



# Active Service Model

HACC Service Provider  
Consultations

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Faculty of Health Sciences

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## Acknowledgements

Provider consultations were undertaken by the Victorian Department of Human Services from May to July 2008, across the regions of:

- Barwon-South Western
- Gippsland
- Grampians
- Hume
- Loddon Mallee
- Eastern Metropolitan Region
- North and West Metropolitan Region
- Southern Metropolitan Region

The following organisations also took the opportunity to provide written feedback:

- Aged and Community Care Victoria
- Barwon Health
- Brotherhood of St Laurence
- Ethnic Communities' Council of Victoria
- Municipal Association of Victoria
- Multiple Sclerosis Limited
- Royal District Nursing Service
- Western District Health Service

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## Abbreviations

ACAP / ACAS	Aged Care Assessment Program / Aged Care Assessment Service
ACCV	Aged and Community Care Victoria
ASM	Active Service Model
AIPC	Australian Institute for Primary Care
ATSI	Aboriginal and Torres Strait Islander
BSL	Brotherhood of St Laurence
BSWR	Barwon-South Western Region
CALD	Culturally and Linguistically Diverse
CHC	Community Health Centre
ECCV	Ethnic Communities Council of Victoria
EMR	Eastern Metropolitan Region
HACC	Home and Community Care
HARP	Hospital Admission Risk Program
LMR	Loddon Mallee Region
MAV	Municipal Association of Victoria
MS	Multiple Sclerosis
NWMR	North and West Metropolitan Region
PAG	Planned Activity Group
RDNS	Royal District Nursing Service
SMR	Southern Metropolitan Region

# Executive Summary

## Introduction

The Victoria Department of Human Services (DHS) is currently exploring a new direction for home and community care service provision that has shown considerable promise: the Active Service Model. The Active Service Model (ASM) is based on the premise that clients have the potential to make gains in their wellbeing and that the Home and Community Care (HACC) service system can improve its capacity to support this. An Active Service Model emphasises the provision of person centred, timely and flexible interventions that prioritise capacity building and restorative care to maintain or promote a client's capacity to live as independently as possible. The changes envisaged by DHS do not constitute a wholesale change to the HACC program but rather a way of strengthening existing practice and building quality improvement.

Similar new directions have underpinned the development of time-limited multi-component programs now operating in the United Kingdom, New Zealand and Western Australia. A growing body of evidence suggests that these interventions result in substantial functional improvements in frail older adults, and are cost effective in that they reduce for a period of time the need for ongoing health and community services for a substantial proportion of clients.

The current report refers to one of a series of activities undertaken by DHS in implementing this new direction. Other activities include funding pilot projects, commissioning a literature review, hosting a National Forum, and publishing a Discussion Document.<sup>1</sup> The consultations reported here were carried out by DHS. Staff from the Australian Institute of Primary Care (AIPC) played a support role, attending all of the sessions, taking notes, transcribing and analysing and data, and compiling this report.

## Consultations with HACC funded service providers

Approximately 700 people working with a range of service-providers participated in the Active Service Model (ASM) HACC funded service provider consultations held in eight regions around Victoria from May to September, 2008. In addition, nine organisations or individuals made written submissions by completing a response template.

Sessions were introduced by Kriss McKie and Meg Henderson of DHS, who explained the concept of the Active Service Model and outlined the steps being proposed by DHS to implement the model. This was followed by discussion in small groups of two sets of questions and by the opportunity to provide individual comment. Main discussion points were recorded in each group and presented in a plenary session. All written material was subsequently entered and analysed by theme.

## Results

Widespread support was expressed for the concept of the Active Service Model and for the directions suggested by DHS for the Model's implementation. Contributors both to the consultation sessions and the written submissions expressed a sense of being "overall positive about the model and its emphasis" (Barwon Health; Municipal Association of Victoria; and Brotherhood of St Laurence).

Five main topics emerged from the thematic analysis of discussions on the local strengths of HACC funded services. The most common perceived strengths were *staff and team strengths* and *existing relationships or partnerships between service providers* (both mentioned by over half of the groups).

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<sup>1</sup> See [http://www.health.vic.gov.au/hacc/projects/asm\\_project.htm](http://www.health.vic.gov.au/hacc/projects/asm_project.htm)

Seven main barriers to implementing the ASM emerged from the discussions. The most frequently reported barriers included in the discussions by over half of the groups were: *staff issues* (mainly related to workforce development, staffing levels and work culture); *community, consumer and other stakeholder issues*; and *funding issues*. Most participants identified two groups of resources to be required for implementing the ASM: *funding* and *staff training and support*.

With respect to the specifically suggested strategies in the ASM discussion document: the self-audit tool received general support; staff training and preparation was widely seen to be essential to the implementation of the ASM; the communication strategy drew a great deal of comment and support; and the suggestions that assessment be strengthened prompted a range of comments on the resource requirements to support better assessment practice.

The concept of a *demonstration project* received broad support from the discussion groups and written submissions. The need for a robust evaluation strategy was emphasised, as was the inclusion of a range of clients from different backgrounds and levels of functioning.

Relatively few groups commented on *further exploration, research and development* (Direction 3), and most of these were on topics covered elsewhere in the discussion.

More resources and the need for new funding models were recurring themes and several groups mentioned the need for a well-designed evaluation plan prior to implementing the model. Finally, the need for a timetable and a gradual approach to implementation was recognised by several groups.

Twenty-seven groups attempted to prioritise the implementation strategies. The top three priorities specified were: *cultural change/education*; *financial/resources*; and *staff training/education*.

### **Summary of feedback from the HACC funded service provider consultations**

The main messages from the HACC funded service provider consultations and the written submissions were similar, and included:

1. Significant support from the sector for the principles and approach proposed in the ASM discussion document.
2. That many service providers already come to the ASM with significant strengths including: examples of innovative practice and programs; partnerships with other key agencies; evidence of client centred practice; and enthusiasm for the ASM approach.
3. The need for financial support to further the implementation of the Active Service Model at the local level. This includes support for specific initiatives (e.g., to employ more staff from the allied professions); to free up staff time (e.g., more time for assessment and care coordination); and to assist with the change management and implementation process.
4. That staff training and workforce development should be a priority (at both the state and local levels).
5. Encouragement for DHS to develop resource materials for the sector such as the Audit Tool, and conduct a communication strategy with clients, carers, and other service-providers.
6. Support for DHS to develop an overall evaluation strategy prior to implementation, to measure change and outcomes as they occur.
7. The importance of involving other services and sectors to support coordinated restorative client care (e.g., GPs, the acute sector, the Aged Care Assessment Program (ACAP), and other providers)
8. The need for a more exploration of the ASM approach for people from a variety of cultural backgrounds, including Indigenous Victorians.
9. That the current reporting and funding model does not fully support the implementation of the ASM and would benefit from review.

## Introduction

The Department of Human Services is currently exploring a new direction for home and community care service provision that has shown considerable promise: the Active Service Model. The Active Service Model (ASM) is based on the premise that clients have the potential to make gains in their wellbeing and that the HACC service system can improve its capacity to support this. Introducing the ASM is not a wholesale change to the HACC program but rather a way of strengthening existing practice and building quality improvement.

An Active Service Model emphasises the provision of person centred, timely and flexible interventions that prioritise capacity building and restorative care to maintain or promote a client's capacity to live as independently as possible. A range of strategies and interventions can be utilised as part of an active service model including: strength based assessment; increased access to physiotherapy and occupational therapy; retraining in activities of daily living; timely provision of aids and equipment; greater utilisation of relationships with community care workers; encouragement to participate in local health promoting activities, and strengthening social support. The defining characteristic is that the starting point for all clients is their strengths rather than their deficits, and that all clients have some capacity to improve.

