

Victorian Triennial Plan

Home and Community Care Program 2008-11 Directions and Expenditure Priorities in Victoria

Aged Care Branch, Department of Human Services

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Introduction

Victoria's Triennial Plan covers the following issues:

1. Context
2. Needs analysis and building the evidence base
3. Consultation
4. National and Victorian reform and development directions
5. Priorities arising from reform and development directions
6. Victoria's approach to the Triennial Plan and regional distribution of funds over 3 years.

1. Context

The Home and Community Care (HACC) Program is a joint Commonwealth/State program that funds a range of basic maintenance and support services to support frail older people and people with disabilities to live independently and avoid premature or inappropriate admission to residential care. Carers of older people and people with disabilities are recognised as part of the HACC target group.

A Review Agreement in relation to the provision of financial assistance by Commonwealth of Australia to Victoria for the Home and Community Care Program 2007 (Review Agreement 2007) came into effect 1 July 2007. The key features of the new Agreement are:

- A focus on maintaining the independence of frail older people, younger people with disabilities and their carers in the community
- A commitment to developing systems to support HACC services to work together effectively to improve care
- Maintaining accountability while reducing administrative burden.

The HACC Program receives growth funding each year. The 2008-11 strategic directions will provide the framework for development over the triennium as well as an indication of how growth funds will be allocated between regions over that period, based on the Australian Government's Forward Estimates.

National Triennium

As part of the Review Agreement 2007, all jurisdictions agreed to implement a national triennial planning framework for the three years 2008-11.

Victoria has planned on a three-year basis since 2003, and is now making a transition from mid-way into its second three-year planning period of 2006-09 to the national triennium 2008-11.

2006-09 Priorities

Priorities informing the allocation of growth funds across 2006-09 were announced in April 2006. The overarching priority was a commitment to addressing relative funding inequity between regions. The commitment was to maintain relative funding per capita in all regions while improving the position of five under-resourced regions.

Within the equity framework, HACC Basic activities were prioritised for growth to:

- facilitate the national redevelopment agenda
- implement the assessment framework
- increase the HACC Program's effectiveness in maximising client independence through supporting a person-centred and capacity building approach to service delivery
- expand planned activity groups by up to 5% of the region's growth allocation.

The remaining priorities aimed to improve access to services for special needs groups:

- Priority 2 – to increase the quantity and quality of services for people from Culturally and Linguistically Diverse Backgrounds (CALD), to extend the Culturally Equitable Gateways Strategy (CEGS) and to grow planned activity groups (PAG) by up to 5% of the region's growth allocation
- Priority 3 – to increase and enhance access to HACC services for Aboriginal people.

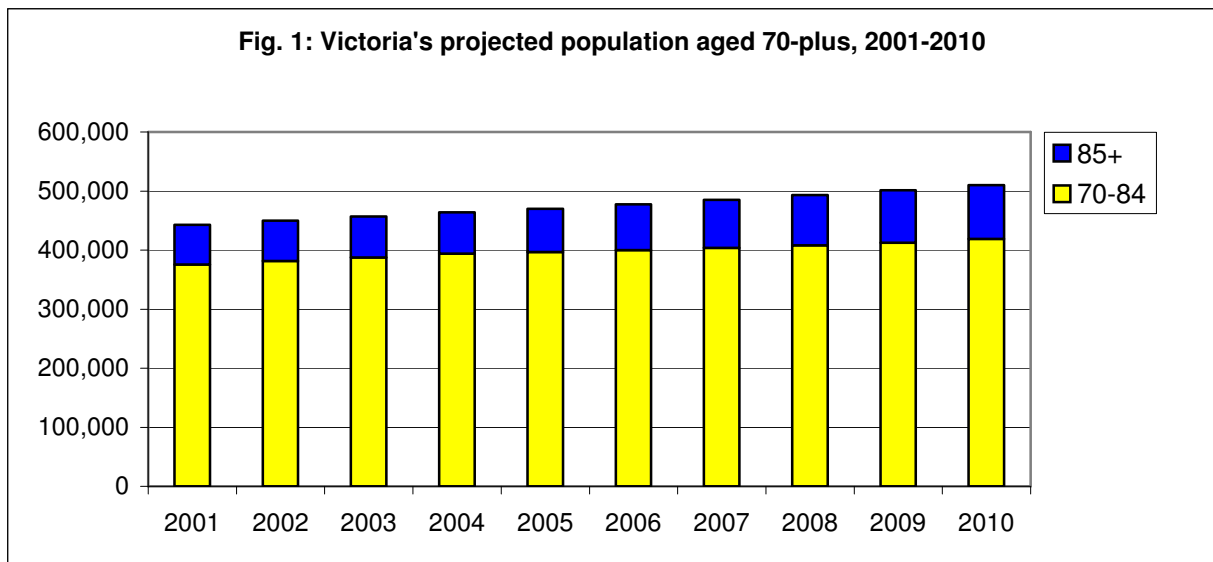
A review of the outcomes from the previous triennium (2003-06) was undertaken in 2005-06 as preparation for the development of 2006-09 priorities. Victoria is still in the middle of the 2006-09 triennium. This second triennium has seen considerable groundwork in the several assessment, the active service model, CALD access to services and capacity building for Aboriginal Community Controlled Organisations (ACCOs). It is too soon to undertake a comprehensive analysis of their impact.

2. Needs analysis and building the evidence base

A number of factors have influenced the development of priorities for 2008–11: demographic trends in ageing and disability, the national policy context, Victorian policy on Care in Your Community, and the progress made during the previous triennium on improving the situation of special needs groups.

Trends in demand

Growth in demand for HACC services is driven mainly by growth in the size of the older population, and by growth in the extent of disability among older people. The last decade has been characterised by a steady increase in the proportion of older people in Victoria's total population. This trend is set to continue, with a higher estimated rate of growth in the oldest cohort (people aged 85-plus). As shown in Figure 1, by 2008 there are estimated to be close to 500,000 Victorians aged 70 years or more.



Source: ABS Census 2001 with population projections

Measuring the HACC target population

Preliminary data from Census 2006 indicate that the 2003 Department of Sustainability & Environment (DSE) projections were not quite accurate. Population figures for 2006 have been incorporated in Victoria's calculations for the distribution of growth funding in 2008-09, shown in Table 7 in section 6 below. New population projections for future years will not be available until late in 2008. When they become available, all these calculations will be revisited. The Relative Resource Equity Formula, which estimates the HACC target population in Victoria and associated resource allocation methods will be subject to review during 2008. Estimated distribution of funds across regions for the two subsequent years will need to be recalculated, in the light of any changes.

Only a proportion of the Victorian population is in need of support services at any given time. This sub-set is described as the *HACC target population*. The HACC target population is defined as people of any age living in the community with a moderate, severe or profound disability who, in the absence of basic support services, would be at

risk of premature or inappropriate admission to long-term residential care or hospital admission. For the purposes of resource allocation, this is measured by the Relative Resource Equity Formula (RREF), which counts all people living in the community with disabilities up to the age of 69 and all people aged 70-plus. Although carers are also part of the target population, they are not counted separately; it is assumed that their need for HACC services is measured by the RREF.

Population projections for the triennium 2008–11 show that the largest absolute increase in the overall Victorian population will be in the 55-64 age group, followed by the 65-74 age group. Within these age groups, demand for HACC services will be chiefly driven by the increase in the number of people with a functional disability, whether this is due to a life-long disability or to conditions acquired with ageing or as a consequence of ill health.

Figure 2 is based on Census 2001 and the 2003 population projections from Victoria’s Department of Sustainability and Environment (DSE). It compares the projected population increases with the increases in the number of people with a moderate, severe or profound disability in Victoria. It can be seen that there will be an increase of about 15,000 people with a disability in the 75-plus age group, and 8,000 in the 65-74 age group, in the three years to 2011. This gives an indication of the likely growth in demand for HACC services during the next few years. Including all people of age 70-plus gives a growth in the HACC target population over this period of 41,000.



