Implementation of Occupational Therapy and Personal Care Growth Funding in the Northern Shires of the Loddon Mallee Region – The First 12 Months

Home & Community Care Program, Victorian Department of Health.

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Section 1: INTRODUCTION

This report provides a summary of the 12 month Project Officer position in the northern Loddon Mallee region and how partnerships were developed and supported between Health Services and Local Government Agencies (LGA's). A focus for the Northern LGA project was individualising partnership development, as it was in the south. This was crucial to sustainability.

On the ground the funding has enabled health services to employ an OT to work in partnership with HACC assessment and personal care services in local government. At a regional level, in addition to increasing OT and PC service capacity, the funding aims to result in a better understanding and some new practice skills for all HACC staff around how the ASM can inform the types of services made available to people. The initiative recognises that OT participation in assessment and planning can value add to the development of effective, person centred plans, and can support personal care staff to implement these plans.

Of great importance for the northern partnership development was the evolving dynamic where the importance of the whole (or relationships) emerged to support ongoing sustainability. This can be explained by the development of more equal relationships between all members of the team, where the role of the OT became enmeshed with the partnership.

Background

$7.4 million of HACC growth funding was allocated to Occupational Therapy (OT) and Personal Care (PC) across all local government areas in Victoria. These funds have been allocated to health services and councils to expand the capacity to deliver the Active Service Model (ASM). In the Loddon Mallee Region this capacity building focus has not only considered expanding the amount of OT service being delivered to HACC clients, but also building the capacity of all staff to work according to the ASM practice principles

> *"The Victorian HACC Active Service Model (ASM) is a quality improvement initiative that explicitly focuses on promoting person centred care, capacity building and restorative care in service delivery."*
> *(ASM Prepare, 2010).*

Supporting the establishment of the partnership work – a project approach

The project was funded for 12 months, employing two Project Officers – one in the Southern region and one in the Northern region. Both Project Officers were auspiced by a community health service, working 3 days a week. The Northern Project Officer finished in late November 2014.

Methodology

The project has been established to implement an action research model to support partnerships between OTs (and their employing agency) and Local Government HACC Assessment Services, and to identify and support the implementation of specific strategies to support health and wellbeing outcomes for HACC eligible clients.

The Project Officer Role

The Project Officer roles were established as a resource to the LGA partnerships to progress the necessary planning for the joint work of OTs with HACC assessment and personal care staff and to promote reflective thinking facilitated by the action.

Focus areas for the Project Officer role included:

- Support partnership development

- Assist local partnerships to reflect on their need for specific planning and partnering agreements to support the OT initiative.
- Support the identification of opportunities and barriers to progress the ASM
- Assist to develop local plans to support agreed actions
- Initiate networking and peer support opportunities for the OTs across LGAs
- Build opportunities for stakeholders to review progress and adapt their approaches as needed.

Project Process

Introducing the Partnerships in the Northern Loddon Mallee Region

Six partnerships across 5 Shires were developed:

- Buloke Shire Council and Bendigo Health Care Group
- Campaspe Shire Council (north) and Echuca Regional Health
- Campaspe Shire Council (south) and Rochester and Elmore District Health
- Gannawarra Shire Council and Northern Districts Community Health
- Mildura Rural City Council and Sunraysia Community Health Service
- Swan Hill Rural City Council and Swan Hill District Health

Each Shire has a unique profile and the organisations involved had a varied history of working on joint projects together.

Developing the Work-plan

Five broad objectives for the project were identified to guide the work of the Project Officer.

1. The OT/HACC assessment partnership is leading to improved outcomes for HACC eligible clients in line with the ASM.
2. Partnerships are strengthened to support HACC assessment and service provision to clients.
3. There is an increased understanding of the enablers and challenges impacting on the implementation of the ASM and interdisciplinary practice, and strategies have been identified to address these issues – both within and across the LGAs if relevant.
4. There is an increase in knowledge/ experience about the use of less formal staff learning experiences on the implementation of the ASM, including mentoring, reflective practice and peer support.
5. The project contributes to the knowledge base around ASM implementation in the HACC sector.

These outcomes were developed into a work plan and periodical reports were provided to the Department of Health.

Work-plan/Activities

Developed from the project objectives

During the 12 months, the northern project followed a similar pattern as the south project (common methodology). It is important to note that while the activities for the work-plan were developed from common objectives for the region the way in which the activities were implemented was different. This difference resulted from the flexibility engendered from an action research methodology which responded to the enablers and barriers that were unique to the northern shires. The following activities summarise the key elements of the work of the Project Officer over the 12 month period.

Table 1. Work-plan objectives

Communicating the intention of the funding and the Project Officer Role.	• During the 12 months the northern project followed a similar pattern as the southern project resulting from common methodology. Clarifying direction for the role of the Project Officers was important. • This information was communicated to the agencies through local meetings, and also through a presentation made at the "Partnerships and Possibilities" workshop in Swan Hill in December 2013. • For the Shires gathering all staff involved together was crucial, so that everyone received the same message about the intent for each shire and how they wanted the project to respond to their needs.
Engaging stakeholders was an ongoing process.	• Building positive relationships between relevant stakeholders through collaborative practice encouraged contribution to the partnership approach. • Project Officer actively engaged early on, as the partnerships were established, organisational staff led the processes of involving others and the Project Officer supported from a distance. • Having everyone on the same page was supported by constant communication and ongoing identification of successes from other shires and projects. • To assist with ongoing motivation it was important to tease out why others had been successful (this was achieved with emails, meeting and phone discussions) and adaption of these to northern shire needs. Thus continual celebration of success was crucial.
Supporting partnership development and local planning.	• A workshop for all participating organisations in the northern Loddon Mallee region was offered in December 2013. This workshop explored intention and possibilities and supported partnering agencies to come together and consider the local outcomes. • Meetings have been more regular in some Shires than others, in response to the local needs and prior relationships. More information about the partnership meetings is offered in Section 2. • Enablers and barriers were identified, such issues as existing relationships, staff changes, expectations of the au spicing

	agencies regarding allocation of OT time and duplication of services.
Establishing the OT Network	• OT Networks were established across the north and offered professional support - these were a point of high success. • Success for partnerships was set up through this process. Staff across assessment
Facilitating reflective processes	• Success for partnerships was set up through this process. • Staff across assessment, OT and the entire HACC system were encouraged to hold case studies, communicate and reflect, and formulate systems and processes that would support implementation of partnerships to develop sustainably.
Capturing change	• A key focus of the Project Officer's role has been capturing change. • An ongoing program of documenting (even the smallest) changes was instigated through maintenance of a Project Officer diary thus reflecting at the change agent level a time model of reflective practice.
Promoting sustainable practices.	• Supporting partnerships to consider what they need to have in place to sustain the partnership has been a frequent question posed at meetings. This is where systems and processes come "into their own". ○ partnership agreements, ○ project plans, ○ policies and procedures, ○ role descriptions and ○ communication pathways; These are some examples of work undertaken by agencies, supported and/or encouraged by the Project Officer.
Project Evaluation.	• Maintenance of notes, a diary and identification of developing changes was facilitated by the action research method. • Through this, the north Project Officer was able to develop adoption of their new ways of doing and of the alteration to the "new ways" as they were identified and changed. Thus the evaluation process was constant.
Working with the Department of Health.	• Working closely with key departmental staff has been an important aspect supporting the work. • The Project Officer has been in regular communication with the Program and Service Advisor and the ASM Industry Consultants.