This type of service model has underpinned the development of time-limited multi-component programs, now operating in the United Kingdom, New Zealand and Western Australia. A growing body of evidence suggests that these interventions result in substantial functional improvements in frail older adults, and are cost effective in that they reduce for a period of time the need for ongoing health and community services for a substantial proportion of clients.

The current report refers to one of a series of projects undertaken by DHS in implementing this new direction. Other projects include funding pilot projects, undertaking a literature review, and hosting a National Forum. The consultations reported here were undertaken by DHS. Staff from the AIPC played a support role, attending all of the sessions, taking notes, transcribing and analysing and data, and writing this report.

## Structure of the report

This report is structured in the same way as the exercises set out for the consultation phase of the project. Examples are given for each response theme. Tables of themes and sub-themes are set out in the Appendices.

## Method

Approximately 700 people participated in the 9 Active Service Model (ASM) HACC funded service provider consultations held in eight regions around Victoria (NWMR hosted 2 sessions). The timetable for the consultations is set out below.

**Table 1: Timetable for HACC funded service provider consultations**

Region	Date	Time
Gippsland	Tuesday 20/05/2008	1.00pm to 4.00pm
Hume	Wednesday 21/05/2008	11am to 2.30pm
Southern (SMR)	Wednesday 28/05/2008	10.30am to 2.30pm
Eastern (EMR)	Wednesday 4/06/2008	12.30pm to 4.00pm
Barwon South Western (BSWR)	Wednesday 11/06/2008	11.00am to 2.30pm
North and West (NWMR)	Thursday 12/06/2008	1.00pm to 5.00pm
Loddon Mallee (LMR)	Tuesday 17/6/2008	10.30am to 2.30pm
North and West (NWMR)	Wednesday 18/6/2008	1.00pm to 5.00pm
Grampians	Tuesday 01/07/2008	11.00pm to 2.30pm

Sessions were introduced by Kriss McKie and Meg Henderson of DHS, who explained the concept of the Active Service Model and outlined the steps being proposed by DHS to implement the model. This was followed by discussion in small groups of two sets of questions and by the opportunity to provide individual comment.

Participants at each HACC funded service provider consultation were divided into small groups with an average of 8 people per group. Altogether, there were 89 groups over the 9 consultation sessions. Each HACC funded service provider consultation was attended by two members of staff from the Australian Institute for Primary Care (AIPC; the consultants for the project). The consultants took notes and assisted with the discussions. Responses to each question were entered electronically, collated and coded into themes and sub-themes. The results are summarised in the body of the report and presented in detail in the Appendices.

Exercises 1 and 2 were completed in groups. Group Exercise 1 focused on questions of regional strengths, barriers to implementation, resources required, and good examples of ASM-type practices and approaches already implemented in the community. Group Exercise 2 asked whether participants agreed with the suggested implementation strategies and asked about additional areas and the priority order for implementation. The Individual Response exercise focused on local top priorities for action in delivering the ASM initiative. The questions for the groups and individuals are set out below:

### Group Exercise 1: Local contexts

Thinking of the organisation in which you work and your community:

- What are the key strengths that you already bring to the Active Service Model approach?
- What are the key areas that you will need to work on and what are some of the barriers you will face?
- What resources will you need?
- Are there some good examples of an ASM type approach already happening in your community?

## **Group Exercise 2: Implementation plan**

Do you agree with the implementation strategies we have described so far (Refer section 5, pp 19-20) in the Discussion Document? Do you want to make any comments about them?

- What additional areas should be included in the implementation plan?
- What should the priority order be?

## **Individual Response**

For your organisation and community, what do you think is the top priority for action in delivering the Active Service Model initiative?

## **Written Submissions**

Nine organisations or individuals also provided written submissions in response to an invitation on the DHS website (see Appendix 3):

1. Aged and Community Care Victoria
2. Barwon Health
3. Brotherhood of St Laurence
4. Ethnic Communities' Council of Victoria
5. Municipal Association of Victoria
6. Multiple Sclerosis Limited
7. Royal District Nursing Service
8. Western District Health Service.

Comments received from these organisations were generally much more expansive than those received during the group consultations. Some of these extra comments are included in this report.

## Results

### General responses

In general, the principles and approach detailed in the ASM discussion document received unanimous support. Comments included the following:

*Only the broad parameters have been outlined rather than a distinct model. In this respect ACCV envisages that several models will be trialled under a broad framework, in order to find models that can adapt to the range and nature of different HACC services. They suggest that the ASM should be renamed the Active Service Framework to reflect this. (Aged and Community Care Victoria)*

*Overall positive about the model and its emphasis. (Barwon Health)*

*Overall positive about the model and its emphasis. We recommend that two principles are added: 1) that people want to remain active and engaged in their community, and 2) that people's health and wellbeing can be improved through health promotion and person-centred care. (Brotherhood of St Laurence)*

*Overall, ECCV supports the ASM's objective 'to improve functional independence, quality of life and social participation' – as long as these objectives are implemented with due consideration given to the special needs and expectations tied to cultural difference and poor English proficiency. (Ethnic Communities' Council of Victoria)*

*Overall very positive about the model and its emphasis. (Municipal Association of Victoria)*

As to whether the approach and principles were applicable to all clients eligible for HACC services the MS Society, RDNS and Western Health provided the following comments:

*The principles of ASM are relevant to all individuals requiring or receiving service support from the health and community care sector. Clients with complex medical needs (such as enteral feeding, swallowing difficulties, medication regime beyond staff capacity, those requiring oxygen and clients with acute behaviours of concern) should be excluded unless there is comprehensive training and support for competent program staff to be involved in this level of individualised care. (MS Society)*

*Yes, [all] clients, as in the Western Australian model, would ... be viewed on admission as having the potential to make improvements in their functional capacity, independence and quality of life. De-selection would occur only in circumstances such as the following: end stage of life, severe cognitive impairment and active mental health issues. (RDNS)*

*There may be some clients assessed as inappropriate for the HACC Active Service Model; for example, those suffering from dementia or with an acquired brain injury (ABI) (this would depend on the severity of their condition). The client requires the cognitive ability to establish individual goals and to strive to achieve these goals. (Western Health)*

## Group Exercise 1: Local context

The first set of questions for the groups asked the following:

Thinking of the organisation in which you work and your community:

- What are the key strengths that you already bring to the Active Service Model approach?
- What are the key areas that you will need to work on and what are some of the barriers you will face?
- What resources will you need?
- Are there some good examples of an ASM type approach already happening in your community?

### 1.1. Key strengths

Five main topics emerged from the thematic analysis of discussions on the strengths of community services organisations. Table 2 (in Appendix 2) shows the sub-themes identified by the analysis for each of the main strengths. The most common perceived strength was *staff and team strengths* (listed by 66 groups).<sup>2</sup> For example:

*Cultural awareness in [the] organisation, particularly [among] care workers.* (Hume)

*Diversity of skills in the workplace.* (EMR)

*Enthusiasm to implement.* (Grampians)

*Volunteers – enthusiasm.* (NWMR)

Many groups (n = 63) also reported *existing relationships or partnerships* between service providers as a key strength. For example:

*Already have a good collaborative partnership [and] established networks.* (BSWR)

*Community programs all on one site.* (EMR)

*Existing links and meeting protocols between health and Shire [of] Ararat.* (Grampians)

*Existing strategies for working with clients* were also perceived as great strength by over half of the groups (48 groups):

*We currently ask people what they would like to achieve already. Rather than just talking about what we can offer.* (LMR)

*Already doing strength training, balance, social connectedness.* (BSWR)

*Already do holistic assessments.* (SMR)

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<sup>2</sup> Although this report includes numbers of groups or comments, to allow some comparison of the importance of topics, these numbers are flawed indicators and should be treated with caution, because: groups varied in size; themes and topics overlap; and written outputs from groups were often ambiguous, lacked detail, and do not indicate which topics aroused most discussion.

