrition. Changes in stereotypes may take many years to emerge, and the effectiveness of Well for Life at this stage of implementation may be as a catalyst for change and a springboard for those in aged care settings – management, staff and older people – who are already advocates of being 'well for

life' regardless of age or impairment.

Further information can be obtained from:
<http://www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm>

Chronic disease self management

Integrated chronic disease management has been gaining momentum in community care settings in Victoria. DHS has introduced policy and programs, particularly within the community health and primary care partnership settings.

Chronic diseases currently make up more than 70% of Australia's overall disease burden due to death, disability and diminished quality of life. Evidence suggests that people with chronic disease, who participate in chronic disease management programs, have a better quality of life, experience fewer complications and reduce their overall use of health care resources.

People with chronic disease need a responsive person-centred and effective system of care. Guiding principles that underpin local chronic disease management work include:

- ▶ providing person-centred care, including support for carers and/or families of people with chronic disease;
- ▶ recognising that consumers are active partners in the management of their chronic disease;
- ▶ increasing choice and control;
- ▶ providing the right care in the right place at the right time;
- ▶ proactively promoting health;
- ▶ targeting population subgroups of greatest need; and,
- ▶ building a whole of service system response.

The 'disease management' movement in the US has also witnessed an increasing emphasis on development of patient empowerment strategies to

enable self-management of chronic illness (Krumholz et al., 2006). Self-management is defined by Barlow, Wright, Sheasby, Turner, and Hainsworth (2002) as “the individual’s ability to manage the symptoms, treatment, physical and psychosocial consequences and life style changes inherent in living with a chronic condition”. There is now a growing body of evidence that self-management education in many cases can be highly efficacious for conditions such as diabetes, asthma and arthritis, with reduced hospitalisations and improved health outcomes, physical activity levels and quality of life (Shaw, Hagger, Graham, & Keleher, 2006; Newman, Steed, & Mulligan, 2004).

Assisting frail older adults to take on an ‘active’ role in the management of their own disabilities and chronic illnesses remains the central tenant of the active service model. In this respect, chronic disease self management programs are well placed to be incorporated within the group of core ‘active service model’ interventions.

Further information can be obtained from:
http://www.health.vic.gov.au/communityhealth/cdm_guidelines.htm

Municipal Positive Ageing Plans

The Australian Local Government Association, with the Australian Government, has invested in an Australian Local Government Population Ageing Action Plan 2004 – 2008, to build local government’s capacity to plan for an ageing population. In Victoria, since 2006, the Municipal Association of Victoria has been conducting a Victorian Local Government Positive Ageing Project in partnership with Council on the Ageing Victoria, funded by the Office of Senior Victorians. These projects build on the ALGA framework and the World Health Organisation’s Active Ageing Policy framework and principles and incorporate the Age Friendly Cities strategy. Most Victorian councils have been developing or updating their local plans, in consideration of their particular

demographics and trends, and incorporating a broad and integrated approach to physical and social planning. The emphases on such planning is about ensuring supportive local physical environments for older people and opportunities for participation, healthy activities and social engagement, as well as planning for services.

Community Health Demand Management Strategy

Community health services (CHSs) are located in every local government area in Victoria. The 100 CHSs in Victoria operate from approximately 400 sites. They are active participants in and contributors to their local communities. This strong connection to communities enables community health services to develop models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. The philosophy of community health is based on promoting health, wellbeing and independence within the social model of health; preventing illness, disease and injury; promoting equity of, accessibility to and participation in service delivery; and reducing health inequalities.

CHSs provide a universal service as well as targeted services to particularly disadvantaged populations, such as people with the poorest health and greatest economic and social needs.

Policy directions for CHSs place the needs of consumers as a central focus in developing an organised and integrated healthcare system that provides consumer’s access to services when and where they need them.