	• Consultation around local approaches and participating in broader planning have been two key (and valuable) activities supporting the work. • The northern Project Officer met regularly with the Program and Service Adviser from the Department and the IC (Industry Consultant). • The regular communication was crucial to the implementation of the initiative and the development of the project.
Multidisciplinary approaches.	There is also an indication that this approach has encouraged the development of multi-disciplinary allied health teams, working collaboratively with the client and carer in order to increase the clients functional capacity (more information is available in section 3 of this report).

Summary

The first 12 months of the implementation of Department of Health growth funding in the northern LGAs of the Loddon Mallee Region has seen the establishment of a project to support partnership and practice development, and has seen the work commence on the ground in all LGAs. The Project Officer worked collaboratively with the southern Project Officer and many resources and ideas were shared. This report offers a summary of the progress made towards each of the identified outcomes; snapshot reports of the progress in each LGA and some broader reflections on the implementation process. Case studies and positive practice examples are also included to demonstrate the impact the partnership work is having for clients.

"There are examples of multidisciplinary allied health teams, the client and carer all working together to increase functional capacity" OT.

Section 2: ACHIEVING THE OUTCOMES

Local partnership development and commencement of the collaborative roles on the ground have developed differently in each Shire. Following the appointment of the Project Officer in December 2013 and clarification of the funding intention, partnership development began. Partnership development varied across the shires for a number of reasons.

Detailed progress of each LGA is offered in Section 3 of this report. This section provides some overall feedback about progress against the specific outcomes for the project.

Outcome 1: The OT/HACC assessment partnership is leading to improved outcomes for HACC eligible clients consistent with ASM principles.

Organisations have identified a range of changes at a systems level that are resulting in improved services to clients.

Table 2: Identified systems and processes changes.

Systems/Process Change	Benefits for Clients
Improvement to Referral Processes – processes are streamlined; quality of referrals is improved; Increased understanding of staff roles supports effective and timely referrals and collaboration between staff from different organisations	Services offered in a more timely manner; reduced wait times; OT involvement at an earlier point maximises restorative care opportunity.
Regular Intake meetings have been pivotal in creating collaborative work, with regards to identifying clients who would best benefit from a joint assessment with a reablement approach.	Clients are identified and assessed by OT and AO in a timely manner, in order to achieve increased independence.
Client centred care plans have a stronger focus on a reablement process – OT's, AO's and CCW's are working together to break down tasks in order to develop more specific client goals and interventions that will empower Clients to regain, improve and maintain their independence.	Clients, working with their CCW, have more focused support plans to help them achieve their goals of increased independence.
Sharing of information (with consent) around joint clients – both through conversation and documentation	Decreased duplication for the client by not having to retell their story; more cohesive planning and review.
Joint planning and collaborative practice between HACC assessment, Community Support Workers and OT, and improved review process by taking a goal setting approach to services.	Clients can work towards goals as a planning and review process is more frequent and results in concrete changes/improvements to care plans.
The co-location or collaborative approach has enabled a sharing of **educational opportunities** for both the council and the health service as to the **council services and allied health disciplines available** eg Dietician	Clients are being referred in a timely manner to a range of services or professionals they may benefit from.

Outcome 1: Celebration points.

There have been improvements in the systems and processes supporting working with joint clients. Please refer to Appendix 1 for a summary.

- Feedback has improved. Some of these case studies are included in Section 3 of this report or attached in Appendix 3. In the Northern Shires this has resulted in higher levels of collaboration and greater interest (across all levels of service delivery) in care planning. Of importance to the North has been the identification of the role of carers.

> *This project has "highlighted (the) importance of acknowledging carer knowledge and valuing their input with client intervention (and) understanding the rapport the carers already have with clients" OT.*

Further to the above OTs have identified

- the emergence of a more holistic approach to clients,
- Focus on a broader range of goals,
- Better coordination of services'
- Interviews conducted by the Project Officer identified that services believe this project has assisted with further implementing ASM.
- Staff believe that ASM is easier to implement with new clients as the expectations of established clients is a barrier to change.
- CCW's are more actively involved in care planning.
- OT's have exchanged learnings with the CCW's resulting in a better understanding of each-others roles. This has built respect and partnership.

> *The community feel a sense of entitlement. I have often been faced with comments like 'my Mother's worked hard all her life, she deserves to have this service'. OT.*

- Joint home visits have resulted in incidental opportunities for education and information exchange.

Utilising information derived from Case Studies it is evident that clients achieved positive outcomes contributing to increased independence as a result of the OT involvement with them. One of the questions that have been challenging to answer is: would this support have happened anyway prior to the funding? However it seems that the collaborative or partnership approach facilitates a referral to the OT when it may not have happened previously, particularly for those more complex issues beyond the installation of rails and ramps, for example.

Outcome 1: Discussion points.

Whilst it is early days in the commencement of this approach, evidence is indicating that the work is having a positive impact on client outcomes and that improvements in agency processes will sustain these changes in the future.

- There is a need to measure the actual effect of this project for the clients.
- Would this support for the initiative have been supported without the addition of funding?
- Would the heightened level of partnership involvement have happened without the project?
- Has the emergence of multidisciplinary approaches been the direct result of the project?

> *The client says "she feels as though she avoided the need to go into permanent care" OT.*

Outcome 2: Partnerships are strengthened to support HACC assessment and service provision to clients.

The project was funded based on the acknowledgement that the success of the joint work relies heavily on effective partnerships that provide leadership to staff.

Table 3: Developing partnerships and benefits to HACC Clients.

Partnership	Benefits to Project
Support staff work in partnership	Staff working on the ground were supported by the partnership to ensure their roles are sustainable in environments of change.
Information provision to support partnership development	As the project started it became clear that there was need to provide: • further information about the opportunities and expectations of the funding, and • some capacity building around partnership development and planning for local outcomes.
Provision of planning workshop	A planning workshop was offered to participating agencies. Titled 'Partnerships and Possibilities' the workshop provided: • information about the funding, • offered a case study presentation, • explored the features of effective partnerships, and • organisations were encouraged to take an outcomes approach to their work.
Progression of local planning	• Mixed feedback was received from the Southern LMR workshop, and while the session was valued it did not encourage progress in their local planning. • This feedback was noted and the workshop planned for the northern LMR was adapted.
Partnership/Project review	• As part of the 12 month evaluation process, all 6 partnerships participated in a review process that included consideration of the impact of the funding on the partnership. • All agreed that the joint work had strengthened the relationships between the organisations at both a management level and a service delivery level.
The partnerships have spin offs	This has not only benefitted the direct work of the OT with council staff, it is also starting to impact in some cases through the allied health teams in the health organisation.