Similar strengths were mentioned by organisations that provided written submissions. For example, the Brotherhood of St Laurence listed the following practice strengths:

*BSL case management approach supports ASM*

*BSL can work with other HACC providers to promote ASM*

*BSL's ethos (e.g., emphasis on staying at home, holistic assessment) is already consistent with much of ASM*

*Organisational strengths* (18 groups) and *community strengths* (6 groups) were also recognised. For example:

*Organisation's flexibility in use of resources. (Hume)*

*Multidisciplinary team. (SMR)*

*Intake services implemented in community health and Council. (NWMR)*

*Council – currently strengthening assessment team and assessment function – consolidating. (NWMR)*

## **1.2 Barriers and areas needing work**

Seven main themes emerged from the discussions on barriers to implementing the ASM. Table 3 shows the sub-themes identified by the analysis for each of the main barriers.

The most frequently report barrier was *staff issues* (64 groups), mainly related to workforce development, staffing levels and work culture:

*Professional boundaries. (NWMR)*

*Shortage of allied health staff (already). (SMR)*

*Home/Community care workers feeling threatened by the model (maintain value of the task oriented role). (BSWR)*

Next, many groups perceived *community, consumer and other stakeholder issues* to be a major barrier (57 groups):

*Generational mindset – professional tells them what to do. (NWMR)*

*Client perception of service delivery and entitlement. (Grampians)*

*Cognitive capacity of some clients in being able to voice their goals and relying on others to do this. (BSWR)*

*Service providers have an outdated idea regarding what PAG services are for. (LMR)*

Similar barriers were recognised in written responses to the website:

*Some older clients may not adapt well to a change if it is perceived as reducing access to service. (Barwon Health)*

*Some seniors from CALD backgrounds have been culturally conditioned to expect that they will be cared for and have things done for them as they age, sometimes regardless of their*

*capacity for independence. They may not be aware [of], nor accepting of, the benefits that come with supporting greater functional capacity and self-sufficiency.* (Ethnic Communities' Council of Victoria)

The third most commonly reported barrier was *funding issues* (52 groups). In addition, several groups (n = 31) perceived barriers within the *aged care sector* and a similar number were concerned about *time*—both the time required to implement change and the time that ASM would add to service delivery.

*Change [management] processes require time and resources.* (NWMR)

*Current HACC guidelines – funding/inflexible.* (SMR)

*Existing HACC funding streams do not fit with an ASM approach.* (ACCV)

*Down time to co-ordinate care.* (Gippsland)

*Too busy to provide flexibility.* (Grampians)

*No ongoing funding for programs.* (EMR)

The Municipal Association of Victoria expressed similar concerns via a written submission:

*The time and costs to achieve goal directed plans for each individual has to be scoped and recognised, as it is likely to be greater than current time necessary to assess and implement HACC services.* (MAV)

*Information management* was perceived as a barrier by nine groups and *risk management and safety issues* were considered a barrier by five groups:

*Lack of consistent service of IT supporting e-referral.* (Grampians)

Responses via a written submission to this issue were often highly specific to the organisation. The Ethnic Communities' Council of Victoria mentioned inequity in access as a barrier to implementation:

*Equity in access and equitability of service distribution of services. In general, larger established migrant communities are better-placed in accessing aged care services than smaller newly arrived and emerging migrant communities. Importantly, the level of need varies markedly from one community to the next, with refugee communities considered to be of greater and more urgent need of support and resources than more established communities. These factors influence the allocation of funding and resources irrespective of aged group and have the potential to create friction if not handled sensitively.* (ECCV)

In contrast, the Multiple Sclerosis Society emphasised the need for better transport:

***Access to transport*** is a barrier to many of our clients who wish to remain independent as they often require assistance to travel anywhere outside their home. Added to this they are often not able to afford the ***costs of accessible transport***. (MS society)

### 1.3 Resources needed

All participating groups (89 groups) highlighted the importance of *funding* to implement the ASM. Most groups also perceived *staff training and support* (83 groups) as important. Several groups listed an *ASM promotion campaign* (36 groups), and *tools and documentation* (30 groups), while a few

groups listed *time* (9 groups). Table 4 in the Appendices shows the sub-themes identified by the analysis for each of the resource types:

*More funded hours for small organisations to be involved in service co-ordination.* (Grampians)

*More staff to deal with demand in order to spend the time in client-centred care planning, review.* (NWMR)

*May need a completely different workforce – how do we get them, skill them up.* (NWMR)

*Advertisements – TV, radio, [and] papers to change community attitudes, shift in thinking.* (SMR)

*Better technological information systems that enable inter-agency communication.* (EMR)

## 1.4 Good examples of the ASM in practice

Groups listed a variety of programs (see Appendix 1). The most commonly mentioned service types that had already incorporated ASM principles were:

- Wellness programs (e.g., Seniors Go for Your Life; Chronic disease management; Healthy, Wealthy and Wise; Well for Life)
- Good eating programs (Café meals and cooking projects)
- Socialisation (Life Skills projects; Art and History; Men’s programs, such as Men’s Shed.)
- Physical activity, strength and balance training
- Foot care.

Other good examples included training of community care staff, joint visits and care planning, and integrated services including with housing support.

Good examples of the ASM in practice identified during the consultations are presented in Appendix 1.

## Group Exercise 2: Implementation plan

The second group exercise focused on the implementation strategies suggested in the ASM discussion document. These implementation strategies are described under three main headings:

- Direction One: Strengthen practice within current structures and policy
- Direction Two: One or more demonstration projects
- Direction Three: Further exploration, research and development

Participants were asked to address the following three questions:

- Do you agree with the implementation strategies we have described so far (Refer section 5, pp 19-20) in the Discussion Document? Do you want to make any comments about them?
- What additional areas should be included in the implementation plan?
- What should the priority order be?

Some groups spent time on each strategy and did not comment on additional strategies or priority order. However, other groups made only general comments about the strategies and had time to consider other implementation issues.

## 2.1 Comment on strategies

There was widespread support for the suggested implementation strategies, both among the discussion groups and in written submissions:

*The implementation steps are comprehensive and appropriate. (BSL)*

Some reservations were also expressed:

*Agree with implementation plan – strategies still unclear. (Hume)*

*How can we finetune implementation to suit individual organisations? (EMR)*

Comments received via written submissions were also generally supportive; for example:

*BSL commends the Victorian Government for its approach, principles and objectives of the Active Service Model. To reflect the stated core elements of the model it is suggested that another two principles be added – that people want to remain active and engaged in their community and that people’s health and wellbeing can be improved through health promotion and person-centred care. (Brotherhood of St Laurence)*

It should be noted that there were a higher number of responses for the strategies identified under direction one (39 comments were received on the self-audit tool, 49 on training and workforce development, and 40 on the communication strategy) than for those identified under directions two (n = 24) or three (n = 12).

### 1. Direction 1: Strengthen practice within current structures and policy

- 1.1 Self-audit tool: Develop a self audit tool to allow agencies to assess their status and develop an action plan to move to implementing an Active Service Model approach

The concept of the development of a self-audit tool to assist agencies to measure and plan implementation of the ASM received general support:

*Self-audit tool to measure readiness makes sense. Will help people to look at things consistently. (Grampians)*

Some groups commented on how the tool might be used:

*Audit [the] partnership, not [the] agency. (EMR)*

*Assumes a homogeneity of progress – not the case!! (Grampians)*

*Self-audit tool – needs to be practical and ongoing. (Unknown)*

There was general agreement that use of the tools should be voluntary for agencies.