The Community Health Program funded services delivered through CHSs include:

- ▶ health promotion and prevention,
- ▶ early identification and intervention,
- ▶ assessment and treatment (e.g. allied health services such as audiology, dietetics,

occupational therapy, physiotherapy, podiatry, speech therapy, nursing, counselling/casework), and

- coordinated care with GPs, other primary providers, the acute, aged care and mental health sectors.

CHSs also provide a platform for the delivery of a range of other primary health services including drug and alcohol, dental, medical, post acute care, home and community care, community rehabilitation and day centres.

The demand management strategy for CHSs has been in development since 2006. It aims to:

- improve the ability of CHSs to meet the growing demand of consumers,
- improve consistency in the practices for managing demand across CHSs in Victoria, and
- support high quality evidenced based practice.

The strategy is designed to provide CHSs a consistent approach to managing demand that provides:

- equitable and timely of access,
- accurate waiting time measurement,
- tools for prioritising clients requiring services, and
- systems and strategies to manage clients throughout the client journey.

Further details can be obtained from:

http://www.health.vic.gov.au/communityhealth/about_chs.htm

<http://www.health.vic.gov.au/communityhealth/demand/>

HACC National Forum 2008: Promoting Independence

DHS organized and hosted the NACC National Forum on behalf of the federal government and other states and territories in February 2008. The Forum aimed

to bring key stakeholders together from amongst academics and researchers, service providers, peak bodies and governments to explore the evidence base and implications for more thoroughly adopting a wellness, capacity building and restorative care approach to HACC service provision. Nearly 400 invited delegates attended. The program was built on the following objectives:

- To explore the evidence on recent advances in understanding the ageing process, including the impact of increased longevity and the potential for functional improvement.
- To explore the evidence on wellness, capacity building and restorative care approaches, with a focus on community care.
- To share information on models that have taken these approaches, both nationally and internationally, and the learnings from these.
- To provide an opportunity for stakeholders to come together at a national level from across academics and researchers, governments and service providers to gain a common baseline understanding of the evidence and discuss the implications for HACC service delivery.
- To broadly consider implementation implications for better incorporating wellness, capacity building and restorative care approaches into HACC services.
- To begin exploring a research and transformative agenda to support the implementation of this type of approach.

There were a range of significant presentations on the New Zealand Restorative Care Approach, UK Enablement and the Western Australian WATCH and HIP programs.

Further details, including podcasts of all presentations, can be obtained from: www.haccforum08.com.au

A Fairer Victoria

A Fairer Victoria is the Government's overarching social strategy for meeting Victoria's future challenges and improving the lives of all Victorians. It emphasises the provision of accessible and affordable universal services and targeting support for those in greatest need, and tackles inequality and disadvantage by:

- ▶ emphasising early intervention and prevention;
- ▶ matching local service delivery to individual needs;
- ▶ assisting communities to support individuals to overcome problems; and,
- ▶ making services easier to access, more responsive and more successful.

These principles have been considered in the development of this framework.

This policy is located at:

[http://www.dvc.vic.gov.au/Web14/dvc/rwpgslib.nsf/GraphicFiles/A+Fairer+Victoria+new+2007/\\$file/070406_a_fairer_victoria_fa2_web.pdf](http://www.dvc.vic.gov.au/Web14/dvc/rwpgslib.nsf/GraphicFiles/A+Fairer+Victoria+new+2007/$file/070406_a_fairer_victoria_fa2_web.pdf)

Improving care for older people – a policy for health services

Improving care for older people: a policy for Health Services highlights the need to change health care practices in response to Victoria's growing and ageing population. As our society ages, all Health Services will experience a rise in the percentage of older people requiring treatment and care. Health Services will need to implement plans, policies and procedures that ensure the quality of care provided to older people is in keeping with practice based on best evidence.

The policy focuses on improving the care provided for older people by Health Services and integrating care across settings to ensure that people have the appropriate care in the appropriate place. Three

fundamental issues have emerged in considering how to improve and integrate the care of older people, namely, the need to:

- ▶ adopt a strong person-centred approach to the provision of care and services
- ▶ better understand the complexity of older people's health care needs
- ▶ improve integration within Health Service's community-based programs and between Health Services and ongoing support services available in the broader community.