Celebrations for Outcome 2

- The Partnerships and Possibilities workshop was highly successful, promoting the project intent and consolidating development of systems and processes.
- Partnerships have spin off to other allied health.
- In summary, evaluation processes indicate that the OT and PC funding, and the process of establishing a partnership around OT and PC, has had a positive impact on interagency collaboration. Organisations have also demonstrated clarity around gaps in their joint work and opportunities for improvement.

"I have noticed an increase in Joint Assessment referrals since I have been sitting within the Council Offices, the referrals are more targeted to the program and the AO's are more enthusiastic" OT.

Feedback from the Partnerships and Possibilities workshop.
"I agree that the Information provided about the purpose and opportunity of the funding was helpful, as learning where the funding came from & understanding why it has become available is going to help our group move forward" OT.

Discussion points for Outcome 2.

- How do the Service Providers sustain the increase in involvement of CCW's?
- Regarding project methodology and processes, could the initial engagement from all parties have been implemented in a different way?
- Identification of the need for Partnerships and Possibilities workshop shows the success of the action research method.
- Could a risk management plan have anticipated the initial glitch during the first stages? (Initial glitch regarding scope and expectations for the project).

Outcome 3: There is an increased knowledge of the enablers and challenges impacting on the implementation of the ASM and interdisciplinary practice.

Establishing the partnership work has provided many opportunities for service providers to reflect both on ASM in practice and the challenges and opportunities of interdisciplinary and interagency collaboration.

Implementing the ASM

At a local level, all organisations have needed to consider the opportunity presented by the growth funding and how it could best be targeted to improve outcomes for clients. Many conversations have taken place around ASM, with some key questions coming up time and again including:

- What is an ASM client? Is there such a client?
- Shouldn't we work with all clients from an ASM perspective?
- Am I the ASM OT for my organisation?
- Or should all HACC staff be working in this way?
- How do we change the way we work with long term clients who are resistant to change?
- How do we bring Community Care Workers along on the ASM journey?
- Does the ASM approach work better with shorter term clients?
- How do we develop effective care plans to support an ASM approach?
- What does ASM actually look like in practice?

As agencies have considered these questions and begun the partnership work, they have identified and addressed barriers, and also noticed what is helping. The following table summarises some of the barriers and enablers, and how agencies have used this knowledge.

Table 4 – Identified challenges to increase understanding of ASM in the Northern LMR.

Barrier	How barriers were addressed
• Staff knowledge regarding goal directed care planning. • Ability to support care plan development with principles of ASM.	• Joint assessment processes or collaborative assessment processes. • OT's working with AO's and CCW's in client specific case planning and intake meetings. • OT supporting development of care plans, and sharing skills and knowledge with the Assessment Staff. • OT doing home visits while the Community Care Worker is in attendance creates collaborative work practice and continuity of care plan interventions. • Formal education sessions with HACC staff.
Staff resistance to change has several aspects. • Existing relationships with clients and workplace. • Age and qualifications of workers. • Hierarchical workforce. • Isolation from information.	• Create opportunities for staff to build relationships and learn about one another's roles. This was addressed by 'shadowing' one another at assessments • Strong leadership from management about the purpose and value of change. • Formal and informal opportunities for conversations between OT, AO and Community Care Workers • Co-location or collaborative work spaces that allow informal conversation and incidental education. • Valuing the perspective and input of all professionals • Maintaining focus on client outcomes.

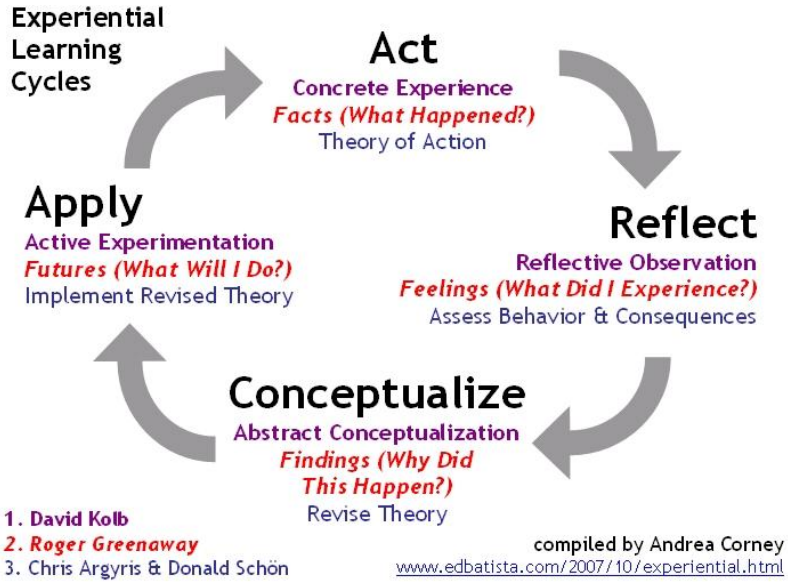
History of staff from different organisations working independently	• Joint assessments led to increased knowledge about roles, improved referrals and in some instances shared care planning. • Increase sharing of client related documentation, • Positive client outcomes are shared and build the momentum for change. • Identifying joint client documentation opportunities.

Table 5. Identified enablers to increased understanding of ASM

Enablers	How enablers were utilised
Valuing and utilising the knowledge of Community Care Workers	• Developed new opportunities to gain feedback from Community Care Workers and used this information to review and adapt care plans. • Improve feedback loops to ensure Community Care Workers receive feedback about their clients, and encouraging Community Care Workers to report any Client changes. • Involve Community Care workers in client review meetings.
Redefining what constitutes Personal Care and its importance in the care continuum.	• Personal Care, was seen by many as the provision of assistance with showering, dressing, shaving etc. • Following redirection, that personal care actually involves any tasks that require 1 on 1 assistance, the scope for change grew.
Increasing understanding about the roles of different staff and disciplines in HACC	• Referral quality improved • Secondary consultation opportunities have increased – formally and informally • In the beginning of the project one of the most effective tools was Staff shadowing one another as they went about their usual tasks. This provided great opportunities for staff to learn more about each other's disciplines.
Effective partnership work at both management and service provision levels of the organisations	• Leadership staff able to lead a change process within their organisations and respond to issues in a timely manner • Service provision staff better able to discuss issues at the time due to the designated OT being readily accessible to council, and reduced time waiting for telephone or email responses.
"Just start" attitude. Permission to create a narrative that supported the joint work being developed.	• For many LGA's the process of defining the partnerships and setting up MoU's was an extremely time consuming one, meanwhile the project wasn't developing on the ground. The ability to report in a narrative fashion on the MDS gave the partnerships the permission or 'freedom' to spend the time developing joint roles from the ground up.

Outcome 4: There is an increase in knowledge/experience about the use of less formal staff learning experiences on the implementation of the ASM, including mentoring, reflective practice and peer support.