Note: Using whole-population rates for profoundly, severely & moderately disabled persons

According to Census 2001 and projections, little change was expected in the balance of rural and metropolitan populations during the period 2008-11. Overall, the non-metro proportion of the Victorian population was expected to decline by 0.1%, but the non-metro proportion of people aged 70-plus was expected to increase by more than 0.3% over the period. The 70 plus group contributes the greatest proportion of the HACC target population.

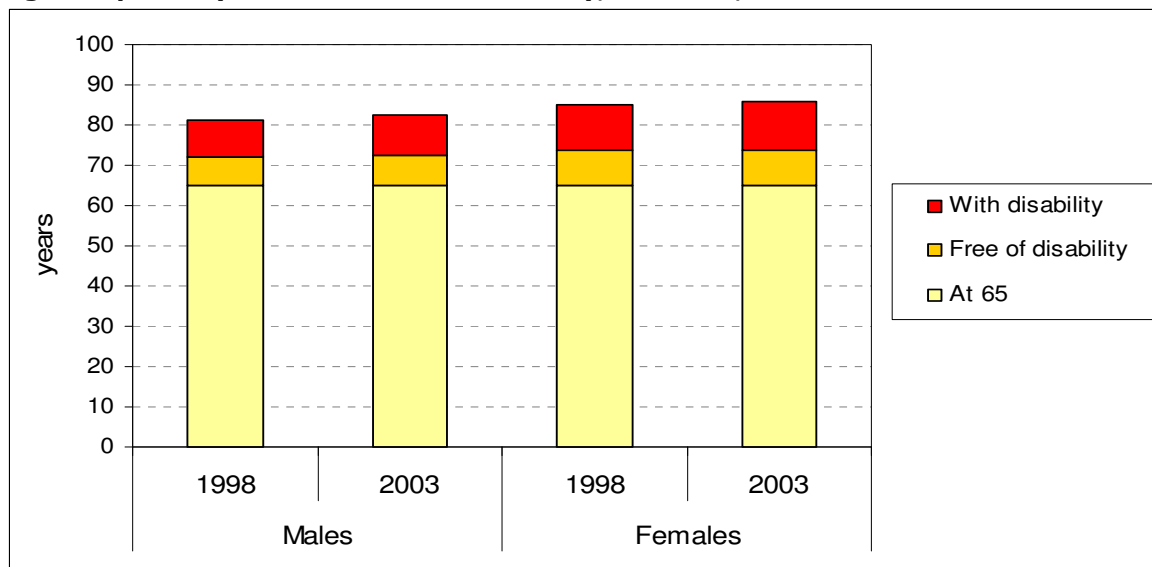
Trends in life-span and disability

There is some evidence that Australia’s increasing life expectancy will be accompanied by an increase in the number of years that a person can expect to have some degree of functional disability. This indicates that demand for HACC-like services can be expected to continue rising steadily.

Figure 3 shows that, for men at age 65 in 2003, life expectancy was 17.6 years. This was expected to comprise 7.6 years without a disability, and 10.0 years with a moderate, severe or profound disability. On average, females aged 65 could expect to experience 12.2 years with a disability (but only about 3.4 years with a severe or profound

disability). Between 1998 and 2003 there was an increase in total life expectancy, for both men and women. However, there was hardly any increase in the expected additional years free of disability, particularly for women.

Fig 3: Expected years of life with a disability, Australia, 1998 and 2003



Source: AIHW Life expectancy and disability in Australia 1988 to 2003, Table 1. Disability series, 2006.Cat. no. DIS 47. Canberra: AIHW.

Client numbers

Nearly 245,000 Victorians received a service from the HACC Program during 2006-07. Client numbers have been growing at around 5 percent a year for the last four years. Between 2002-03 and 2006-07, according to the MDS, the number of people receiving a HACC service rose by 19 percent. See Table 1.

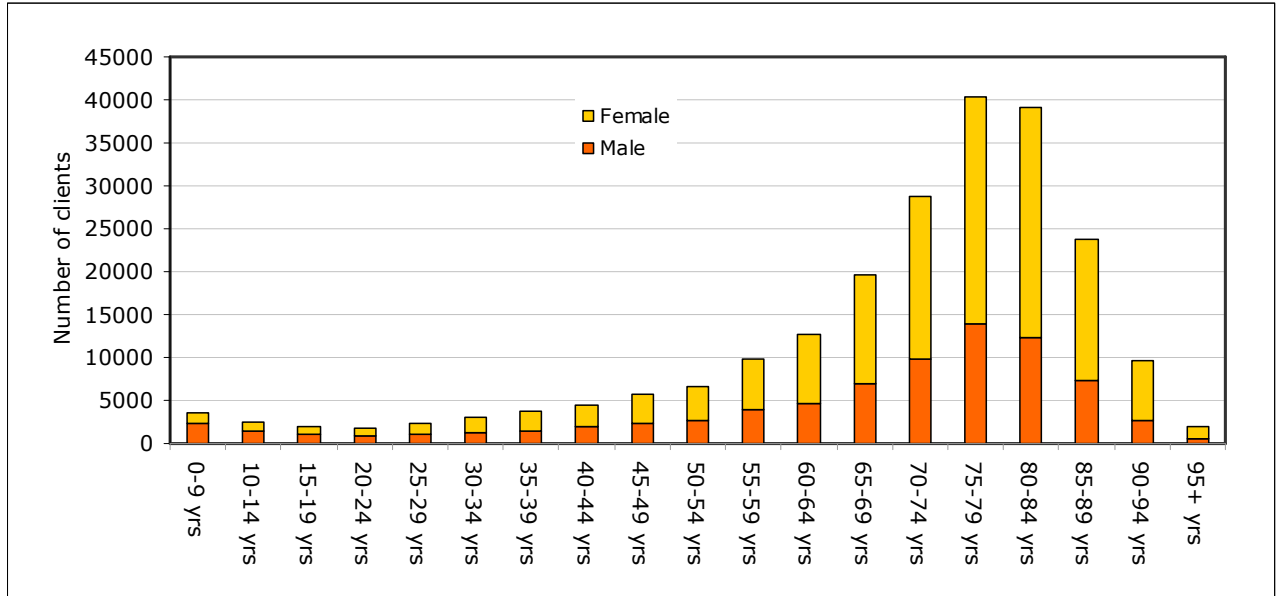
Table 1: Number and age range of HACC clients in Victoria

	2002-03	2003-04	2004-05	2005-06	2006-07
Under 20	7,660	8,103	8,026	8,227	9,597
20-54	25,081	27,692	28,879	29,854	30,548
55-69	34,115	36,728	38,656	43,251	43,432
70+	136,218	141,358	144,724	145,611	160,882
Total	204,450	216,257	222,393	229,128	244,459
Annual growth (%)		5.8	2.8	3.0	6.7

Approximately 64 percent of HACC clients are female. Females outnumber males in all age groups, with the exception of children and young people under 20. Above age 65, women outnumber men two to one. The preponderance of women as HACC clients is the result of the conjunction of three demographic factors: the fact that older people who live alone are more likely than couples to require home care services; the fact that female life expectancy is longer than male life expectancy; and the fact that women tend to marry men a few years older than themselves, which increases the chances of being widowed.

Table 1 also includes some 10,000 people each year who received services because they were the carers of people in the HACC target group (apart from the roughly 50 percent of all HACC clients who have carers).