Twelve core principles underpin this policy. These principles form the basis of practices and processes that address the fundamental issues for Victorian Health Services in providing care for older people.

Person-centred care is defined by DHS as 'treatment and care provided by health services [that] places the person at the centre of their own care and considers the needs of the older person's carers'. The main feature of person-centred health care is the concept of partnership. At its foundation person-centred care has collaborative and respectful partnering between the service provider and user. The service provider respects the contribution the service user can make to their own health, such as their values, goals, past experience, and knowledge of their own health needs, and the service user respects the contribution the service provider can make, including their professional expertise and knowledge, information about the options available to the service user, and their values and experience.

The following principles of person-centred care are all encompassed within the concept of partnership:

- ▶ getting to know the patient or client as a person (holistic approach as well as individual approach)
- ▶ sharing of power and responsibility (patient or client as expert in their own health, sharing of decision making, information, the idea of common ground)

- accessibility and flexibility (of service provider as a person and of the services provided)
- coordination and integration (consideration of the whole experience from the point of view of the service user)
- having an environment that is conducive to person-centred care (supportive of staff working in a person-centred way and easy for service users to navigate).

This policy is located at:

<http://www.health.vic.gov.au/older/index.htm>

Primary Care Partnerships

The State Government initiated the Primary Care Partnership (PCP) Strategy in 2000. Over 800 agencies have come together in 31 Primary Care Partnerships (PCPs) across Victoria with the aim to improve the overall health and wellbeing of Victorians by:

- improving the experience and outcomes for people who use primary care services; and
- reducing the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.

These benefits are being delivered through the service coordination and integrated health promotion work program of PCPs. Service coordination is a statewide vision to align practices, processes protocols and systems through functional integration. Agencies within a PCP catchment come together to agree on how they will coordinate their services so that consumers experience a human service system that responds to their needs in a timely, effective efficient and integrated manner. Whether it is from a health service care setting back to the broader community or from the GP to the CHS, service coordination is increasingly delivering a consistent, statewide approach to the collection and sharing

of consumer information and streamlining referral between agencies and across sectors.

Community health services and local government home and community care (HACC) providers that are advanced in service coordination implementation are reporting efficiency gains and quality improvement. Improving the practice of collecting and sharing consistent information is freeing up health professionals to provide more services. Consumers save time and effort by needing to provide information only once and through more streamlined navigation between services.

Integrated health promotion happens when agencies, the community and organisations from other sectors (such as education and recreation) work together to identify common health needs for key population groups and use a mix of health promotion interventions to tackle their priority health and wellbeing issues together. Instead of individual agencies providing similar interventions in isolation and often to the same population, working in collaboration to agreed priorities means that the capacity of the sector is enhanced, and duplication and fragmentation of health promotion effort and investment is eliminated. Evidence shows that single interventions, such as simply providing health information, have limited impact. Using a mix of interventions to achieve a health promotion goal is consistent with the evidence that working at both individual and population-wide levels provides the best outcomes.

This policy is located at:

<http://www.health.vic.gov.au/pcps/publications/access.htm>

Care in your community

Care in your community provides the strategic directions for an innovative, efficient and effective Victorian health system. The Victorian health care system will increasingly deliver person and family

centred health care in community-based settings, reducing the need for inpatient care and improving the health outcomes of Victorians. The delivery of health care will be integrated and coordinated around the needs of people, rather than service types, professional boundaries, organisational structure, program funding or reporting requirements. Health care organisations, in partnership with the people they treat, will be collectively responsible for health outcomes.

Some services currently delivered in hospital-based inpatient settings will be able to be provided safely and effectively in community-based settings. An increasing focus on health promotion, prevention, early intervention and self-management will allow services to respond to and meet people's health care needs before they become seriously ill. Services will coordinate and deliver the best possible care, informed by people's needs and preferences.