In order to complement action research methodology the Northern project Officer introduced the concept of Experiential Learning. Like action research, experiential learning is based on a reflective cycle.



It is important to note the success of this approach as feedback from the OTs and partnership evaluations indicates that both formal and informal capacity building approaches have been used, and have been effective. This is directly related to the learning methodology.

Co-location (or collaboration) builds increased these learning opportunities
The presence of the OT within the council offices and alongside HACC staff has undoubtedly been a key factor that has created new opportunities for learning, or strengthened existing processes within councils.
It has been recognised that the achievements so far in the project rely not on the OT coming in as an expert, but rather coming in as part of a team, working collaboratively and bringing all of the HACC roles together to learn about one another's work, and the approaches and systems of both organisations.

Table 6 - Formal examples of experiential learning opportunities include:

Learning opportunity	Outcome
Case review or intake meetings	
Formal training provided by the OT to Community Care Workers in large and small groups.	
Training sessions in the home, focused around the specific needs of a client.	
OT's observing and discussing with AO and CCW's	The OT's have reported that they too have learnt a lot, the learnings have definitely not been one sided.

Reflective Practice supported by Experiential Theory Model

As mentioned in Section 1, the approach of the Project Officer has been to create opportunities for partnerships to reflect on their approaches, noticing what is changing, and addressing what is not working.
An interesting theme that arose was that the focus of the partnership work could not be completely predetermined. Whilst organisations had some ideas about what might work, it wasn't until the collaborative work commenced and conversations started that the real opportunities for the work emerged. All Shires have identified the need for the work to evolve, and regular communication between key staff has enabled the focus to flex and change to meet the needs of clients and the organisation.

Table 7 – Examples of informal experiential learning opportunities include:

Learning opportunity	Outcome
Shadowing – AO's with OT's, OT's with CCW's, AO's with other Allied Health Staff	
Joint home visits	• A more holistic view of the client, their environment and needs. • Informal learnings have also reportedly happened as a result of car-pooling to joint assessments.
Informal Office Conversations – which only happen as a result of the OT being present at the Council offices	• Organisations report that this informal education has perhaps been the most valuable aspect of the work as has been the launching pad for a range of unanticipated outcomes.

Networking and Peer Meetings

Assessment Officers have had the opportunity to network via the annual Assessment Officers Forums. Thus, establishment of an OT Network was an important peer support opportunity for the OTs involved in the project roles as it demonstrated equality of effort. The intention is that these will continue in to the future. Establishment of networks has resulted in regular meetings facilitating exchange of information; problem solving and strategic planning focussing on the quotation "where to from here?" or "what are our next steps?"

The 'Project' OT Role

Both the OTs and the leadership from the partnering organisations have acknowledged that the OT positions involved in this partnership work are quite unique, with a specific skill set and interpersonal approach required. As such, creating a space for OTs doing similar work appears to have assisted people to feel supported in their roles, along with offering a learning and reflection space. The OT Network meetings have offered OTs the opportunity to share their approaches to the role, and how they have negotiated some of the challenges of the work. They have shared tools developed for the role and success stories.

Celebrations for Outcome 4

- The December 2014 meeting sees all of the OT's involved in the project in the entire LMR coming together in Bendigo for one big meeting.
- As part of this years' Assessment Officers Forum, the OTs were invited to participate in the second day. For many partnerships the knowledge gained and ideas shared on this day provided a pivotal moment in the progression of the project within their LGA. This opportunity also enabled the partnerships to celebrate their successes.
- The amount of success of the experiential learning model was unexpected. The ways

that this occurred (formally and informally) was an achievement that the participants in the project have said they valued.

Discussion points for Outcome 4.

- This co-location approach has not been possible in some areas, for a number of reasons; however, a consistent collaborative approach to the partnership has in some cases been as effective (see more in section 3 of this report).
- How can experiential learning be incorporated into change management/leadership?
- Co-location is only one model to assist with facilitating change. What other models show success and why?
- How can (beside enablers and challenges) the variety of results across the Northern sector be accounted for.

"To enhance collaborative practice the OT and AO travel to joint assessments together, which allows for further discussion and reflection" Assessment Officer.

Outcome 5: The project contributes to the knowledge base around ASM implementation in the HACC sector.

The progress made towards the above outcomes has contributed to building the knowledge base around ASM implementation – both of individual staff and organisations. Perhaps one of the key themes that has emerged is that the challenge does not lie in knowledge about the ASM (the theory), but rather in implementing this in real ways for clients (the practice).

It is clear that the pairing of OTs with Council (and other) HACC services has been an effective approach. The OT profession has at its core the ASM principles around client independence and autonomy, and OTs bring with them a well-developed skill set in communicating about change and about the purpose of the ASM approach – this is what they do with clients. Following on from extensive ASM training for Assessment and Care Staff, the pairing of OT, AO and CCWs has seen dramatic increases in the uptake of the ASM approach. This is further evidence of the challenge of knowing the ASM in theory but learning how to put it into practice.

HACC Assessment Services staff are at the centre of client assessment, planning and review for HACC personal care and domestic assistance. They also play a pivotal role in identifying other needs the client may have, and linking in appropriate services. The contribution of assessment staff has been a key enabler of the partnership work, identifying opportunities to involve the OT and facilitating links to the personal care teams.

The role played by Community Care Workers has been a focus of most partnership work. In recognising that these staff are the regular and ongoing providers of services to HACC clients, the opportunity to harness their knowledge of clients and engage them in client reviews is work that has commenced in all northern LGAs. Building opportunities for discussions involving the Community Care Worker, OT and Assessment Officers enables the sharing of skills and ideas, and has led to client services being effectively adapted to meet changing needs.

In addition, the partnership work has started the process of breaking down the barriers between HACC roles – allied health staff, assessment services and personal care. In many instances prior to this project, these services have taken a 'silo' approach to service provision. As a result of this work, a 'team' approach is emerging. Staff have a better understanding of respective roles; there is a shared appreciation of the value and unique opportunities that each aspect of the service provision brings to the client; and collaborative practices are being developed.

The progress of the 12 month project has been well documented, as has the work within each LGA. It is hoped that this report captures a good measure of the work done by each organisation in implementing the ASM approach in their work. The local approaches in Section 3 of this report can act as a resource for other organisations embarking on similar partnership work.

Section 3: Progress in the Shires

Buloke Shire Council

The partnership agencies are Buloke Shire Council and Bendigo Community Health Service. Some initial conversations and planning were investigated in August 2013; however, a more directed approach took place in January 2014 following the recruitment of the Project Officer. This allowed more detail of the scope of the funding to be provided. The OT was appointed in February 2014 and met with the Buloke Shire in early March 2014.

The co-location approach
Following some initial hesitation from the Buloke Shire Council, co-location was agreed upon and began in March 2014. Due to the OT being required to travel for up to three hours a day, an agreement was made that overnight stays in the Shire every fortnight would facilitate access to Sea Lake, in the north of the region, and assessments of those Clients receiving PC services which occur relatively early in the morning. The OT has endeavoured to make her role flexible with regards to days of work and accessibility.