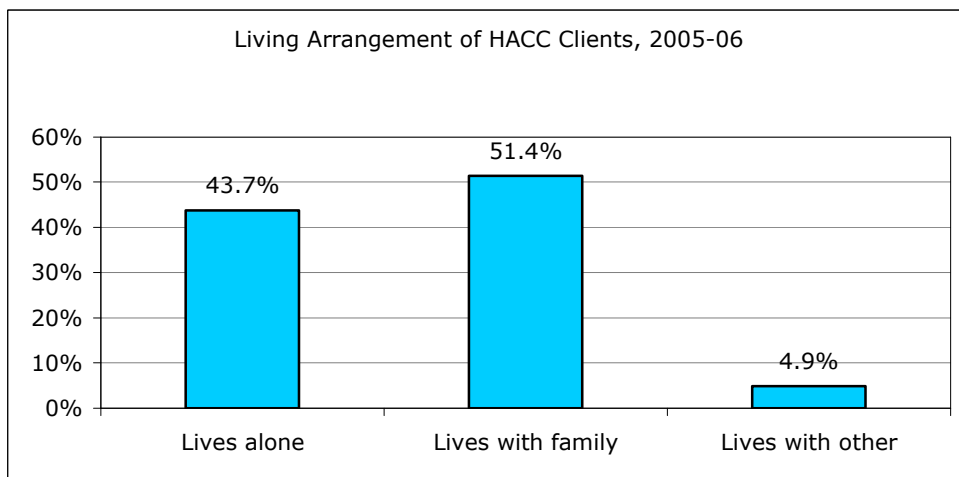
Fig. 4: Age range of HACC clients in Victoria 2005-06



Client living arrangements

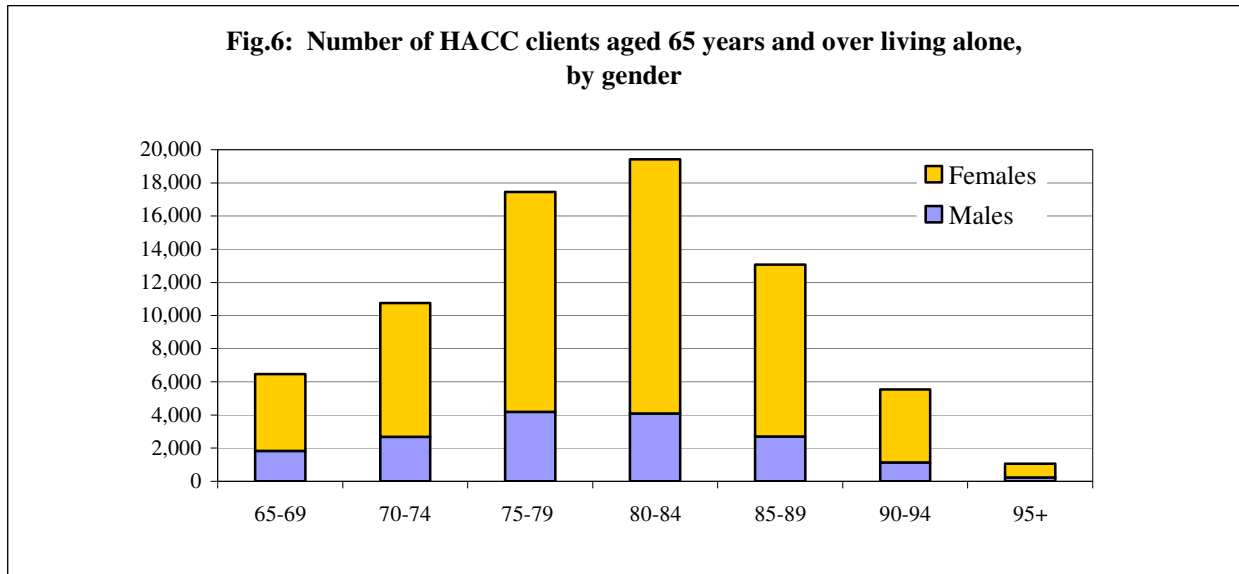
Planning for the next triennium will need to take account of two principal components of the target population in terms of living arrangements: people living alone, and people living in rental accommodation or rooming houses. As shown by Figure 5, fifty-one percent of clients live with spouse or other family, 44 percent live alone, and 5 percent live with other people.

Figure 5: Living arrangements



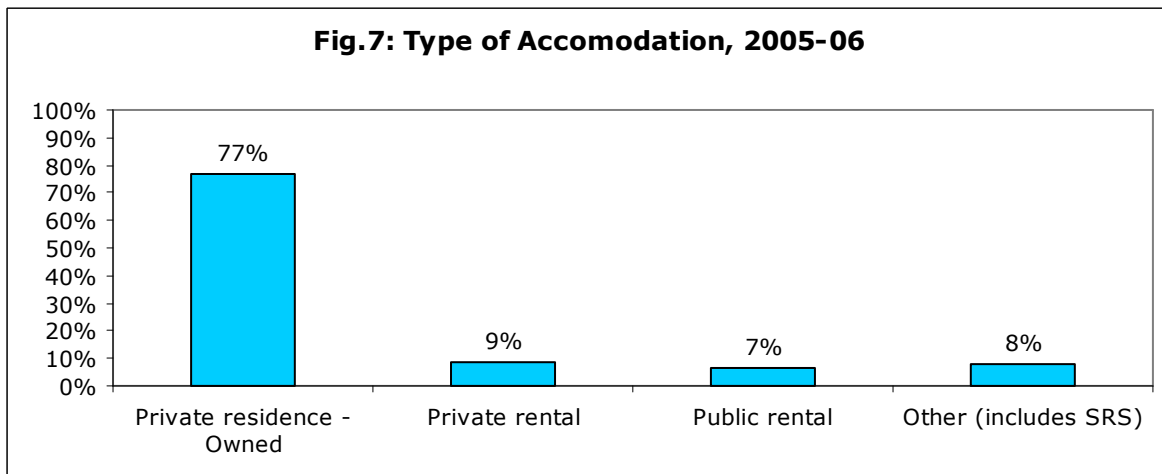
Note: Missing data excluded

For planning purposes, it is important to note that the proportion of HACC clients living alone rises steadily with age. At the age of 80 years, 50 percent of clients are living alone. At age 90, an even higher proportion—60 percent—live alone. See Figure 6.



Clients in rental housing

Nearly 77 percent of HACC clients live in owner-occupied dwellings. Another 16 percent live in rented housing, split evenly between public rental and private rental. 'Other', with 8 percent of clients, includes rooming houses and supported residential services. Clients in the 20-54 age group are the most likely to live in rented accommodation. See Figure 7, excluding 14 percent Not Stated.



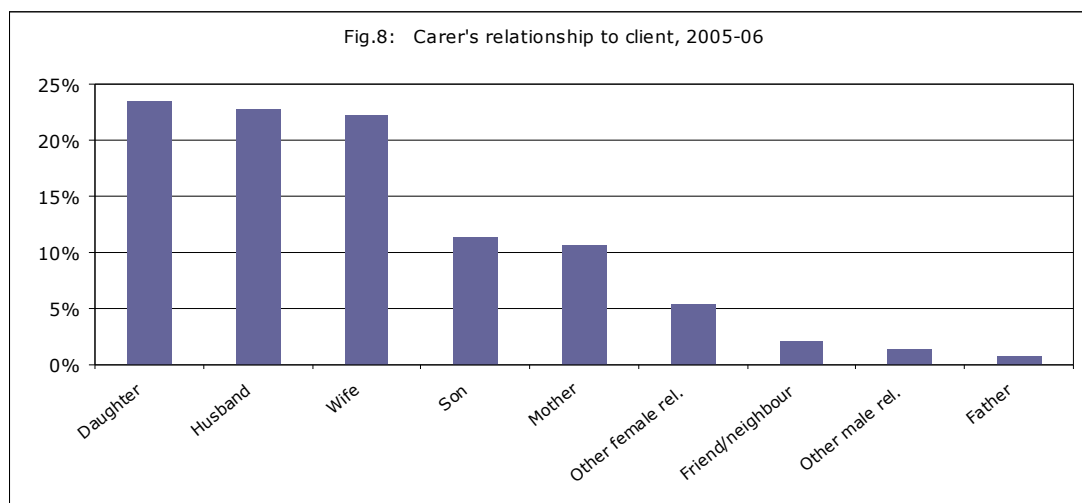
Caregiving arrangements

Family carers and caregivers who are friends and neighbours are an essential part of the community care system. The role of the HACC Program is to find the most effective ways of supporting these 'informal' caregiving arrangements for the benefit of frail aged and younger disabled people. In Table 2, it can be seen that about 50 percent of clients have a carer.