Hospital-based services will continue to evolve the way they provide care, further increasing same day attendances and modifying patient management systems, physical facilities and clinical practice to better suit care on a walk-in, walk-out basis. Information technology will give both the people receiving services and the providers of those services quick and easy access to information. More medical technologies will be available to people in their homes and local communities.

Care in your community builds on established and successful elements of the current health system. The guiding principles aim to maximise access, quality and continuity of care, service flexibility, opportunities for service substitution and diversion as well as optimal use of scarce resources.

This policy is located at:

<http://www.health.vic.gov.au/ambulatorycare/careinyourcommunity/index.htm>

The Victorian State Disability Plan

The Victorian State Disability plan has been developed as a policy direction for people with a disability. The strategy detailed below has many synergies with the ASM and provides consistency for those clients that span both HACC and disability services.

A priority strategy of the *Victorian State Disability Plan 2002-2012* is to reorient disability supports to be more flexible, to work with people as partners and respond to individual needs. The introduction of an individualised planning and support approach is part of this strategy and aims to ensure that supports are provided based on people's needs, aspirations and choices that they make about their lives. This includes:

- ▶ Planning that is directed by the person or is family centred for children
- ▶ Supports that are flexible and tailored to individual needs
- ▶ A focus on community participation and strengthening informal supports

Disability Services will continue to work with people with disabilities, families, carers and service providers to both refine and expand the implementation of an individualised planning and support approach.

The objectives of continued service reorientation are to:

- ▶ Enable people with a disability and their families to explore their goals, needs and aspirations and a blend of informal, community based and disability supports they need
- ▶ Enable people with a disability and their families to exercise decision making about their support arrangements, providing more choice and control over supports

- ▶ Enhance flexibility to respond to the wide variety of needs, strengths, circumstances and preferences of people with a disability and their families and to enable creative solutions
- ▶ To make it simpler to understand, navigate and self manage support services, if desired, through clear information, guidelines and processes.

A key priority to achieve these objectives is to introduce a new single Individual Support Package as of 1 July 2008.

Person Centred Active Support (PCAS) Program

This program is targeted at Disability Accommodation Services staff working in DHS Community Residential Services (CRUs). PCAS involves staff supporting people with a disability to participate in activities of

choice in their home and local community. The DHS PCAS experience has show that when people with a disability are involved and engaged in everyday tasks and activities they experience more independence, greater levels of happiness, more control, increased decision-making and are provided with more opportunities to demonstrate what they are capable of achieving. Staff also seem to derive benefits. A recent evaluation of the rural roll-out of PCAS across a randomly selected sample of 20 of 44 CRUs found that 85% of staff felt more satisfied with their work since the introduction of PCAS because:

- ▶ people with a disability were happier;
- ▶ the workplace was more enjoyable and less stressful; and,
- ▶ better relationships exist between staff and people with a disability.