The OT has presented at Community Care Staff meetings and attends fortnightly Intake meetings with Assessment Staff, where individual clients and cases are discussed. These Intake meetings give all involved a rounded understanding of workloads and allows opportunities for incidental education and collaborative practice. The AO from the Sea Lake region is included in these Intake meetings via speaker phone.

The OT has attempted to block days on a calendar for certain towns, to allow the AO's to book visits in those specific regions. This would eliminate the need to travel for 1 assessment; however, due to the work load of the Assessment staff and the timeliness in which they action their referrals, this is not always suitable. Therefore joint assessments have not fully been established within Buloke.

Progress Highlights.
Staff at Buloke state that the ASM was already embedded in their work practice; however, this partnership has expanded the scope of ASM in practice. There have been many highlights in the work done to date:

- The implementation of fortnightly Intake meetings between AO's and OT, Northern AO contributes via speaker phone.
- Regular OT attendance at Assessment Staff meetings.
- OT availability to work with CCW's to develop and implement interventions designed to increase capacity of clients.
- Improved sharing of information, and continuity of care between agencies.

- **Enablers of change.**
- A positive attitude amongst all staff.
- OT access to all Council Staff.
- Intake meetings.
- OT being flexible with days of work and having regular overnight stays in Buloke to eliminate some of the travel components of her workday.
- OT Network meetings – opportunity to speak freely without strict structure.

- Identifying exactly what constitutes Personal Care.
- CCW contact and input.

Challenges

- Staffing issues at Buloke – HACC Coordinators perform many tasks; they are Assessment Officers, Intake Officers, Pay Roll and Roster, they also fulfil many administration roles.
- Extended leave allocated to HACC Coordinators, with minimal replacement staff.
- Client attitudes and perspectives – 'service entitlement'.
- Travel – distances between clients and OTs place of employment, OT currently travels 3 hours per day just to reach the Buloke Shire Office, without travelling to Clients homes.
- Inability to schedule Joint Assessments due to availability and time-tabling of AO/OT/CCW/Client.
- Guaranteed minimum hours for DCW's, makes it more difficult to make roster changes to allow OT to be present whilst CCW is in attendance with Client.
- Technology – OT unable to print from laptop whilst at the Buloke Shire Offices. Therefore she emails to BSC Staff and they print for her.
- OT does not have access to BSC client files

Some future priorities and ideas

- Encourage a stronger relationship with East Wimmera Health Service OT's and investigate other services such as PAG.
- Review the Communication Tool when new Team Leader is appointed.
- Update MoU when new Team Leader is appointed.
- Develop a shared Care Plan.

Buloke - Positive Practice Example

OT attended a joint personal care home visit with a CCW. The CCW requested some guidance as to how to safely transfer Diana using a sliding bath transfer bench. OT worked with the CCW to adjust the sliding bath transfer bench to the correct height and demonstrated how to clip the seat to avoid the client sliding when dressing and drying. The CCW and OT discussed methods to develop Diana's independence when completing showering and dressing. Both Diana and the CCW were very pleased with how much of a difference the small changes to the equipment benefitted the personal care routine. As a result Dianna felt a lot safer and could do more of the showering dressing and drying herself.

Gannawarra Shire

The partnership agencies are Gannawarra Shire Council and Northern Districts Community Health Services. Some initial partnership conversations took place prior to the recruitment of the Project Officer; however a more detailed outline of the scope of the funding was required. The partnership struggled initially to determine the direction they would take with the funding. There was much discussion concerning whether it was normal HACC OT or something quite different. The partnership decided that a regionally specific approach was required and the target client was developed. The Gannawarra partnership chose to explore the benefits the funding could provide for those younger clients with complex needs who would not meet the criteria for services following the Age Care Reforms and NDIS, as well as some regular clients who exhibit a readiness to be change.

The co-location approach

Co-location was not going to be considered in Gannawarra as NDCHS were reluctant to allow their staff to sit off-site and they preferred to see a 'team approach' be developed. However due to the close proximity of their offices, regular scheduled meetings and case consultations continue to occur. Whilst GSC and NDCHS stated that they already had a strong working relationship, the funding has allowed this to develop further.

The 'project' has taken a long time to unfold in Gannawarra due to extended staff illness, leave and staff shortages; however, has produced some wonderful results in a short time frame. The working relationship between the OT, AO's and CCW's is strong. The OT has presented at Community Care Staff meetings and attends weekly meetings with Assessment Staff, and CCW's where individual clients and cases are discussed. These meetings give all involved a rounded understanding of workloads and allows opportunities for incidental education and collaborative practice.

Progress Highlights

GSC and NDCHS had a strong history of working together; however, this partnership has expanded the scope of ASM in practice and allowed time to explore where this could lead.

There have been many highlights in the work done to date:

- The implementation of client review meetings where CCW's AO's and OT freely discuss a client's care plan and explore where opportunities exist for change and improved independence.
- The development of a shared Universal Care Plan that remains the property of the Client, in the Clients home. This is in the trial stage only.
- OT attendance at every 2nd Staff meeting.
- OT availability to work with CCW's to develop and implement interventions designed to improve independence and re-able clients.
- Incidental education received during client specific team meetings.

Enablers of change

- A positive attitude amongst all staff.
- The Partnership would like to mention the important work the ASM IC has played in this role. They describe her as providing a clear, direct, solid part of the success in the LGA.
- OT stated that "the funding gave the scope to spend time with clients".
- Improved relationships where CCW's are considered professionals, and their input with Client Care co-ordination is valued and acknowledged.
- Defining PC as anything that is 1 on 1.

Challenges

- OT staffing as a result of extended sickness and leave.
- The word co-location has proven to be a major barrier; it was immediately presumed that this was the intended direction.
- Initially, insufficient direction or information regarding the purpose of the funding.
- Accessible funding and time frames required to make the required changes to improve Clients independence; these include 'big ticket' items via SWEP funding.
- GSC short staffing issues.
- NDCHS had a "team approach" to the program which didn't allow sufficient collaboration, more flexibility was required.

Some future priorities and ideas

- The Universal Care Plan being developed which will retained by the Client in their home to be used by all Community Service, Medical and other professionals. There would be no issues of confidentiality as the Care Plan would be the property of the Client who is free to share the information with whomever they choose.
- Investigate the Independent Living Skills program.
- Link the Action Plan to the Quality Review.

Mildura Rural City Council

The partnership agencies are Mildura Rural City Council and Sunraysia Community Health Service. SCHS appointed a dedicated OT for the project in 2013 and she began shadowing AO's in order to learn what a Living at Home Assessment involves. The appointment of the OT/LGA Project Officer saw a meeting scheduled for February 2014 and further direction was received from the Department. This meeting outlined the intention of the funding to further develop the scope of the ASM and accordingly gave direction to the project. After initially targeting people new to HACC it became evident that inappropriate referrals had led to clients who had more complex needs; with regards to issues of mental health and chronic pain management. It was then decided that this funding would best suit relatively new HACC clients who saw re-enablement as a priority and had the capacity to increase their participation in life.