- 1.2 Training and workforce development: Pilot an adapted version of the WA Wellness program in Victoria; and, inclusion of Active Service Model approach within the professional development of assessment staff.

The issue of staff training and support was widely seen to be essential to the implementation of the ASM. Participants were keen to see training available to all staff involved in HACC service delivery not only to promote practice change, but also to facilitate cultural change and challenge perceptions of ageing. Comments included:

*Direct care workers should also be trained – not just assessment officers. (BSWR)*

*ASM formal training should commence immediately. (Grampians)*

*Workforce development – need to address this early. Current workforce issues exist. (NWMR)*

Written submission responses mentioned similar issues:

*Training needs to be broader than only specific designated assessment officers. The approach needs to be understood and applied more broadly than those undertaking assessment to ensure that the client's wellness is continuously encouraged and supported rather than only through a formal re-assessment interview. (Barwon Health)*

Some groups felt that they did not know enough about the Western Australian Wellness approach to be able to support it unconditionally, or that it was not directly applicable to Victoria:

*More information required about WA wellness program. (SMR)*

*WA approach cannot be transferred to current Victorian model due to different structure. (BSWR)*

- 1.3 Communication strategy: 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.

This aspect of the implementation plan also attracted a great deal of comment and support. Many groups believed that the strategy should aim as widely as possible:

*Communication strategy [needs a] two-pronged approach: local engagement and state-wide marketing of ASM message. (BSWR)*

*Communication strategy will be the key to ASM and deliverable at all levels. (Hume)*

*Dealing with CALD communities on raising their awareness of ASM in a creative way. (NWMR)*

Written responses expressed similar support:

*Media campaign should be developed to ensure people have a good understanding of this model. (Barwon Health)*

- 1.4 Share good practice examples among HACC service providers.

While this strategy received fewer comments, it was universally supported.

*Critical that agencies are proactive in sharing info, progress etc. (SMR)*

*Sharing should be broader than HACC service providers (community houses, ACAS) across LGAs. (NWMR)*

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

This strategy drew relatively few comments, and some groups responded with questions about what was meant, or made suggestions that were difficult to interpret:

*Scope for greater flexibility what does this mean? Funding across programs? (Hume)*

*Yes to flexibility but the “how to do” within existing resources? (SMR)*

*Recognition of ASM and associated flexibility required in current accreditation models (HACC, EQuIP, QICSA). (BSWR)*

- 1.6 Strengthen assessment: Implementation of the Assessment Framework

A variety of comments were received to the suggestion that assessment be strengthened. Some groups commented on the resource requirements for better assessment practice, while others suggested some solutions:

*Real costs could impact on organisations re: staffing levels required, car access – Assessment Officer to be out more – admin staff workload increase. (Hume)*

*Comprehensive and Living at Home assessment conducted by one individual. (EMR)*

Many groups supported the development of assessment tools, and some mentioned the SCTT as incompatible with the ASM approach:

*Exploration of Assessment and care planning tools important. (SMR)*

*Assessment and care planning tools need to be validated and consistent (no duplication). (NWMR)*

- 1.7 Review the resource requirement to provide assessment and review to meet ASM objectives

Some groups commented that it was not clear what was meant by “review”, and that review is time-consuming:

*What is a review? Need criteria to define what a review involves (how long, what process?). (SMR)*

- 1.8-1.10 Further developing partnerships

Many groups believed that their partnerships with other organisations, either within or beyond Primary Care Partnership (PCP) structures, were a strength, but other groups questioned how such partnerships would work:

*How do the different agencies, with different approaches and models, come together? (NWMR)*

*Inclusion of small organisations in partnerships – resource challenges. (NWMR)*

*Further development of partnerships and cooperation between similar services (not in competition). (EMR)*

*Depends on access to transport and across municipalities – boundaries. (SMR)*

1.11 Forum for consumers and carers: Establish a forum for consumer and carer contribution to the development and implementation of the HACC Active Service Model

A few groups commented on this aspect of developing partnerships, again with a mixture of support and issues:

*Evaluation important – is it working for the care recipient? (Hume)*

*Question strategy around establishing forum for consumers and carers – how equipped will they be? (SMR)*

*Yes Please! – in an innovative way – already huge stress on consumers and carers. (Unknown)*

**2. Direction 2: One or more demonstration projects**

This strategy received wide support from discussion groups and written submissions. Evaluation was emphasised, as was the inclusion of a range of clients from different backgrounds and different levels of functioning:

*Yes, to gather and test model. CALD input is vital. One size does not fit all. Funding to make this happen. (SMR)*

*Yes. [There] have not been enough pilots to assess people's functionality. (Hume)*

*Trial models to include CALD communities -- new, emerging and sandwich groups and well-established groups. (NWMR)*

*[There] needs to be specific piloted initiatives to test models of "living at home" assessment which facilitate an active service approach and outcomes. (Aged and Community Care Victoria)*

**3. Direction 3: Further exploration, research and development**

Relatively few groups commented on future directions, and most comments were covered elsewhere in the discussion. Cultural awareness was mentioned twice.

The written submissions provided some additional feedback on future directions. For example, Aged and Community Care Victoria suggested the following directions (some of which are national rather than state issues):

- *The ASM [should be] factored into the planning of preventative health strategies for younger people who are not yet HACC users.*
- *A workforce strategy including: training and education; career pathways and pay structures; financial modelling for budget planning; and a workforce recruitment strategy.*
- *Engagement with the planning process of the higher education sector to ensure that the workforce requirements for allied health professionals needed to drive the ASM are factored in ASAP.*
- *Attempts to ensure that scarce allied health workers are well-supported within the system.*
- *To review the current HACC funding model to ensure that an appropriate model is developed which will enable an ASM to operate transparently and viably.*

- *A proper annual funding adjustment system of no less than 4% annually is set into place to maintain the real value of HACC funding.*

The Ethnic Communities' Council of Victoria reinforced the need to consider groups from culturally and linguistically diverse backgrounds:

*ECCV ... cautions against placing the CALD target group as a final point of consideration for further exploration, research and development. This risks creating the impression that the many challenges faced by this group are too difficult to contemplate. (ECCV)*

## 2.2 Additional strategies

Relatively few groups addressed this question (see Table 6). Group discussion on additional strategies covered a range of topics, some already addressed in discussions on the suggested strategies, rather than being new suggestions. Some groups used this opportunity to pose questions about implementation rather than make suggestions about additional strategies:

*Are private providers on board? DVA? (Hume)*

*Culturally appropriate services with principles of empowerment, inclusiveness and collaboration that underpin – how do we get the CALD clients on board, make services more accessible? (NWMR)*

*Engaging volunteer workforce – change to volunteer roles – moving away from concept of volunteering? Is it reasonable to expect ASM responsibilities of volunteers, especially existing volunteers? (BSWR)*

*Who counts the stats when multiple agencies are involved? (EMR)*

*Care coordination? It is a big gap, but who follows up? (SMR)*

The most common theme for additional strategies was *policy issues* (21 comments). About half of these comments were about funding issues, but some were not. For example, this group was concerned about the capacity to deliver coordinated care within a disconnected system with many service-providers:

*What is the interface with the commonwealth funded programs? How do we braid state/federal service 'culture' to achieve consistency? (Hume)*

Other policy issues discussed by groups included how the active service model was conceptualised and communicated:

*Emphasize a community development approach to reach pre HACC clients, or those with low level needs. (Hume)*