Table 2: Existence of a carer

	2002-03		2003-04		2005-06	
	Number	Percent	Number	Percent	Number	Percent
Has a carer	82,533	40	102,396	47	107,204	47
Has no carer	86,579	42	85,671	40	93,132	41
Missing data	35,338	17	28,190	13	26,688	12
Total	204,450	100	216,257	100	229,128	100

Relationship of carer to care recipient



Where a client has a carer, the carer is most likely to be a spouse/partner (43 percent of cases) or a daughter (24 percent). In many cases a client would have more than one carer, but the data only allows one carer to be identified. In Figure 8, missing data has been excluded.

Special needs groups: CALD

The HACC Program needs to continue to cater for consumers drawn from a wide range of cultural backgrounds. In 2005-06, some 22 percent of clients came from over 85 different non-English speaking countries. The proportion of people from non-English speaking countries has been fairly stable since 2003-04. Italy continues to account for the largest number of such clients (a quarter of all clients from non-English speaking countries).

Table 3: HACC clients by country of birth

	2003-04		2004-05		2005-06		2006-07	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Australia	146,889	68	150,554	68	153,052	67	165,257	68
Main English Speaking Countries	16,046	7	16,342	7	17,204	8	17,318	7
Non-English Speaking Countries	44,916	21	48,131	22	50,423	22	52,642	22
Missing data	8,406	4	7,366	3	8,449	3	9,243	3
Total	216,257	100	222,393	100	229,128	100	244,460	100

Note: Main English Speaking Countries include: New Zealand, Canada, United Kingdom, South Africa, Ireland and the United States of America.

CALD clients tend to be older than other clients. About 70 percent of clients born in non-English speaking countries are over 70 years old, compared to 62 percent of clients born in Australia. Of younger clients from non-English speaking countries, the largest component were Vietnamese, reflecting their relatively recent migration.

The rate of service usage for a given CALD community is an indicator of equity of access to services. Although each ethnic community is likely to have somewhat different needs, depending mainly on its age profile and rates of disability, no systematic information is readily available on what these differences in need might be. For planning purposes, the assumption must be that each ethnic group will have a similar level of need for HACC services.

Table 4 shows that older people born in non-English speaking countries were less likely to use HACC services than their counterparts born in Australia. Among people aged 70-plus, the number of HACC clients per 1000 people was 275 for people born in non-English speaking countries, compared to 344 for people born in Australia. This appears to indicate a gap between supply and underlying demand.

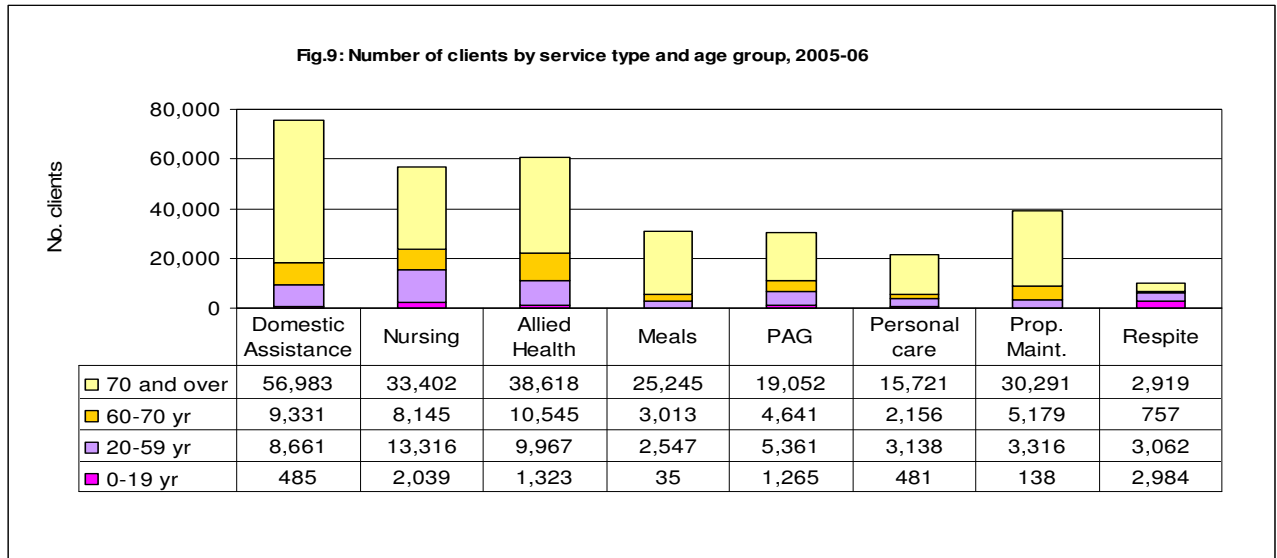
Table 4: Rate of usage of HACC by people aged 70-plus, by birthplace, 2005-06

Birthplace	2006 population aged 70-plus	% of pop.	2005-06 HACC users aged 70-plus	% of all users	HACC users aged 70+ per 1000 pop. 70-plus
Australia	269,967	55	92,994	64	344
Main English Speaking Countries	47,034	10	12,895	9	274
Non English Speaking Countries	120,682	25	33,245	23	275
Unknown	48,876	10	6,477	4	—
Total	486,559	100	145,611	100	299

In the next triennium, Victoria will undertake more detailed analyses of available data for planning purposes, in order to continue to find ways of targeting HACC resources on the range of CALD communities according to their relative need.

Range of HACC services

Planning for the next triennium has been informed by the existing pattern of service usage among HACC clients. Domestic Assistance was the most frequently used service type during 2005–06, followed by allied health and nursing. Note that any given client could have received more than one type of HACC service during the period. See Figure 9.



People aged 70-plus are the dominant group for all service types, accounting for 60–70 percent of clients. The exception is Respite, where the 70-plus group comprises only about 30 percent of clients. Children and young people comprise a full 30 percent of respite clients.

The aggregate number of hours for each of these service types is shown in Figure 10. The pattern is different to the client count above. Planned activity groups (PAGs) accounted for the largest number of hours, followed by domestic assistance, nursing and personal care. Clients typically attend PAGs for 3-4 hours at a time. As well, almost 3.4 million meals were delivered during the year.

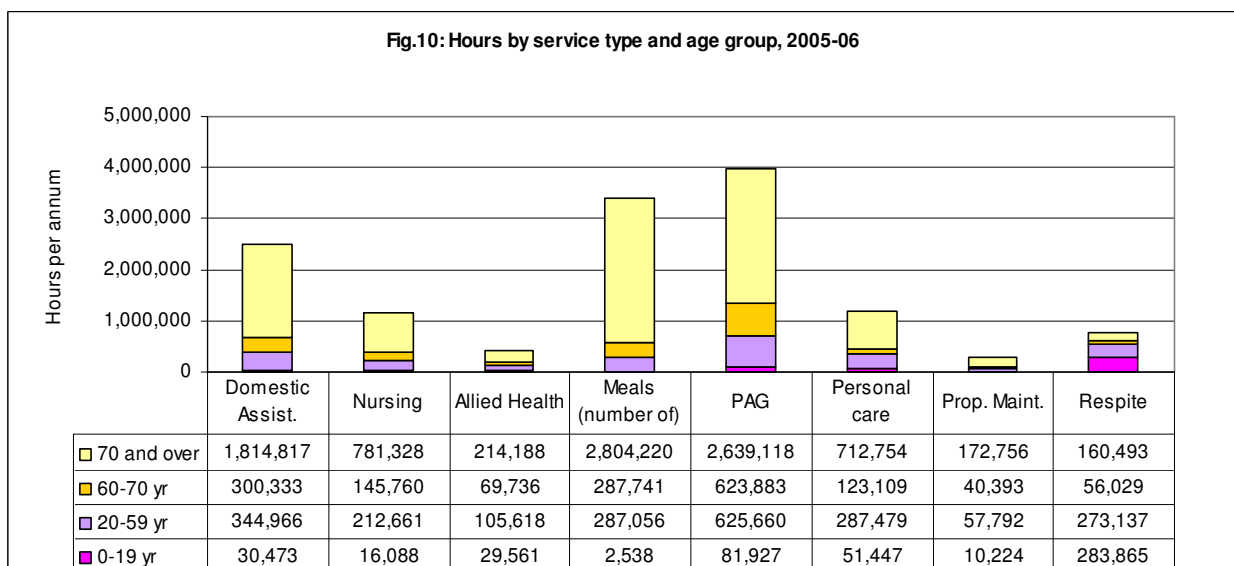


Table 5 shows the average hours per client for each of these service types. It is clear that the typical length of stay varies by service type; for example, an allied health intervention may be completed in a few weeks or may be a visit every few months.