The co-location approach

MRCC and SCHS saw co-location as a beneficial step in developing the partnership; consequently the OT spent 2 days per week within MRCC Offices. This requirement has become more flexible following the strengthening of the Partnership, the development of procedures and a better understanding of the role.

The OT and AO's enjoy weekly case discussions, regular team meetings; attend regular CCW meetings and informal discussions with AO/CCW where individual clients and cases are discussed. To enhance collaborative practice the OT and AO travel to joint assessments together, which allows for further discussion and reflection.

Progress Highlights

The partnership between MRCC and SCHS has taken a proactive approach to embedding the ASM in practice. There have been many highlights in the work done to date:

- The development of a referral process that reduces duplication of documents.
- An improved Intake practice that identifies suitable 'project' clients.
- Continual opportunities for communication.
- Regular meetings which further develop and progress the project, eg: action plan development and ongoing continuous improvement.
- Via the implementation of joint AO/OT assessments, the assessments are now carried out with a more OT focus which allows a more comprehensive and goal directed assessment.
- The benefit of working together reduces the 'silo' effect.

Enablers of change

- A sense of humour.
- Implementation of the GDCP.
- Joint visits.
- Motivational interviewing techniques.
- Holistic assessment – considering co-morbidities, pain, mental health and social issues.
- Experience and learnings as the project progresses.
- Presentation of the project by OT at SCHS OT meeting, via case studies in annual report and during OT week on the SCHS intranet.
- Modelling ASM to other practitioners at SCHS.
- Educational components – Assessment Officers Forum/OT day saw a big shift in direction.
- OT Network meetings.
- OT mentoring with Team Leader at SCHS.

- Reflective journaling.
- Liaising with Project Officer.

Challenges

- Client perceptions – 'service entitlement'.
- Historical Service provision – doing for rather than with
- Experience and knowledge of using the ASM approach.
- Project Officer employed after the project had already begun.
- Pre-conceived ideas that were different between SCHS and Project OT.
- Time required developing the MoU.
- Staffing issues at MRCC.

Some future priorities and ideas

- OT would like to work more closely with CCW's by working 1 on 1 with the Client and CCW in the Clients home – on the job training.
- OT would like to provide educational sessions to appropriate service providers on the history and development of the project.
- Up skilling of CCW's.
- Up skilling of other OT's and Allied Health Professionals.
- Improve Mildura Base Hospital referrals by making them aware of the project and the information required in referrals sent.
- Maintain connection with the OT Network.
- Continue learnings via joint AO/OT assessments.
- Work with other service providers to meet additional needs of clients regarding, for example, pain and chronic disease management.
- Creating a more unified approach to Clients care plans by involving other service providers who are already engaged with that client.
- Focussing on MBH and PC.

Mildura - Positive Practice Example

A joint assessment was completed with an assessment officer and the occupational therapist following a referral for personal care assistance. This client was recently discharged from hospital following a fall and a fractured NOF. Previously she was independent in showering and home care. Following the joint assessment, the occupational therapist visited the client during her personal care service. The client, carer and occupational therapist sat down and discussed how Mrs A was managing showering. The carer reported that Mrs A had lost a lot of confidence and needed quite a lot of assistance for preparing to shower, showering and dressing. The occupational therapist organized for rails and a hand held shower in the shower and a shower chair. Through discussion with the carer, the aim was for Mrs A to become independent in showering. The Occupational Therapist referred Mrs A to physiotherapy for a mobility assessment and to determine her physical capacity to shower independently. The physiotherapist assessed Mrs A and found that she has adequate range of movement and strength to shower independently while sitting. The occupational therapist, the carer and the client worked together to establish strategies to enable Mrs A to shower independently. Mrs A can now shower independently, but requires supervision due to her fear of falling. The plan from here is for the carer to work with Mrs A to build her confidence in walking unaided to the shower. This is a good example of the multidisciplinary allied health team, the client and the carer working together to increase functional capacity.

Shire of Campaspe

The Shire of Campaspe is unique, in the northern LMR, given that two (2) Health Services received funding to develop this project. Echuca Regional Health received .5EFT and Rochester and Elmore District Health received .25EFT. This has been both a benefit and a challenge within the Shire of Campaspe with regards to expectations around the roles and availability of OT's.

Initially there was much work centred around the development of the Memorandum of Understanding (MoU), would it be a three (3) way MoU or two (2) separate documents. To date, this has not been resolved, there are however individual MoU's in draft form, but no decision had been made regarding their use.

It became apparent, that for the partnerships to develop, work on the ground had to begin. The Project Officer instigated a weekly meeting and the AOs and OTs began developing the project.

The co-location approach
Due to insufficient office space at the SoC full co-location was not an option; however, collaborative practice is definitely their preferred option. Due to the close proximity of their offices, the OT from ERH spends considerable time within the SoC offices, and on the road conducting joint assessments with AOs. In comparison, the REDHS OT has considerably less hours to dedicate to the project, is situated further away from the SoC, and as a result is often not available to participate in joint assessments.

Progress Highlights

- The implementation of joint assessments has seen a shift in 'target' clients.
- Appropriate referrals are identified at intake.
- The development of a fortnightly Intake meeting to identify clients who may benefit from a restorative approach.
- Urgent referrals can happen more quickly as there is a reduced waiting list for OT service.
- The inclusion of OT input into council care plans, OTs from ERH and Red's send their care plans into council.

Enablers of Change

- Joint assessments have supported assessment staff to learn new intervention strategies and have supported staff to get to know one another and further developed a meaningful understanding of individual roles.
- OTs have gained an increased knowledge and appreciation of the complexities of Shire services.
- Shire staff have a better understanding of the OT role.
- The establishment of the joint meetings has supported service coordination, scheduling, sharing of skills and knowledge and enabled better identification for joint assessments.
- The broadening of the OT focus.
- A big enabler of change has been the ability for shire staff and OTs to work together at a ground level.

Challengers

There have been many challenges to developing these partnerships further.

- Time taken to set the work up, especially given that there was no extra funding provided (from a Council perspective).
- The project has taken time to develop and clarity around the approach required has been time consuming.
- Geographical refining with regards to which OT services which region.
- The Shire of Campaspe has an extensive wait list for domestic assistance.
- Understanding the purpose of the funding.
- Identifying the right Client group.
- Funding constraints around the use of PC funding as the Shire of Campaspe have a high demand for Domestic Assistance and limited need for Personal Care hours.
- The inclusion of three (3) organisations in this work has created some challenges with regards to different approaches of health services requiring altered administrative processes. The Shire of Campaspe is required to change their working practice dependent on which Health Service they are working with.
- These differences have also affected the ability to reach a consensus at a management level with regards to finalising the MoU's.
- Expectation of the OT role.