*Principles rather than prescriptive. (BSWR)*

More resources and the need for new funding models were recurring themes, among the written submissions as well as in consultation groups:

*Should be package of service \$s per client no matter where the services come from but there should be a lead agency. See disability funding model! Currently too cost shifting to make this work effectively. Money from disability funding should be accessible for client receiving HACC funding. (BSWR)*

*Support (\$) local development and training of the specific integrated model of care that incorporates the principles. Support (\$) the initial trialling and assessment of the local approaches. (Barwon Health)*

Almost as many groups mentioned evaluation:

*Build in evaluation ‘up front’ for ASM model and tools for measuring progress along implement in pathways. (Hume)*

*Consider and develop an evaluation plan and consider success factors along the way. (SMR)*

*How do you prove the positive outcomes? (Hume)*

The Municipal Association of Victoria supported the need for a comprehensive strategy including evaluation:

*Implementation strategy, with evaluation and performance measures built in from the start. Consideration of currently available and future development of measures to reflect stages of implementation and capture progress. (MAV)*

Planning issues were also recognised by several consultation groups, including the need for a timetable and a gradual approach to implementation:

*Allow time for conversations to take place to get everyone on board. (Grampians)*

*Important to prioritise “right things at the right time” otherwise things out of sync and certain things dependent on others. (SMR)*

*Clarify expectations of time lines. (BSWR)*

Aged and Community Care Victoria also recognised the need for a timetable:

*A specific timeline and plan needs to be defined – and factored into individual agencies timeframes. (ACCV)*

The theme of care coordination and its implications for service coordination were mentioned by several groups:

*Need for care coordination to be an integral part of service provision. (EMR)*

*Reporting/feedback mechanisms inter and intra agency need to be solid. (Grampians)*

Targeting was another issue that overlapped with planning:

*Identification of target groups initially – recognition that different groups need to be addressed in different ways e.g., start with new referrals. (Grampians)*

*New clients accept better than existing clients. Dependent on client need for complexity of assessment. (SMR)*

The MS Society mentioned the special case of younger HACC clients whose needs may not be met by service-providers:

*Specialist assessment for the people who are in the younger end of the HACC population (not frail elderly) who are living longer and will be spending more time in the community rather than being admitted to residential care. Some ACAS Teams are reluctant to assess clients in*

*the younger age bracket, and many case management agencies will close their books to providing packages to clients under 65 yrs. (MS Society)*

Once again, training was mentioned as a strategy. One group suggested that staff in tertiary institutions could be used to support assessment and direct care staff:

*Look at extending partnerships to TAFE/Universities – within the Allied Health Care, e.g., OT support the person who could work with clients and assessment agencies, mentored by Allied Health and OT Physio/OT/Health Promotion/Nursing. (Hume)*

Small numbers of groups linked strategies to assessment and infrastructure, for example:

*More info on the Assessment required. (Hume)*

*Affordable allied health in addition to timely and responsive access to same services for ongoing gains. (NWMR)*

The MS Society also suggested strategies to improve the performance of some HACC services:

*More creative ways of combining Social Support and Meals on wheels could be looked at; that is, opportunities should be given to individuals to be matched appropriately by agencies into small groups to have meals together on a regular basis, in generic community settings. (Current thinking is that people who eat alone are less likely to enjoy their food, thus they are more prone to have poor nutrition). This could happen in local pubs cafés or clubs that cater to their tastes in culture and cuisine. This would give people an opportunity to meet new people and to link back into their local community. They could be given choice as to whether they prefer lunch or early dinner. This is an extension of the voucher system but with more agency support as many people do not have the ability to plan and organise their social outings. (MS Society)*

### **2.3 Priority order**

Some groups (n = 27 altogether) were able to specify priorities, but most did not address this question. The analysis examined which strategies were mentioned regardless of order, and which were specified as having top priority (see Table 7). However, the results of the two analysis strategies were virtually identical. In order, the strategies mentioned as having priority (including only those mentioned by more than one group) were:

1. Cultural change/education
2. Financial/resources
3. Staff training/education
4. Getting the assessment right
5. Self-audit tool
6. Demonstration project
7. Workforce / capacity building
8. Partnership development
9. Evaluation.

When strategies were ordered by the number of times they were given first priority, the only change was that financial/resources headed the list, with cultural change/education second. Using either analysis strategy, the third top priority was staff training/education.

Most responses were highly telegraphic, so it is not possible to tell exactly what was meant by some of these priorities. Some of them appear to overlap but without more detail it is difficult to know whether these refer to the same thing or to different things. For example, staff training/education could be the same as to workforce/capacity building, as it appears to be in this priority list from a Grampians group:

1. *Assessment framework implementation decrease partnership arrangements*
2. *Self audit tool – agency/community*
3. *Develop communication strategies – staff- clients*
4. *Education and training*

In contrast, in the following example (from a Hume group) it is clear that education refers instead to the communication strategy:

1. *Top priority – financial resources right mix*
2. *Cultural change education*
3. *Getting the assessment right*

Written submissions tended to present broader priorities than the strategies presented in the ASM discussion paper. The Municipal Association of Victoria presented a case for taking a wider perspective:

*In context of Council of Australian Governments (COAG) proposals to streamline special purpose payments and achieve clearer accountability for aged care, with possible separation of accountability for disability and aged care - what is the best model of achieving better accountability and integration of aged care/community care planning and provision without losing momentum, innovation and uniqueness of HACC in the Victorian service system? (MAV)*

In contrast, the Multiple Sclerosis Society's first priority was:

*Specialist Assessment for the HACC target group who are diagnosed with a chronic illness (especially neurological) so their needs are met in a timely manner. (MS Society)*

The RDNS suggested the following priorities:

1. *Review and evaluation of the current ASM pilots.*
2. *Development of resources and workforce training and development*
3. *Collaboration between service providers. Unity of purpose and approach is mandatory.*

## **Individual response: Local priorities for implementation**

Participants at the HACC funded service provider consultations were invited to provide feedback on the question:

*For your organisation and community, what do you think is the top priority for action in delivering the Active Service Model initiative?*

Over 500 comments were collected from 183 individuals. These comments were coded by theme and subtheme. (Themes and subthemes are listed in Table 8. Again numbers are provided in this table only so that the most common responses can be identified, given that themes and subthemes overlap.)

Although respondents were specifically instructed to list local priorities, the largest response category was the need for state-wide leadership on a range of issues. This theme was labelled *Policy and*

*implementation. It covered a range of sub-themes, with particular emphasis on the communication/information strategy (60 comments). Some respondents focused on the need for a general culture change, while others mentioned specific subgroups, such as clients and consumers, carers, GPs, and other sectors:*

*Communication strategy needs to be targeted at the population level, as it is not just our HACC consumers who need to understand the model. (Gippsland)*

*Information, communication and education of assessment staff, care workers, clients, carers and families on the ASM and what it means in reality. (SMR)*

*Information (consistent message) across all stakeholders especially GPs. Education (cultural change) with agencies as well as other stakeholders. (Hume)*

A second sub-theme was about *service coordination and partnerships* (45 comments). Suggestions were made on how DHS could take a lead:

*I feel you should begin to have a closer alliance with Disability Service and determine where common funding can be applied to HACC. (BSWR)*

*Establishing community partnerships formally, to achieve goals of ASM. (EMR)*

*Collaboration within the service sector is important; however, there should be collaboration within DHS between departments to facilitate a person-centred approach. (NWMR)*

*Feel it's a respectful, empowering model, however, responsibility needs to be shared by state, community and service providers in principle of partnership. (NWMR)*

*The change is a way for working but the danger in promoting the "how to work" is that the model of care is set and may not fit with local services mix or integrated care. (BSWR)*

The second major theme, with almost as many comments (n = 196), was *Staff training and roles*. The need for education and workforce development accounted for the bulk of comments under this theme. Several respondents mentioned specific groups—especially assessors, but also allied health and community care staff:

*Intensive education for assessment staff as they will become the pivotal point for ASM and the success of moving into this model. (Grampians)*

*Up-skilling of direct care staff as services are brokered or sub-contracted. (Gippsland)*

Several comments focused on staff roles and functions. Again, assessment staff received most of the attention.

