

Victorian HACC Program

Active Service Model Project

Aim

The aim of the Active Service Model Project is to increase the Victorian HACC Program's effectiveness in maximising client independence through person centred and capacity building approaches to service delivery. The outcomes sought are:

- Changes in perception of the capacities of frail older people and younger people with disabilities' among policy makers, community, workforce and clients
- Clients' capacity to do their own personal and domestic tasks, and to participate in social and community activities, is improved or maintained such that their need for recurrent HACC services is delayed or reduced.

The case for change

The HACC Program seeks to maximise the independence of frail older people and younger people with disabilities so as to prevent premature admissions to long-term residential care. However, the services that were grouped together to form the HACC Program in 1985 assume a dependency model of service delivery.

Policy development and service delivery in HACC has largely assumed that functional and cognitive decline are inevitable and that people need propping up. While the ageing process is very real and does involve decline, this is not a linear or universal phenomena and therefore should not underpin service delivery.

The challenge

An emerging body of research indicates the likely benefits of proliferating a more 'active' service model in HACC. The Victorian Minister for Aged Care has responded by calling for a reshaping of HACC services and the service system in line with this body of knowledge to better meet the challenges of the new century. He has challenged service providers to emphasize a more active model of service and to think about how to achieve efficiencies in service delivery.¹ In *A Fairer Victoria: Creating opportunity and addressing disadvantage* the Government states:

Instead of delivering 'passive' services, we will create more opportunities for older people to be involved in decisions about their own care, stay connected to their neighbourhoods, take up new interests and be supported to remain physically and mentally active. ... Services will aim to help people stay involved in everyday activities to maintain or rebuild their confidence and stay active and healthy.

The challenge for the HACC Program is to move from a 'dependency' model of service delivery where tasks are largely done for clients, to a restorative care and capacity building approach. Instead of assuming dependency or constant decline, the aim is to retain or improve clients' independence and self-efficacy thereby minimizing the impact of functional decline on the person's capacity to live at home and participate in everyday social interactions. This might mean assisting a client to shower themselves rather than doing it for them, or introducing clients to lighter and easy

¹ 'Ideas for the future of Community Care in Victoria' Speech by the Hon Gavin Jennings MLC, Minister for Aged Care to VAHEC Seminar 27 August 2004.

to use cleaning equipment in preference to doing all cleaning for the person, or making minor modifications to the home environment, or improving the person's sense of self worth through social activities. It might also involve learning how to cook for one, or joining a strength-training program to improve balance, energy, physical strength as well as the person's sense of well-being.

The aim is that clients stay as active and well as possible for as long as possible by maintaining or improving their abilities, and that HACC services be provided to supplement for the person's functional disabilities. Over time, our learnings about longevity may herald a different suite of basic maintenance and support services in the HACC Program.

Assessment is critical

Pivotal to this approach is assessment, since the factors underlying the person's request for HACC services need to be understood and addressed. The aim is that clients stay as active as possible for as long as possible by maintaining or strengthening their functional abilities, and that HACC services be provided to supplement the person's functional abilities.

Strategy leading to new policy

The Department of Human Services' (DHS) strategy for developing the active service model includes:

- Reviewing literature and identifying innovative practice in Victoria, interstate and internationally
- Supporting and evaluating a limited number of pilots to implement this approach in Victoria
- Using knowledge gained from service providers, health professionals, academics and peak agencies to inform policy and program development, including exploring practice and workforce development issues arising from this approach.

The intelligence yielded will inform a policy and funding framework in which active service principles underpin HACC assessment and service delivery in Victoria. Opportunities to support active service delivery practice will be highlighted. The report will be presented for the Minister's consideration in early 2007.

Case studies

Referral 1

Person referred for domestic assistance because too frail and incapacitated to clean house.

Current outcome:

Person receives fortnightly home help indefinitely.

Possible alternative outcome:

- Person referred to physiotherapist for assessment of shoulder. Receives treatment for frozen shoulder and is referred to ongoing hydrotherapy at the local leisure centre to maintain functioning
- Also receives house spring-clean to restore house to level that can be maintained by fortnightly house cleaning service until shoulder is fixed
- The client and their home environment are assessed and strategies identified to teach alternative cleaning techniques. Client trials new and affordable cleaning equipment/products that are easier to use and more effective than the heavy bucket and mop and vacuum cleaner they have been using for many years
- Home care staff provide fortnightly cleaning service for 6-8 weeks and gradually support the client to resume their own home care duties by reinforcing new techniques
- Once the client has maximised functioning of his/her shoulder, they resume cleaning their house and receive quarterly 'heavy duty' cleans.

Referral 2

Person referred for personal care because unable to shower self.

Current outcome:

Person receives 3 times weekly personal carer to shower them, indefinitely.

Possible alternative outcome:

- Person referred to occupational therapist for assessment in home. A shower chair, installation of rails, energy efficient strategies for self care, and strengthening exercises are recommended
- Client receives personal carer 3 times weekly to shower them while OT recommendations are implemented
- Shower chair and installation rails provided
- OT familiarises client and personal carer with how to use equipment safely and introduces client to more energy efficient and independence promoting methods of self care
- Personal carer supports client to master new equipment and self care techniques; client showers self with personal carer assisting only in tasks client cannot do
- Personal carer accompanies client to strengthening/exercise sessions twice to ease person's entry into group; person attends weekly indefinitely
- After 3 months of exercise program, OT reviews client's functional gains and assesses that person can shower independently; personal care service ceases
- Review at 6 months: client stable and satisfied to be showering independently.