Future Opportunities

- Shared care plans – council to share plans back with health services.
- Explore service delivery, boundary issues and the potential to shift to a service need/responsiveness approach – eg: if a client is available on a Tuesday for assessment, but the OT in that region does not work on a Tuesday, can another OT respond to this need? Similarly around case load/OT capacity?
- Finalise MoU ('s).
- Marketing and development or Client awareness.
- Training of CCW's – eg: transfer slide sheets.
- OT input into Council newsletters.
- Consider the benefits of OTs and CCWs working together more often.
- With increased funding, staff could meet together for capacity building opportunities.
- Investigate further funding options for Assessment.
- To gather clarity from DH regarding consistency around OT fees.

Project Officer Thoughts

- Investigate a shared care plan between Health Service and SoC (other LGA's using Kate Pascale's Goal Directed Care Plan).
- Redefine PC to include anything that is one-on-one, not just showering and ADL's. This includes domestic assistance where the client and carer are working together. This would reduce the DA waitlist and would encourage a restorative, capacity building practice.
- For the purpose of this project only refer clients who are ready for capacity building.
- Streamline referrals to eliminate an OT waitlist.
- Perhaps utilise the OT with less EFT to be more focussed on contributing to newsletter and up skilling of CCW's.

Swan Hill Rural City Council

The partnership agencies are Swan Hill Rural City Council and Swan Hill District Health. Prior to the LMR appointing a Project Officer for this region, SHRCC and SHDH held a planning meeting in November, 2013. This meeting identified an initial need for reviews of clients receiving Personal Care. Many clients receiving personal care did not have scheduled reviews and many continued receiving services long term. A plan was developed to address this; however, was implemented for only a short time as following the appointment of the OT/LGA Project Officer a meeting was scheduled for March 2014 and further direction was received from the Department. This meeting outlined the intention of the funding to further develop the scope of the ASM and accordingly altered the direction of the project. It was identified that this funding would best suit relatively new HACC clients and those that saw re-ablement as a priority. A designated OT was appointed for the role in April 2014, with an initial view to rotating the role in-line with SHDH practice; however, for continuity, the OT has remained on the project to see it fully implemented as best practice.

The co-location approach

Due to the close geographical location of the two agencies and some hesitations from SHDH management regarding staff safety and liability/insurance concerns, co-location was never a valid option. However the challenge was then to ensure continual contact and regular collaborative client discussions.

> *"Regular contact is required; if not co-location then other mechanisms should be in place to ensure close and regular communication, to facilitate learnings across the three disciplines – OT, PC and AxO. For example, the OT would be invited to attend AxO meetings; joint assessments and care planning sessions." (Minutes from March, 2013)*

The OT has presented at Community Care Staff meetings and attends Intake meetings weekly where individual clients and cases are discussed. These Intake meetings give all involved a rounded understanding of workloads and allow opportunities for incidental education. The OT has also taken the opportunity to present to the other Occupational Therapy department staff at SHDH to educate them on the new direction of the work being done.

Progress Highlights

Much work has been done to further implement the ASM within Swan Hill. The partnership has taken a proactive approach to embedding the ASM in practice. There have been many highlights in the work done to date:

- The development of a shared Goal Directed Care Plan.
- The implementation of joint Intake meetings.
- The removal of an OT waitlist.
- Educational OT components at Community Care Staff meetings.
- Regular OT attendance at Assessment Staff meetings.
- OT availability to work with CCW's to develop and implement short term interventions designed to re-able clients.
- Improved sharing of information, and continuity of care between agencies.

Enablers of change

- Visualising the big picture.
- OT access to Council Staff.
- Intake meetings.

- Implementation of the GDCP.
- Educational components – Assessment Officers Forum/OT day saw a big shift in direction.
- OT Network meetings.

Challenges
- Staffing issues at SHRCC – Assessment area is understaffed.
- Client attitudes and perspectives – 'service entitlement'.
- CSW's were initially doing 'for' not doing 'with'.
- The GDCP was not implemented in the early stages.

Some future priorities and ideas
- Involve the TCP OT in the project – increase communication between TCP and SHRCC.
- OT presentation to OT staff and CSW's on the direction of the project.
- Development of a Client Functional Survey to be conducted every 3 months by CSW's to inform OT and AO's of the need to flag client for review.
- OT to complete shower assessments post TCP or PAC, as clients are generally not reassessed and may have improved function post their acute stage and go on to receive unnecessary services more long-term, risking their decreased independence and increasing their reliance on services.
- If staffing levels allowed, further joint OT/AO assessments would embed the ASM.

Section 4: Project Officer Reflections and Recommendations

The final section of the report offers some broader comments about the project implementation.

Capacity Building Approach

The Loddon Mallee regional office of the Department of Health took a broad approach to the capacity building focus of this growth funding, electing to consider not only increasing the amount of OT and PC services available to HACC clients, but also addressing the quality of these services. By encouraging organisations to use the funding to build staff and systems capacity through co-location (or collaborative practice), innovative and responsive work has resulted. Staff and service capacity has been improved for the benefit of all clients.

This approach has given OTs the scope (and permission) to build relationships with relevant staff, spend more time in review conversations about clients (indirect client work) and take time to share skills and information with relevant staff in a timely manner.

The OTs have also been keen to note that they, too, have learned a great deal in their roles, increasing their knowledge about council HACC services, increasing their understanding about the challenges and value of Community Care Workers, and learning to negotiate some of the challenges in partnership work.

Similarly, capacity building has also happened on an organisational and partnership level, leading to improved communication in some instances, better referral and collaborative practices, and contributing to a sense of working in a more cohesive manner with joint clients.

It could be anticipated that these changes will support sustained collaboration and also provide a good foundation for future service improvement and innovation between the partnering agencies.

Value for staff

As noted in this report, the OT work with council HACC services is having a positive impact on clients, as demonstrated through case study examples and partnership evaluations. In addition, the partnerships also made a range of comments about the benefits of this work for staff in both health services and local government.

Increased understanding about the different roles of staff is a key part of the foundation on which the success of the work is built. As knowledge about individual roles has increased, so has their skill and confidence in being able to make appropriate referrals and initiate conversations about their client work. All involved are more familiar about the range of services that can be helpful in working with HACC clients, and they are also gathering new intervention ideas and tools to use to support clients. This up skilling and resourcing of staff is building capacity of individuals and of services, and evaluation meetings recognised this as one of the key benefits of the work.

Similarly, the OTs also noted that their role is acting as a key conduit of information between the health organisation and councils. This two way communication is supporting a broader sharing of information with staff that are less directly involved in the work. For example, OTs have described being able to share information about council services and processes with the broader allied health team in their organisation, facilitating referrals, dispelling myths and ultimately increasing staff knowledge.

These examples of benefits to staff should lead to improved services to clients into the future.

Collaboration or Co-location?

The term 'co-location' was initially used almost exclusively in the establishment phase to describe the role and placement of the OT, until it was recognised that this term was creating a barrier to progressing the partnerships, in some instances. For some LGAs co-location was not deemed an option either due to lack of space at the Council, or due to the travel that would be required by the OT to be physically based at a council office.