APPENDIX 3: List of References

- AIHW. (2006). *Life expectancy and disability in Australia 1988 to 2003*. Canberra: Australian Institute of Health and Welfare.
- AIPC. (2008). *Efficacy of the 'Active Service Model' for the provision of HACC services: A review of recent Australian and international literature (1996-2006) with implications for service development*, Melbourne: Australian Institute for Primary Care.
- Buys, L., & Miller, E. (2006). The meaning of "active ageing" to older Australians: Exploring the relative importance of health, participation and security, *39th Australian Association of Gerontology Conference*. Sydney: Queensland University of Technology.
- CSED. (2007). *Homecare reablement workstream: discussion document*, London: Care Services Efficiency Delivery Programme.
- Department of Human Services. (2002) *Victorian state disability plan: 2002 -2012*, Melbourne: Victoria.
- Department of Human Services. (2003). *Improving care for older people: a policy for older people*, Melbourne: Victoria.
- Department of Human Services. (2004). *Primary Care Partnerships: strategic directions 2004-2006*, Melbourne: Victoria
- Department of Human Services. (2005). *Well for life evaluation: highlights from the evaluation - phase one projects*, Melbourne: Victoria.
- Department of Human Services. (2006). *Care in your community: A planning framework for integrated ambulatory health care*, Melbourne: Victoria.
- Department of Human Services. (2006). *Recognising and supporting care relationships: a Department of Human Services framework*, Melbourne: Victoria.
- Department of Human Services. (2007). *Framework for assessment in the Home and Community Care program in Victoria*, Melbourne: Victoria.
- Department of Human Services. (2007). *Towards a demand management framework in community health services*, Melbourne: Victoria.
- Department of Planning and Community Development. (2005). *A Fairer Victoria: creating opportunity and addressing disadvantage*, Melbourne: Victoria.
- Department of Planning and Community Development. (2006). *A Fairer Victoria: progress and next steps*, Melbourne: Victoria.
- Howe, A., Doyle, C., & Wells, Y. (2006). *Targeting in community care: a review of recent literature and analysis of the Aged Care Assessment Program Minimum Data Set*, Melbourne: Australian Department of Health and Ageing.
- Kent, J., Payne, C., Stewart, M., & Unell, J. (2000). *Leicestershire County Council: External Evaluation of the Home Care Reablement Pilot Project*. Leicester: Centre for Group Care and Community Care Studies, De Montfort University.
- Lewin, G., Vandermeulen, S., & Coster, C. (2006). *Programs to Promote Independence at Home: How Effective Are They?* Perth, Western Australia: Silver Chain.
- McMurray, A. (2007). *Community health and wellness: a socio-ecological approach*. Sydney: Elsevier Australia.
- McWilliam, C., Diehl-Jones, W., Jutai, J., & Tadrissi, S. (2000). Care delivery approaches and Seniors' Independence. *Canadian Journal of Ageing*, 19(1), 101-124.
- NARI. (2006). *What is person centred health care? A literature review*. Melbourne: Department of Human Services, Victorian Government.
- O'Connell, H. (2006). *The WATCH Project: Wellness Approach to Community Homecare* Perth: Community West Inc and Western Australian Department of Health, Home and Community Care.
- O'Connell, H. (2007). *The WATCH Project: Wellness Approach to Community Homecare*, Perth: Community West Inc and Western Australian Department of Health, Home and Community Care.
- Parsons, M., & Parsons, J. (2005) *Ageing in place discussion paper* (unpublished)
- Peel, N., Bartlett, H., & McClure, R. (2004). Healthy Ageing: How is it defined and measured. *Australasian Journal on Ageing*, 23(3), 115-119.

Pilkington, G. (2006). *Homecare Re-ablement Workstream Discussion Paper*. United Kingdom: Care Services Efficiency Delivery Program, Department of Health.

Seeman, T. E., & Crimmins, E. (2001). Social environment effects on health and ageing: Integrated epidemiologic and demographic approaches and perspectives. *Annals of New York Academy of Sciences*, 954, 88-117.

Silver Chain Nursing Association. *Home Independence Program: User Manual*. Available from Silver Chain Marketing and Communications, 6 Sundercombe Street, Osborne Park, WA, 6017.

Stuck, A. E., Walthert, J. M., Nikolaus, T., Bula, C. J., Hohman, C., & Beck, J. C. (1999). Risk factors for functional status decline in community-living elderly people: A systematic literature review. *Social Science and Medicine*, 48(4), 445-469.

Tinetti, M. E., Baker, D., Gallo, W. T., Nanda, A., Charpentier, P., & O'Leary, J. (2002). Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care. *Journal of American Medical Association*, 287, 2098-2105.

WHO. (2002). *Active Ageing: A Policy Framework*: World Health Organisation, Ageing and Life Course Programme.

Wistow, G., Waddington, E., & Godfrey, M. (2003). *Living Well in Later Life: From Prevention to Promotion*. Leeds: Nuffield Institute for Health, University of Leeds.