Table 5: Average annual hours per client by service type, 2005-06

	Hours per client per annum
Domestic Assistance	33.0
Nursing	20.3
Allied Health	6.9
Meals (number of)	109.6
Planned Activity Group	131.0
Personal care	54.7
Property Maintenance	7.3
Respite	79.6

Planned service mix 2008–11

The foregoing analyses demonstrate the existing patterns. Work will be done during the next triennium, in consultation with service providers and consumers, to ensure that the optimum service mix is planned for and delivered. Analysis has already been done on the pattern of multiple service use, and its relationship to length of stay as well as to age and dependency. More such analyses will be done as reliable data on client dependency becomes available from the HACC MDS (functional status items).

This work will be an essential aspect of planning for the Active Service Model in HACC.

3. Consultation

Victoria released a consultation paper in December 2007 setting out proposed directions and priorities for 2008-11. Because this consultation occurred in the middle of Victoria's current triennium and there is a high level of continuity between the directions in the 2006-09 triennium and those proposed for the 2008-11 triennium, consultation has not been as extensive as at the beginning of the 2006-09 triennium.

The paper was circulated to all peak bodies and other groups represented on the DHS Departmental Advisory Committee on HACC, both as a draft and in its final form. The final paper has also been circulated for feedback to all HACC service providers. Comments were due by 15 February, but where representatives sought additional time for response, that was agreed to.

In all, thirty two responses were received.

Peak organisations	7
CSOs	5
Ethno specific and multicultural agencies	2
Health services, including community health and district nursing services	10
Local councils	8
Total	32

In general, submissions supported the directions and priorities, with the following specific comments.

Overall service system

- Disjunction between basic services and packaged care is a major problem for continuity of care and access to higher level care.
- There is also a problem with the extent to which people on CACPs can access HACC basic services that needs resolution.
- There needs to be greater linkage with Disability Services.
- Consumer engagement needs to be highlighted.

Special Needs Groups

- People with dementia need to be recognised as a special needs group.
 - Also recognise the complexity that cultural diversity adds to responding to dementia.
- Carers should be specifically recognised in the triennial plan.
- DHS should facilitate incorporating the specificity of each CALD community's needs into the way services are delivered, given the expected extent of growth in people aged 65+ born in a non English speaking country and now resident in Australia.

Specific Services

- More resources are needed for respite which is experiencing high demand
- There are high waiting times to access allied health practitioners, particularly occupational therapists in several regions with consequences for access to home modifications and aids and equipment.
- Addressing social isolation needs to be prioritised.
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- More funding needed for aids and equipment and funds for wound dressings needed.
- Grievance procedures are inadequate, advocacy should be funded.

Reform

- Price by volume purchasing arrangements restrict innovation. It's time to consider new service models that are more person centred and responsive.

The Way Forward projects

- Progress on The Way Forward projects should be accelerated.
- Victorian **Access Points** model including 'no wrong door' approach supported but concerned that it will only be for HACC and Commonwealth funded community aged care services when there are other services that could be incorporated.
- Access Points need to be made known to CALD and Aboriginal people.
- **Planning** needs to encompass all related community care services, such as CACPS, EACH, disability services, health promotion and prevention.
- **Rationalised financial reporting** across HACC and other services including Commonwealth community aged care (but not limited to those services) would be welcome.

Assessment Framework

- Change management needs to be funded where new policy is being implemented eg Assessment Framework.
- The needs of carers must be built into the Assessment Framework.
- Concern that supported access workers are constrained by service catchments areas when community members live outside them.
- Supported Access projects and Access Point project need to be coordinated.

Active Service Model

- Community expectations need to be managed in relation to the active service model and the role of Linkages needs to be considered in developing the model.
- Opportunities need to be explored in planned activity groups.
- Targeting is an issue: who is it for? Everyone or a select group?

Review of Social Support

- A high level of enthusiasm to engage with this review.
- Needs to be **more emphasis on evaluating outcomes** of reform projects eg assessment and access point projects.

Resource allocation – the RREF Review

- Consider using the 80+ population instead of the 70+ in defining the HACC target population
- Factor in rurality and remoteness – costs of service delivery are greater particularly in relation to travel.
- Consider the sustainability issues for rural areas with declining populations that need to continue to be able to deliver services.

Funding and accountability

- Review unit prices and indexation to align more with actual costs of service delivery
- Services that are underperforming should not receive any growth funding
- Counting rules need to be applied consistently
- Infrastructure funding needs to be reviewed.

Capacity

- Working in partnership is an important principle that needs support through additional funding.
- Partnership with Aboriginal Controlled Community Organisations should be a condition of funding for agencies working with Aboriginal communities.
- Workforce development, recruitment and retention is a major issue across the system.
- Take into account the need for a culturally diverse workforce in light of Victoria's diverse 65+ population.

4. National and Victorian Reform and Development Directions 2008-11

A. National Objectives

The Way Forward and The Review of Subsidies and Services

The Commonwealth Department of Health and Ageing is working with all States and Territories to develop the statements of intention in '**The Way Forward – A New Agenda for Community Care**'. The focus of this work is to improve the system to reduce complexity and achieve greater consistency, as well as simplifying and creating a fairer system for people requiring care to stay at home. More information about this can be found at www.health.gov.au/communitycare_thewayforward

The Council of Australian Governments, including Commonwealth, State and Territory Heads of Government, agreed in February 2006 that access to and assessment for HACC services would be simplified. This is a key element of the work being undertaken through 'The Way Forward'.

In addition to this work, the Commonwealth Department of Health and Ageing has been undertaking a review of its own community based aged care Subsidy and Services programs. This Review is intended to complement the work already being progressed through the Commonwealth Government's *A New Strategy for Community Care – The Way Forward* and build on this by looking specifically at the structure and funding arrangements for Australian Government funded community aged care programs.

The Commonwealth's **Review of Subsidies and Services Programs** will focus on identifying areas where current structure and funding arrangements could be refined and service delivery improved, with a view to identifying opportunities for a more integrated set of aged care programs that support frail older Australians as their needs change. It will examine the relationship between community care and residential care, and between federally-funded programs and those run by other jurisdictions such as the Home and Community Care (HACC) Program.

National Objectives as expressed in the HACC Review Agreement

Through the Review Agreement 2007, the aims of the HACC Program have been reframed to better reflect current community aspirations and realities. The Program aims to support people in the target population to remain in their own homes and communities by funding and providing services to those people and their carers in a way that:

- maintains and promotes independence and
- helps avoid premature or inappropriate admission to long term residential care.

Common arrangements

Under the Review Agreement, there is agreement nationally to improve access to services for those most in need. This goal will require governments and agencies to work more effectively across programs to target services efficiently and effectively in a way that promotes independent living and avoids duplication. New approaches to service delivery and planning will be developed through appropriately targeted projects as appropriate over the life of the Review Agreement.