*Separation of assessment and care coordinator positions. (Hume)*

*How does assessment work with Community Health and manage conflicts of priority? That is, priority of need for increasing abilities (e.g. dusting) leading to a decrease in HACC service provision vs. priority of CHSs for Allied Health (e.g. risk of falls/risk of hospitalisation). (EMR)*

Many people wanted to see staffing levels increased. A particular concern mentioned in several of the regions was the lack of allied health support:

*Availability of Allied Health staff (5-6 week wait for OT).*

Some people suggested that new jobs were required to assist in the implementation of the ASM, or to take on care coordination with an ASM focus:

*Local level – dedicated project worker to assist initial roll out. (Gippsland)*

*Concern that assessment agencies will be required to pick up more de facto case management (care coordinator) that must be resourced. (Hume)*

The third major theme was *Funding and funding models* (n = 99). Many people insisted that more resources were required to fund a range of activities, including general implementation of the model, and more specific activities such as staff development, change management, service coordination, extra staff positions, transport, and extra services (e.g., planned activity groups).

*Funding – increased resources and flexibility with aim of delivering flexible, accessible and appropriate services. (SMR)*

*Responsibility of government to provide adequate funding to enhance and develop the ASM. (NWMR)*

Some of the written submissions supported the need for extra resources and funding:

*Additional funding needs to be provided to make it all happen. (Western Health)*

Finally, several comments were about a variety of more specific local issues, such as management, IT requirements, transport, rural issues, and client groups (n = 74). The consultations in Loddon Mallee Region and the Southern Metropolitan Region were particularly concerned with consulting Indigenous and CALD communities, and questions on how the model might apply to these groups of clients. Rural areas often mentioned transport as a barrier to implementation.

## Summary of feedback from the HACC funded service provider consultations

The priorities listed by the participating groups and through the individual responses (local priorities) were very similar, and in fact many respondents did not differentiate between local issues and broader concerns. The main messages from the HACC funded service provider consultations included:

1. Significant support from the sector for the principles and approach proposed in the ASM discussion document.
2. That many service providers already come to the ASM with significant strengths including: examples of innovative practice and programs; partnerships with other key agencies; evidence of client centred practice; and enthusiasm for the ASM approach.
3. The need for financial support to further the implementation of the Active Service Model at the local level. This included support for specific initiatives (e.g., to employ more staff from the allied professions); to free up staff time (e.g., more time for assessment and care coordination); and to assist with the change management and implementation process.
4. That staff training and workforce development should be a priority (at both the state and local levels).
5. Encouragement for DHS to develop resource materials for the sector such as the Audit Tool, and conduct a communication strategy with clients, carers, and other service-providers.
6. Support for DHS to develop an overall evaluation strategy prior to implementation, to measure change and outcomes as they occur.
7. The importance of involving other services and sectors to support coordinated restorative client care (e.g., GPs, the acute sector, the Aged Care Assessment Program (ACAP), and other providers).
8. The need for a more exploration of the ASM approach for people from a variety of cultural backgrounds, including Indigenous Victorians.
9. That the current reporting and funding model does not fully support the implementation of the ASM and would benefit from review.

## Appendix 1: Examples of good practice

Examples are provided below from the consultation groups first, then the responses via written submissions.

### *Hume Region*

- Six week ‘Look good, feel good, eat well’ program
- Educating home care workers on ASM
- RCOW and Ovens & King working together
  - Joint visits / care planning with occupational therapist
  - Trialling equipment
  - Regular meetings on progress
  - Short term / regular reviews
- Education re: empowerment through Healthy, Wealthy and Wise program (e.g. Katamatite)
- Swimming program
  - Socialisation
  - Physical outcomes
  - Health promotion
- MHA – designated assessment provider for new assessment model
- Community development activities; e.g., Youanmite History Group
- City of Greater Shepparton
  - 12-week active service program
  - Case manager
  - Educate re basic living tasks
- Healthy, Wealthy & Wise with VMFC Wodonga. Carers develop skills – pass on to care recipients
- Developed kit – respite. Workers take into clients home assist with exploring healthy activities / options
- Mitchell – client accessing 72 hours HACC services
  - re education of client and family
  - positive feedback from client and direct care staff
  - service now 2 hours per work and shortly 2 hours
  - motivation for agency – unable to supply hours
  - motivation for client – realise service will be reduced
  - 6 weeks to change
  - Eventually no service

### *Loddon Mallee Region*

- Active HACC PILOT PROJECT
- Loddon Mallee Housing – integrated service

- Community connections program HACC funding. Housing support for the aged
- Active Health Mc Ivory – only funded project, need to sustain
- Mt. Alexander hospital – carer initiated program
- Foot care program at Campaspe

### ***Barwon-South Western Region***

- Southern Grampians Shire community takes clients to strength and balance training
- Colac Otway Shire (COS) – ditto plus lunch in local (in local gym)
- Moyne – strength training in local gym. (need a bigger gym now)
- Moyne Shire ID clients life skills reading and writing, shopping, cooking, bowling club, swimming
- Men’s Sheds Moyne PT, Hamilton Fairy, Colac Otway
- Scooter plug-in sites around town – Port Fairy
- Centre-based meals with client pick-up for social connection C.O.S.
- Barwon Health Council assessment officer working within acute sector – discharge planning services.
- Brotherhood of St Laurence – Restorative Practice – self-identifying
- Community skills bank
- Project work, mentoring (WCC)
- Positive aging process (WCC) DIY information sessions

### ***Eastern Metropolitan Region***

- Manningham Council/Doncare social support
- Community Kitchens/Buses/Gardens (Golden Wattle)
- Partnership with Leisure Centres/YMCA/U3A/Universities- student placements
- Employing professionals to run programs i.e. Artists/MS
- Men’s Shed
- Well for Life and Strength Training in PAGs
- Small Group activities – some people removed from main group
- Three-page leisure and rec. assessment
- Co-location with Seniors’ Centres (BWA)
- Hands up to do demonstration project in partnership with other CSO
- PAG and other services
- MECWA- Nursing/HC initial assessment and then one- on- one central point
- Wagner model → chronic disease
- RDNS - Active Service Model project: “incontinence” project
- Yarra Valley Community Health - Integrated HACC within Aboriginal Health
- Excellent partnership with M.I.C.