A set of common arrangements have been agreed to advance the objectives of the program. Common arrangements are the same as the projects identified in *'The Way Forward – A New Strategy for Community Care'*. The common arrangements include developing principles and practices to enhance consistency across programs including:

- A consistent eligibility framework for access to home and community care Services, recognising the range of care needs and the continuum of care Services a client may need;
- Streamlined assessment processes to identify the level and complexity of care needs, and to support sharing of assessment information with relevant service agencies where appropriate;
- Access points to provide people seeking home and community care Services with information, assessment and referral to appropriate Services;
- Better alignment between basic services and packaged care;
- Improved planning and identification of priorities for community based aged care services including HACC;
- A streamlined and consistent approach to quality assurance and reporting processes across home and community care programs.

Victoria will continue to work actively and constructively with all other jurisdictions to develop and implement the common arrangements, starting with Access Points and simplified assessment.

B. Victorian Directions 2008-11

Three priorities have been identified for 2008–2011. They continue work that began in 2006 and the Department plans to deliver practical outcomes as a result of this work over the coming triennium. The three priorities are:

- (a) **Access and equity** to improve client access to services and address inequity in funding;
- (b) **Refocus service delivery models** to improve the capacity of the service system to better maintain and improve client independence through client centred approaches and responsiveness to particular clients' needs;
- (c) **Capacity building** to strengthen and support the sector to understand and respond to client needs.

(a) Access and Equity

This priority includes work on:

- establishing access point demonstration projects
- implementing the HACC assessment framework
- measures to improve access to services for CALD and Koori communities
- improving funds equity
- review of the resource allocation formula and methodology

Simplify access to services – Access Points

Victoria has been actively working with the Commonwealth to develop the necessary elements that will make Access Points work in practice in the Victorian health and community care system.

The goal is to improve the navigation of the service system for those frail older people, younger people with disabilities, their carers, families and friends who don't know where to go for initial information and assistance, including (if required) a referral for an

assessment. The Access Point will also assist service providers who may require information about services.

In 2008 there will be two regional demonstration projects in Victoria – one in the Eastern Metro Region and one in the Grampians. Both demonstration projects will absorb the capacity and infrastructure that Carelink represents into the new Access Point Service. By the end of 2008 we will have a specification for operation that all future Victorian Access Point sites will implement.

The basic principle underpinning Victoria's approach is that there is **no wrong door**. This means that if people have a sense of what they need and they go to the agency that provides that service, they will get a response

In Victoria, the objectives and functions of Access Points cover much of the same ground as the Primary Care Partnership's Better Access to Services strategy; and there is also close connection between implementing Access Points and implementation of the Victorian HACC Assessment Framework (see below). To ensure that the development and implementation of Access Points are aligned with these related strategies, the following principles have been developed to guide the work in 2008-11.

Access Point Demonstration projects will:

- complement work on implementing service coordination already in place across Victoria and the implementation of the Victorian HACC Assessment Framework;
- add value to Victoria's agenda on health and community care reform, particularly Care in Your Community and Integrated Chronic Disease Management;
- be an incremental enhancement on what is already in place across Victoria
- avoid duplication
- ensure continuation of existing practices and processes - implementation of Access Point capacity in the system will not change existing requirements and responsibilities for agencies who are members of PCPs and engaged in Service Coordination
- provide an opportunity to implement service coordination in agencies funded to deliver Commonwealth programs that are within scope.

Throughout 2008 the demonstration sites will be testing:

- Volume of inquiry
- Scope of work (breadth of inquiries and intensity of work effort required to respond)
- Business processes required
- Protocols required
- The nature of staffing required (levels, competencies)
- Funding implications to achieve the desired outcome.

Work is currently underway to ensure that the Access Point Demonstration Site is accessible by people from CALD communities and Aboriginal people.

It is anticipated that by early 2009 we should have a clear view about what would be required to implement Access Point services across Victoria in 2009-11 for the remaining six Regions.

Simplify Assessment – Implement the Assessment Framework

The Framework for Assessment in the HACC Program in Victoria was published in June 2007. It sets out a revised policy for Assessment as a funded activity. It details the requirements for the delivery of **Living at Home Assessments** whose key component is home-based holistic assessment of need.

The Framework also describes the related processes of Client Care Coordination and Supported Access, which are adjuncts to Assessment for specific client groups.

Staff of designated assessment agencies provide **Client Care Coordination** for a subset of HACC clients with complex needs or circumstance who require a service response from more than one agency, including inter-agency care planning.

Supported Access describes the role that ethno-specific, multicultural and Aboriginal organisations play in supporting clients to access mainstream services. A number of pilot projects in are piloting supported access in 2008.

The goal of the HACC Assessment Framework is to build good practice in delivering Living at Home assessments and to assist designated HACC Assessment Services to build alliances with the other designated assessment agencies in their PCP and other providers of assessment such as Aged Care Assessment Services. The Framework also aims to support partnering arrangements with agencies that have expertise that is important to contribute to Living at Home Assessments such as Community Health services and agencies funded to provide Supported Access. These alliances and partnerships will ensure a more coordinated, streamlined and client-centred approach to Assessment.

Good assessment in the HACC Program is important to efficiently managing client pathways and providing well targeted responses.

Implementation will occur over the triennium 2008-11. The first step was to formally identify HACC organisations that are currently funded for Assessment and that have the commitment and capacity to meet the criteria to deliver Living at Home assessments. In the first instance, the intention was to consolidate assessment in those agencies. This process is now complete.

The next step is to work with those organisations and other relevant agencies over the next two years on the following tasks:

- Develop a funding model for Living at Home assessments
- Develop a Victorian HACC Assessment tool based on the national ACCNA-R and state screening tools (Australian Community Care Needs Assessment and the Victorian Service Coordination Tool Templates), including a carer module;
- Implement a Professional Development Strategy for HACC Assessment staff including a component that will provide training on assessment for people with dementia
- Pilot Supported Access to support CALD and ATSI clients to access mainstream services
- Develop Victorian protocols that describe the operational relationship between HACC Assessment Services and other relevant providers such as ACAS, allied health staff in Community Health Centres, Supported Access agencies and Access Points.

Non-recurrent seed funding is available in 2008 for selected projects that will help organisations to further develop existing partnering arrangements. Future funding will be made available to develop innovative models of organisational partnering to deliver HACC Living at Home assessments in subsequent years.

Other tasks in 2008-11 include monitoring and supporting supported access pilot projects and developing Practice Guides for Assessment in HACC.

Improving Access to Services for CALD Communities

Over the past three and a half years the Culturally Equitable Gateways Strategy (CEGS) developed innovative responses to improve access to HACC services for people from CALD backgrounds and has forged working relationships between a diverse range of HACC providers. Data analysis has indicated that there was a positive overall improvement in the participation of people from CALD background accessing services in the local government areas targeted by CEGS.

The evaluation found that all organisations reported positive outcomes from participating in the Strategy, including the opportunity to dedicate time and resources to enhance their HACC services or their community's understanding of the HACC service system and the partnership and relationship development between a variety of organisations and individuals. CEGS has now concluded and the lessons learned from the diverse range of projects that constituted CEGS will be integrated into general service provision over this triennium.

As noted above, during the course of CEGS, DHS undertook concurrent work to redevelop HACC assessment in Victoria. The work undertaken in CEGS, particularly around CALD assessment and the support that CALD agencies provide to their communities to access services, has informed and influenced the work on HACC assessment and client care coordination.

The primary focus of improving CALD access to HACC services over 2008-11 is through implementing the HACC assessment framework and developing supported access to help people gain access to services where they are unfamiliar with or anxious about the agencies that deliver services.

Eight agencies have been funded to pilot this concept over 2008. The pilots will be evaluated and the future work of supporting access to services for CALD communities more broadly will be considered in consultation with stakeholders in 2009.

The recommendations of the evaluation of the Cultural Planning Strategy will be implemented over 2008-11.

Work is being done to ensure that Access Points are accessible by people from CALD backgrounds and the success of that work will be evaluated as part of the State and National evaluations.