### ***Grampians***

- St Arnaud – PAG – involve services in PAG. Goal setting – planning
- Inter-agency co-operation between Dist Nursing and Ararat HACC

- Pyrenees Shire social planning in assessment
- HARP program
- Hindmarsh L.G. – support to Horsham RCC
  - Prepare meals in the home
  - Client assists with housework
  - Take client shopping, don't do it for them

### ***Southern Metropolitan Region***

- Publication of resource manual for older adults for clients and other agencies
- Dial a bus service/programs
- Joint home visits between council and FCHs looking at increasing ADLs
- In PAG and other services groups encouraging clients to get involved in activities they previously engaged in and letting them 'drive' the activity
- Lifelong movers to focus on wellness
- Well for Life/strength training
- Transition programs – *socially isolated* mainstream communities
- Cooking programs – socialisation, healthy eating
- Life skills program
- Life Project (Casey & Clts)
- Cooking Project (Casey)
- Life long movers (Casey) strength (southern health) training
- Presentations with a Facilitator
- Carers working with individual clients (GD).
- MRC Spanish PAG working on positive aging art project with Casey Council. Increasing awareness/participation
- Implementing exercise program within CGD PAG
- MECWA/CGD – Café Meals as alternative to MOWs

### ***North and West Metropolitan Region***

- Health promotion projects e.g. falls prevention. Well for Life
- Seniors Go for Your Life
- Darebin CHC 'Chronic Disease Management Project'.
- North Yarra Community Health and City of Melbourne OT working with assessment worker.
- Men's group, City of Yarra
- HARP re partnership
- CALD/ATSI – Cultural concepts of "the elder" related to service provision.
- Joint assessment/follow up with NYCH of ASM project
- RDNS/Banyule – continence focus
- Moreland – ergonomic equipment. Efficiency/style
- Volunteer programs – social inclusion, connectedness
- HARP and Disease management and self-management
- Chronic disease programs e.g., intervention in C.D.

- Neighbourhood renewal
- Partnership between DCH and DCC re providing timely OT assessment
- Well for Life
- Flexible response to ACES.
- Maribyrnong – WRHC, physio, Victoria University, strengths training, Water exercise.
- Make a Move

### ***Gippsland***

- Strength and conditioning strengthening exercise program
- B.B.S partnerships Tai Chi
- Client focused care plans – meeting true needs
- Dining out group
- Community kitchens
- Falls prevention
- Strong active/communities networks
- Community forums
- Proactive service providers to embrace theme's
- Info shared across agencies and LGAs networking

### ***Brotherhood of St Laurence***

As indicated above, BSL is very much aligned to the Active Service Model. It has developed its programs to incorporate aspects of the approach regardless of whether they are HACC funded. BSL is in the process of considering further development of this approach.

BSL has developed a Socialisation Program which has been in operation for over three years to combat the social isolation experienced by older people and people with a disability. This program reflects the principles outlined in government's Active Ageing Framework, Well For Life and Go For Your Life campaigns for which it has gained funding. Partnerships with business in the local community, RDNS, local councils and private service providers have generated social community hubs of friendship, physical activity and nutrition.

Evaluation of the Socialisation Program showed an increase in several components that constitute quality of life. It was reported that there were fewer medical and hospital instances from the participants of the program since their participation in the program.

BSL has partnered with a private service provider, local hospitality business and RTO to develop training for personal carer workers in the provision of low-cost nutritional meals that are prepared in the client/carer home. The client and/or carer participate in the preparation of the meals.

Although an extension of the proposed Active Service Model, BSL also has incorporated ways that clients/carers are able to participate in citizenship and advocate for themselves in respect of issues that are important to them. This is also a way of impacting positively on health and wellbeing. Some examples of this are assistance with communicating with politicians prior to the last Federal Election, campaigning for disability access to local community venues, improvement in service from taxi drivers, wheelchair access within community, issues with paid carers, submission by Carers for Government Funding, involvement in feedback for the Victorian Dementia Framework and the recent Federal Inquiry to Review Better Support for Carers.

**Barwon Health**

- Implementation of Partners in Health framework across the Community Health Division.
- Implementation of the Community Health Assessment, Care Planning and Evaluation guidelines across all service areas in Community Health.
- COPD pathway project – patients being referred from The Geelong Hospital who are provided with District Nursing support visits on discharge to settle them back into their home environment.
- Safe Assessment
- Access and availability of Quickscreen assessment clinics within our Allied Health Service
- Processes to support patients being discharged into the community from the Rapid Assessment Unit at The Geelong Hospital is currently being developed
- BH support a City of Greater Geelong assessment role collocated within the hospital-based Home Referral Service
- Integrated interdisciplinary and multidisciplinary service teams that pool funding streams and focus on comprehensive clients needs rather than funding “exclusion criteria”
- Clients have access to local Better Health Self-management courses and groups targeted at specific chronic conditions such as the Diabetes Group program, and these are run locally across the three main community health sites.

***Multiple Sclerosis Limited***

- MSL’s current service framework is underpinned by a **self-management approach** to health and wellness.
- Engagement commences with a **comprehensive holistic assessment** and person/family-centred planning process.
- Assessment considers all life areas, uses a strength-based approach and aims to identify life areas that can be strengthened / maintained.
- MSL provides a range of short-term intensive education, health promotion, case management and allied health supports as well as longer-term socialisation, health promotion and peer support programs to help our clients achieve their individual goals.
- MSL current strategic objective is to expand all service options to rural/regional areas. MSL has recently developed and established Physical Activity/ Social Support Programs in the **rural centres** of Colac, Hamilton and Warrnambool with the support of Barwon South Western DHS regional HACC funding.
- MSL values strong **collaborative partnerships** with all key stakeholders engaged with the client. These partnerships facilitate a joint understanding and commitment to the individual/family goals.
- The Confident Living Program is currently expanding its **Physical Activity programs**. We were able to train 4 staff in Cert 111 in fitness with funding received through the Well for Life Initiative. This has allowed us to offer Physical Activity opportunities to our clients. Working in partnership with community leisure /recreational staff, CLP staff support small groups of clients attending their local Leisure Centres on a weekly basis to engage in gym and aquatic programs. We combine this with a social support component where the participants are able to enjoy socialisation and relaxation time after completion of their program, with fellow attendees.
- We have worked in **partnership** with the Leisure Centre fitness staff to manage these small groups, giving our clients an opportunity to partake in community programs on an ongoing basis.
- Clients who would normally be excluded from HACC programs because of complex care or behavioural needs may, in fact, have their special needs addressed (and be able to be integrated

into programs) if additional funding was available to employ a competent carer to accompany them at all times, to enable them to participate in program initiatives. **Families cannot avail themselves of specialised carer support services without additional funding.**

### *Royal District Nursing Service*

The following projects and practice within RDNS are good examples of ASM principles:

- Participation in two pilot ASM projects (North & West Region) RDNS/MAV Active Service Model Project: Caring for Continence
- Participation in an ASM initiative with City of Greater Dandenong ASM/Living at Home Assessment/Functional Assessment Project
- Implementation of the HACC Assessment Framework which incorporates the ASM principles
- Development of a clinical care model for continence clients by the CLG which imbeds the principles of ASM
- Share care arrangements with other HACC providers such as local government
- RDNS services are provided 24 hours a day, 7 days per week, based on client need.

### *Western District Health Service*

Involvement in COAG LSOP, which is designed to maximise the health of older patients during their stay in hospital. By doing some regular moving and exercise patients can recover faster and prevent complications occurring as a result of being less active while in hospital. The program aims to promote patient independence and to avoid lack of confidence in carrying out tasks of daily living which can occur during a stay in hospital.

The results of this program can have enormous positive impact on HACC case planning and service delivery once the client is discharged from hospital.

Similarly, the Service's Rehabilitation, HARP and Chronic Disease Management programs also focus on capacity building, autonomy and building independence. The delivery of services under the HACC Active Service Model would support these programs very well.

## Appendix 2: Tables

**Table 2: Key Strengths**

<b>Strengths within the current system</b>	<b>Total number of groups</b>
<b>Strength 1. Staff and team strengths</b>	<b>66</b>
a. Staff knowledge, experience and skills	30
b. Positive staff attitudes/staff qualities	18
c. Supporting and training staff	5
d. Existing multidisciplinary teams and approach to care	13
<b>Strength 2. Existing relationships/partnerships</b>	<b>63</b>
a. Collaborative relationships between service providers	47
b. Relationships with consumers and communities	14
<b>Strength 3. Existing strategies for working with clients</b>	<b>48</b>
a. Client-centred models of care (individual care plans/goals/reviews)	16
b. Family-centred approach	1
c. Holistic approach to assessment and/or service provision	13
d. Restorative approaches/rehab philosophy	9
e. Flexible service provision	19
f. Ethno-specific service provision	1
g. Existing practice reflects ASM approach/Wellness Model	19
<b>Strength 4. Organisational strengths</b>	<b>18</b>
a. Co-location of teams	7
b. Strategic/ageing well/positive ageing plans	5
c. Other organisational strengths	6
<b>Strength 5. Community strengths</b>	<b>6</b>
a. Volunteers	4
b. Community characteristics	2

**Table 3: Barriers**

<b>Barriers and key areas to work on</b>	<b>Total number of groups</b>
<b><i>Barrier 1: Staffing issues</i></b>	<b>64</b>
a. Staff expectations/attitudes/work culture	11
b. Current staffing levels	14
c. Staff skills/training/workforce development	39
<b><i>Barrier 2: Community, consumer and other stakeholder issues</i></b>	<b>57</b>
a. Changing client and family expectations/resistance to change	50
b. Attracting and training volunteers	4
c. Explaining ASM to GPs	3
<b><i>Barrier 3: Funding issues</i></b>	<b>52</b>
a. Restrictions of current funding structures/lack of funding	41
b. Increase in staff skill level will require increase in pay levels	2
c. Money for programs that support ASM	9
<b><i>Barrier 4: Aged care sector issues</i></b>	<b>31</b>
a. Issues for organisations	12
b. Pathways between sectors	4
c. Interagency communication	15
<b><i>Barrier 5: Time</i></b>	<b>31</b>
a. Additional time to deliver services	21
b. Time required for implementation of change	10
<b><i>Barrier 6: Risk management and safety issues</i></b>	<b>5</b>
<b><i>Barrier 7: Information management</i></b>	<b>9</b>

**Table 4: Resource for ASM**

<b>Resources required</b>	<b>Total number of groups</b>
<b>1. Funding</b>	<b>89</b>
a. Funding for staff	36
b. Funding for programs	24
c. Funding for equipment	7
d. Funding for transport	9
e. Funding for administrative support	3
f. Funding for IT support	10
<b>2. Staff training &amp; support</b>	<b>83</b>
<b>3. ASM promotion campaign</b>	<b>36</b>
a. Community Education	15
b. Marketing and communication in health and aged care sectors	21
<b>4. Tools and documentation</b>	<b>30</b>
<b>5. Time</b>	<b>9</b>

**Table 5: Responses to implementation strategies**

Themes	Total number of comments
General support	34
1.1 Self-audit tool	39
1.2 Training and workforce development	49
1.3 Communication strategy	40
1.4 Share good practice	17
1.5 Flexibility in funding and reporting	11
1.6 Strengthen assessment	39
1.7 Review resource requirement	8
1.8 Strengthen partnerships	17
1.9 – 1.10 Stronger links	22
1.11 Forum for consumers and carers	11
2. Demonstration projects	24
3. New directions	12

**Table 6: Additional strategies**

Themes	Total number of comments
Policy issues	21
Funding	11
Evaluation	10
Planning	8
Care coordination	8
Targeting	5
Training	5
Assessment	4
Infrastructure	4
Communication strategy	3

**Table 7: Priority order**

Themes	Ratings											
Cultural change education	2	1	4	2	3	3	2	4	2	1	1	1
Financial resources right mix/ resources	1	1	3	1	1	1	1	2	1	2	2	
Training/education	3	3	1	1	4	1	3	3	1	3	4	
Getting the Assessment right	3	5	1	1	1	4	2					
Self-audit tool	2	2	2	1	1							
Demonstration project	1	4	2									
Workforce / capacity building	1	4	3									
Partnership development	5	1	1									
Evaluation	3	1	4									
Indigenous and CALD Community to be included throughout	1											
Care plans	1											
Timeframes	1											
Emphasis on social support (ASM)	2											
Targeting	3											
Employ area project worker	4											

**Table 8: Local priorities**

Themes	Total number of responses
<b>1a. Funding</b>	<b>72</b>
a. Funding for staff training	16
b. Funding for new staff	10
c. Funding for equipment	8
d. Funding for transport	9
<b>1b. Funding models need review</b>	<b>30</b>
<b>2. Training, staff roles and other workforce issues</b>	<b>196</b>
a. Training, workforce development	108
b. Workforce recruitment and retention	5
c. Assessment roles (and training)	63
d. Allied health (need for, training)	36
e. Need for program coordination staff	2
f. Case management / care coordination (need for more staff)	9
g. More staff (general)	10
h. Professional roles need attention	2
i. Volunteers (roles, training)	2
<b>3. DHS support, policy and provision of materials</b>	<b>244</b>
a. Communication, information strategy	60
A1. Culture change	21
A2. Attention to clients, consumers	13
A3. Attention to carers	15
A4. Attention to GPs and other sectors	20
b. Incorporate more flexibility	15
c. Encourage service coordination and partnerships	45
d. Self audit tool (need for)	10
e. Evaluation	8
f. Pilot / demonstration projects	4
g. Other implementation comments	43
<b>4. Other infrastructure and local issues</b>	<b>55</b>
a. Management support required (including change management)	6
b. IT required	8
c. Reporting requirements (HACC guidelines)	5
d. Rural issues (costs)	3
e. Transport	9
f. CALD/Indigenous	31

## Appendix 3: Written Submission Form

### Victorian HACC Active Service Model Discussion Document Feedback Form

#### Department of Human Services

Aged Care Branch

Rural and Regional Health and Aged Care Services Division

#### Purpose of Document:

This document has been developed to enable you to submit individual feedback to the consultation process underway in May/early July 2008 for developing an implementation plan for the HACC Active Service Model.

#### Background

The Active Service Model is a quality improvement initiative which explicitly focuses on promoting capacity building and restorative care in service delivery.

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

The discussion paper is acting as the basis for a series of consultations with HACC funded service providers and peak bodies through late May and July 2008. The aim of the 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.

#### About the Feedback Form

This pro forma details the key questions from the discussion document for your individual response. You can complete all or part of the form. There is no expectation that all questions will be answered.

If you wish to complete the form, please download and either:

- Fill in electronically and return by email to [kris.mckie@dhs.vic.gov.au](mailto:kris.mckie@dhs.vic.gov.au) (preferred method).
- Or send hard copy to Kriss McKie at Aged Care Branch, Department of Human
- Services, PO Box 4057, Melbourne 3001.

#### The closing date for submissions is 4 July 2008

For further information please contact either Kriss McKie on (03) 9096 7998 or above email or Meg Henderson on (03) 9096 2163 or email [meg.henderson@dhs.vic.gov.au](mailto:meg.henderson@dhs.vic.gov.au).

**Contact Details:**

<b>Name of Agency</b>	
<b>Address of Agency:</b>	
<b>Your Name:</b>	<b>Position title:</b>
<b>City/Town:</b>	<b>Postcode:</b>
<b>Telephone Number:</b>	<b>Fax:</b>
<b>Email:</b>	
<b>Lead DHS region:</b>	

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

**Implementation priorities**

1. What are the best elements of the models you have seen so far? (e.g., NZ Restorative Care; UK Enablement; ASM pilot projects; WATCH project)
2. What would be worth pursuing in Victoria and why?
3. Should the implementation steps outlined to date (in section 5 of the document) form part of the Active Service Model implementation plan?
4. What additional areas should be included in short term, medium term and long term?
5. What should the priority order be?
6. What change management support will your organisation need to put the Active Service Model into place?
7. Do you have any other comments?

**Thank you for taking the time to complete this form.**