Data will be provided to CALD and mainstream agencies comparing at an LGA level, the presence of people from particular communities as recorded by the Census with their representation among HACC clients, by service to support agency planning and engagement.

Improving Access to Services for Aboriginal Communities

The Strengthening HACC in Aboriginal Communities Strategy focuses primarily on building the capacity of agencies and direct care staff. Further information about this strategy is set out below under Capacity Building.

Resource allocation and the equity strategy

Victoria has a Ministerial commitment to achieving population-based equity of funding and access to services. This equity strategy governs the annual allocation of HACC growth funding, because relative levels of HACC base funding vary in different regions

and local government areas (LGAs) across the state, as a legacy of submission-based funding. A population-based planning model, the Relative Resource Equity Formula (RREF), has been systematically improving this situation since 1998.

'Equity' is defined as approximately equivalent resources being provided to each region and local area in the state, relative to its share of the target population. The equity strategy requires that resources should be allocated where there is evidence of relative under-funding based on the estimated target population. The equity strategy must therefore keep abreast of changes in the size, age profile and distribution of the target population in growth corridors and elsewhere across the State.

It is six years since the revised RREF was implemented. New data is now available, particularly the 2006 Census; updated datasets on income and burden of disease are available. For the purpose of allocation in 2008-09, the method used in the last two years is being used with the RREF updated with new data sets. That is funds are being allocated for population growth and then the balance of funds are allocated to improve the equity position of under funded regions, primarily the three metro regions, Gippsland and Barwon South West.

The benchmarks used in 2006-08 (\$523 per capita for metropolitan regions and \$598 for rural regions) have been indexed to 2008-09 values. The new benchmarks for 2008-09 are \$565 per capita for metropolitan regions and \$646 per capita for rural regions.

Resource Allocation Review

New evidence regarding factors associated with need for HACC services has been published in the literature. A key project for the 2008-11 triennium is to review and refresh the evidence and methodology used for allocating HACC growth funding in Victoria.

An expert review is being commissioned and will be undertaken in 2008. It is expected that a final report will be available in first half of the 2008-09 financial year. Planned allocations for 2009-10 and 2010-11 will be reviewed when the new methodology becomes available.

(b) Refocus service delivery models

This priority includes:

- Work to implement the Active Service Model in Victoria
- The Review of Social Support and Respite and implementation of outcomes.

Work Program for the Active Service Model

The HACC Active Service Model is a quality enhancement initiative that aims to increase capacity building, restorative care and person-centred approaches within HACC service delivery to better maintain and improve clients' independence.

The focus in the first triennium has been on exploring the evidence base for taking this approach. La Trobe University has been contracted to undertake a conceptual and empirical international and national review of the literature to identify existing models and transferable learnings. Victoria has also funded nine pilot projects to explore implementation issues. Six of these have been completed and evaluated and three are still underway.

Victoria also put significant effort into hosting a HACC National Forum on Promoting Independence that took place in February 2008. This event brought key stakeholders together from across Australia to explore the evidence base and implications for adopting a wellness, capacity building and restorative care approach to HACC service provision.

A discussion paper will be released in the first half of 2008 as the basis for consulting with the sector on options for short medium and longer term steps to implement this approach in Victoria.

An implementation plan will be finalised in 2009. This is likely to include development of a number of demonstration projects and strategies to assist organisations to implement the Active Service Model over time. Likely short term measures include:

- continued investment in the availability and capacity of allied health
- seed grants to assist organisations to manage the change and develop sustainable partnerships with complementary services
- investment in training and support for staff including training for staff to work with people with dementia within an active service model framework
- embedding the principles of this approach in assessment (see above)
- increased availability of health promoting and capacity building options for clients as part of mainstream services.

Longer term consideration will need to be given to:

- Targeting: is it for everybody or for a group whose characteristics can be defined?
- Funding: do we need different funding models to deliver the outcomes sought or can they be achieved within current funding arrangements?
- Workforce development
- Managing community expectations including those of clients, direct care workers and health professionals.

Work program for Social Support and Respite Review

Social support and respite programs have been a part of HACC since its inception in 1985. 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. A further consideration is the relationship between services provided by the HACC Program and similar services funded through Aged Care, Disability Services and the Commonwealth's National Respite for Carers Program.

In July 2006 the Victorian Government launched a policy framework on recognizing and supporting care relationships. The goal is to respond to both the individual and the caregiving relationship when providing support services.

In 2007, the Department commissioned a consultant to undertake an extensive range of consultations with service providers and other interested people about what they issues they would like the review to address. The feedback from this consultation is informing the scope of the review.

A consultant will be commissioned to undertake the review in 2008. The purpose of the review is to provide a basis for targeting future HACC Program growth funding to these services in Victoria.

Over the triennium funds will be made available to support the recommendations of the Review of Social Support and Respite.

(c) Capacity building

Building capacity in Aboriginal Community Controlled Organisations and Generic Agencies to improve access to services for Aboriginal Communities

Over 2003-06, DHS engaged consultants to undertake an *Aboriginal and Torres Strait Islander Home And Community Care (HACC) Funding Models Project*. The project report was distributed to the sector in November 2006. The report provided a basis for DHS to develop a strategy for providing HACC services to Aboriginal people over the longer term.

The report's recommendations include:

- consolidation of funding around a smaller group of activities that are priorities for Aboriginal organisations
- a focus on strength based service provision in line with community needs and population demographics
- developing partnerships between ACCOs and generic service providers.

DHS has developed the *Strengthening HACC in Aboriginal Communities* strategy as a response to the report. The strategy was published in February 2008, after extensive consultation, and outlines a range of actions for 2008-11 focused on strengthening the capacity of HACC funded Aboriginal organisations to provide services to HACC eligible Aboriginal people and the inter-relationships between HACC funded Aboriginal and generic organisations.

DHS has identified the following themes for action:

Client centred approach - Increase access to a range of services for HACC eligible Aboriginal people by training direct care workers in service coordination practices in use for referring clients between mainstream agencies and bringing workers from mainstream agencies and ACCOs together to develop working relationships.

Building capacity in Aboriginal organisations – resource medium size ACCOs to develop networks with generic agencies in their geographic area to ensure the needs of Aboriginal people are taken into account when those agencies are planning their service provision.

Developing sustainable models of HACC service delivery consistent with community needs –assist ACCOs to focus their effort on those services that are most culturally sensitive for their communities, to improve the viability and sustainability of their agencies, while ensuring that their communities get access to the other services they need from generic service providers.

Accountability and performance management

Assist agencies to manage their performance by providing them with regular electronic reports that show how the data they report through the HACC MDS translates into performance against targets on a quarterly basis.

Continue to monitor agency performance against National Service Standards and the implementation of agency continuous improvement action plans, based on quality audit findings. Continue to hold information sessions with agencies to brief them on areas of less than good performance and to suggest steps that can be taken to address them. Work with Regions to develop an accepted and consistent process for monitoring agency action plans, including regular reports on progress.

Workforce development

- Implement the Assessment Professional Development program
- Make training on working with people with dementia, including people from CALD backgrounds, a priority for HACC direct care workers in Regional training programs.
- Develop short and medium term training and development programs to support implementing the Active Service Model.

5. Expenditure Priorities to meet National and Victorian Directions

Funds will be targeted to the following measures organised under the priorities referred to above.

Access and equity

- Fund basic services, including respite, where demand is demonstrated, as a result of regional consultations and data analysis.
- Continue to fund planned activity groups at up to 5% of growth funds available in each region.
- establish access points in Victoria and fund the developmental work associated with their establishment
- fund expansion of assessment consistent with the assessment funding model and fund development work associated with implementing the assessment framework
- fund supported access pilots for CALD agencies and their evaluation
- pilot supported access in Aboriginal organisations in 2009
- continue the emphasis on improving equity in funds allocation
- fund a review of the RREF and resource allocation methods in the HACC Program in Victoria in 2008

Refocus service models

- fund development of an implementation plan for the Active Service Model and the implementation steps
- fund implementation of the recommendations from the Review of Social Support and Respite

Capacity building

- fund partnership development to improve service efficiency and effectiveness in delivering better outcomes for people using services.
- Fund training and professional development associated with implementing the assessment framework, the active service model, and Strengthening HACC in Aboriginal Communities.
- Fund training for direct care workers on caring for people with dementia and ensure that it is a priority in regional training programs.

6. Victoria's approach to the Triennial Plan and planned funding by Region from 2008-09 to 2010-11

Indexation and administration

Throughout 2006-07, the then Victorian Minister for Aged Care received consistent representations from service providers about an increasing gap between funding rates in the HACC Program and the cost of delivering services and concerns about the clear differential between the rate at which Victoria indexes community service organisations and the Commonwealth rate in HACC, often for the same service. For 2007-08 the Victorian Minister decided to fund indexation in the HACC Program at 2.9%, the same rate at which the Victorian Government was funding its own programs delivered by Community Service Organisations.

This decision was a considered approach to trading off growth in services against price at the margin, to make service delivery sustainable.

Consistent with its practice in 2007-08, Victoria will again index its funding rates at the Victorian Government rate for Community Services Organisations of 2.9%. The amount taken from growth to achieve this rate is \$2.4m (assuming a Commonwealth indexation rate of 2.3%) with the difference being made up from Victorian funds.

Victoria has also taken an amount of \$0.401m from growth funds as the second tranche of the additional program funds allocated to administration, agreed when the Review Agreement was finalised last year. The total amount of funding from the program for administration is approximately \$3.5m in 2008-09. Victoria estimates that it contributes an additional \$5.5m to Program administration, primarily focused on managing its contracts and relationships with service providers.

Taking these two decisions together, the funds available for service expansion are reduced by \$2.8m for 2008-09.

Distribution of funds to regions

As required by the national planning framework, **Table 7** sets out the proposed distribution of estimated growth funds by region for each year of the triennium.

As noted in section 4 above, Victoria is currently commissioning a review of the Relative Resource Equity Formula used to estimate the HACC target population within the State and associated resource allocation methods. The results of the review are likely to affect the distribution of growth funds after 2008-09, so it is not possible to specify the distribution of growth funds with any certainty. Forward population projections based on 2006 Census data are not currently available and will also affect the distribution in the outyears.

The distribution in Table 7 uses essentially the same method as used last year but with updated population data from the 2006 Census. The equity strategy (allocating funds to acknowledge population growth and preferentially distributing the balance of funds to regions with low per capita funding levels) underlies regional distribution. Because we are embarking on a new triennium, the benchmarks have been indexed to 2008-09 values and now stand at \$646 for rural regions and \$565 for metro regions. The equity strategy

aims to preferentially fund those regions below the benchmark to reach it, while keeping those above it steady.

The effect is to provide equity funds to metro regions, Barwon South West (specifically to recognise the equity position of City of Greater Geelong) and Gippsland.

Next steps

Detailed regional consultation with service providers and other interested people will occur in April/May to inform which services Victoria will purchase in 2008-09. The results of these consultations will be incorporated into Annual Supplement tables that will be forwarded to the Commonwealth in July together with Victoria's response to the expected letter from the Commonwealth Minister for Aging offering growth funds.

Table 7 is the settled distribution of funds for 2008-09. The subsequent years may vary depending on the outcome of the review of the Regional Resource Equity Formula in 2008. Victoria will consult with the Commonwealth on the outcome of the review.

Victorian HACC Triennial Plan 2008-11
Subject to Australian Government Approval April 08

Table 7: Distribution of funds by Region from 2008-09 to 2010-11

2008-09

Region	Base Recurrent \$ at 1 July 2008	Base funding plus indexation at 2.9%	Real growth (PYE)	Real Growth (FYE)	Total Regional (PYE)	Total Regional (FYE)
Eastern Metropolitan	\$73,333,390	\$75,460,058	\$1,453,455	\$2,906,910	\$76,913,513	\$78,366,968
North and West Metro	\$113,913,324	\$117,216,810	\$2,117,484	\$4,234,968	\$119,334,294	\$121,451,778
Southern Metropolitan	\$95,209,339	\$97,970,410	\$1,789,674	\$3,579,348	\$99,760,084	\$101,549,758
Barwon South Western	\$37,646,437	\$38,738,184	\$562,500	\$1,124,999	\$39,300,683	\$39,863,183
Gippsland	\$28,715,413	\$29,548,160	\$507,911	\$1,015,823	\$30,056,071	\$30,563,983
Grampians	\$25,846,994	\$26,596,557	\$282,836	\$565,671	\$26,879,392	\$27,162,228
Hume	\$27,541,412	\$28,340,113	\$477,752	\$955,503	\$28,817,865	\$29,295,616
Loddon Mallee	\$35,028,177	\$36,043,994	\$419,730	\$839,460	\$36,463,724	\$36,883,454
TOTAL	\$437,234,486	\$449,914,286	\$7,611,341	\$15,222,682	\$457,525,627	\$465,136,968

2009-10

Region	Base Recurrent \$ at 1 July 2009	Base funding plus indexation at 2.9%	Real growth (PYE)	Real Growth (FYE)	Total Regional (PYE)	Total Regional (FYE)
Eastern Metropolitan	\$78,366,968	\$80,639,610	\$1,667,666	\$3,335,331	\$82,307,276	\$83,974,942
North and West Metro	\$121,451,778	\$124,973,880	\$2,429,559	\$4,859,119	\$127,403,439	\$129,832,998
Southern Metropolitan	\$101,549,758	\$104,494,701	\$2,053,437	\$4,106,873	\$106,548,137	\$108,601,574
Barwon South Western	\$39,863,183	\$41,019,215	\$623,449	\$1,246,898	\$41,642,664	\$42,266,113
Gippsland	\$30,563,983	\$31,450,338	\$578,246	\$1,156,492	\$32,028,584	\$32,606,831
Grampians	\$27,162,228	\$27,949,933	\$298,196	\$596,392	\$28,248,129	\$28,546,325
Hume	\$29,295,616	\$30,145,189	\$420,106	\$840,211	\$30,565,295	\$30,985,400
Loddon Mallee	\$36,883,454	\$37,953,074	\$442,525	\$885,050	\$38,395,599	\$38,838,124
TOTAL	\$465,136,968	\$478,625,940	\$8,513,183	\$17,026,366	\$487,139,123	\$495,652,306

2010-11

Region	Base Recurrent \$ at 1 July 2010	Base funding plus indexation at 2.9%	Real growth (PYE)	Real Growth (FYE)	Total Regional (PYE)	Total Regional (FYE)
Eastern Metropolitan	\$83,974,942	\$86,410,215	\$1,756,978	\$3,513,956	\$88,167,193	\$89,924,171
North and West Metro	\$129,832,998	\$133,598,155	\$2,559,675	\$5,119,350	\$136,157,831	\$138,717,506
Southern Metropolitan	\$108,601,574	\$111,751,019	\$2,163,409	\$4,326,818	\$113,914,428	\$116,077,837
Barwon South Western	\$42,266,113	\$43,491,830	\$660,825	\$1,321,649	\$44,152,655	\$44,813,480
Gippsland	\$32,606,831	\$33,552,429	\$584,591	\$1,169,181	\$34,137,019	\$34,721,610
Grampians	\$28,546,325	\$29,374,168	\$314,575	\$629,150	\$29,688,743	\$30,003,318
Hume	\$30,985,400	\$31,883,977	\$385,326	\$770,653	\$32,269,303	\$32,654,630
Loddon Mallee	\$38,838,124	\$39,964,430	\$466,832	\$933,663	\$40,431,261	\$40,898,093
TOTAL	\$495,652,306	\$510,026,223	\$8,892,211	\$17,784,422	\$518,918,434	\$527,810,645