When returning to the intention of the partnerships – services working together to improve outcomes for clients - it became evident that co-location was only one approach to supporting this process. Focus shifted to agencies identifying approaches that would support collaborative practice between relevant staff, which may involve some co-location, but would always involve purposeful opportunities for the OT to work with Assessment Officers, Community Care Workers and other HACC staff as relevant.

It is important to note, however, that OTs, some assessment staff and organisational leaders involved in a co-location approach have all recognised the unique opportunities this OT presence in the council office brings. The informal, timely conversations about client work and the chance to quickly establish positive working relationships, along with the OT feeling like 'part of the team' at council, are some of the recognised benefits.

The "D" word – Documentation

Perhaps the key challenge experienced by the Project Officer over the 12 months was meeting the role expectation of documented partnership agreements for all Shires. At the end of the first year, 3 of the 6 partnerships have finalised partnering agreements and 3 have a draft developed.

In approaching this work, the Project Officer was conscious that these Agreements needed to be meaningful to the organisations involved, and that the agreements are not about having a piece of paper, but having a record of the agreed purpose, roles and responsibilities of the partnership. Given this, the Project Officer avoided doing the agreements for organisations, believing that the partners would then have little sense of ownership over them.

The Project Officer initiated a range of actions to support the development of the agreements, including discussions at each partnership meeting, providing templates for partnerships to use as a starting point, offering assistance to progress the work, emphasising their importance in supporting sustainability and providing deadlines. But still the task remains incomplete. It is considered that the main barrier to the completion of these agreements is staff time, and the recognition that this partnership work is one relatively small part of the service provision and role responsibilities of the people and organisations involved. For many partnerships the formal documentation could not be developed until work had begun as there was insufficient project direction supplied by the Department. It wasn't until collaborative work began that the intent and direction the funding would take became evident.

Initially the intentions to have partnerships complete the relevant planning and partnering documentation prior to commencing the work on the ground has proven ineffective. It has been noted by organisations and the Project Officer that this was in-fact an unhelpful goal. As noted in Section 3 of the report, the work needed to start on the ground before the partnership could fully realise the potential of the work. Partnerships were then able to adapt their approaches and refine their thinking about what was going to work best in their region.

All LGAs have been urged to support the sustainability of their partnership work through documentation – of their partnerships, their policies and procedures – to embed the work in practice and build continuity in the event of staff changes. Department of Health staff will continue to follow up this work in the months ahead.

The OT Support Project – reflections of the Project Officer

The northern LMR Project Officer role was a Department of Health position sub-contracted to East Wimmera Health Service, and this position began in December 2013. There was also a Project Officer appointed for the southern region, and they began their position in August 2013. So some of the initial hurdles had been addressed prior to the northern Project Officer being appointed. The ability for both Project Officers to work collaboratively has also been an advantage.

The southern Project Officer developed some broad objectives and further developed these into a work plan, including detailing the project outcomes. The northern Project Officer utilised this work and included this documentation into their role.

Perhaps the biggest challenge for the Project Officer, and in turn for participating agencies, was the low level of detail provided by the Department of Health about the specific intentions of the funding. This made it difficult in the early days to be able to clearly focus the work and provide consistent and accurate information to organisations. The Project Officer continued to seek clarity about this issue, and the regional staff at the Department of Health developed some more detailed parameters for the funding at a local level. This clarification was a great support to all involved and very quickly assisted progress to be made.

An additional challenge experienced by the Project Officer lay in the level of authority that came with the role. At times, the Project Officer was faced with questions and issues related to funding agreements and compliance – well beyond the scope of the role. Engaging the Program and Service Advisor (PASA) in the work was a key moment of change. The PASA was able to support the progress of the work in LGAs by providing clear and consistent information regarding funding expectations and in some cases this supported barriers to be addressed. Clearly the project was not only about supporting collaboration in LGAs, but also between the Project officer and relevant Department of Health staff.

The other key resource for the Project Officer role has been the ASM Industry Consultants. Due to travel distances involved in the northern LMR the role of ASM Industry Consultant is shared between two Department of Health staff. The orientation, supervision and support offered to the Project Officer has given clarity to the role, acted as the link to the Department of Health and provided consistent strategic advice.

Another challenge for the northern project Officer was travel. The northern region of the LMR is a vast area, the Project Officer was required to travel for approximately 700km's (round trip) to attend a meeting in Mildura. This travel component has been a barrier for all LGA's in this region, hence all LGA's stating that they are understaffed. Perhaps some regional mapping and restructure is required regarding funding when travel is considered as a valid obstacle to effective client care.

The key contribution of the Project Officer has been in supporting the partnership development and supporting the discussions that led to joint work in its infancy. Following on from that was the scheduling and chairing of regular development meetings, planning discussions, and the OT network. The Project Officer has aimed to be a helpful resource to do some of the leg work in setting up the partnerships – work that community service organisations often struggle to find the time to do – and to facilitate reflective conversations, notice and celebrate change and document progress in the form of meeting minutes etc.

As to the value of the project, from the Project Officer's perspective; the role has opened conversations that are further developing collaborative practice between LGA's and Community Health Teams. There is evidence that other allied health disciplines are being encouraged to also work in this manner, creating a more person centred

approach for the client. This process in some cases is also reducing the need to duplicate data collection. One LGA is trialling a Care Plan that is the property of the Client; therefore, the Client is free to share it with whomever he chooses. From the visiting District Nurse to the appointment with the GP, continuity of care can be guaranteed by sharing this documentation, and as the client owns the documentation there are no issues with confidentiality providing they consent to it being seen by all service providers.

The role has added a resource to the regional Department of Health team, with the dedicated time enabling a greater level of planning, follow up and resourcing of partnerships and planning than would otherwise have been possible.

The partnerships have achieved a great deal in a short amount of time, and the passion, professionalism and leadership from the OTs, together with the commitment and client specific knowledge of HACC staff in local government and the development of the 'Team' approach have been the critical factors in the progress of the work.

Looking Ahead

With the partnerships established locally in all LGAs, focus now shifts to considering how this work becomes part of 'business as usual' for the organisations, and also identifying other opportunities with the work.

Key recommendations for future action:

- Encourage a review of assessment funding for LGA's in the northern LMR to take into consideration travel components, this also effects the CCW's and their capacity to travel long distances for client care.
- Consider mapping areas, especially those with more than one health service provider.
- Embed approaches in policies and procedures and complete Partnership Agreements.
- Continue to build opportunities to support Community Care Workers in their work and mobilise their skills and expertise to inform client reviews.
- Consider how this work becomes everyone's business in HACC, and not just the 'ASM OT'.
- Consider opportunities to support ASM implementation across other HACC services – for example: District Nursing and Planned Activity Groups.
- Consider the role of Allied Health Assistants in the work and investigate opportunities for CCW's to up skill to fulfil this role.
- Department of Health to continue to support the partnership work through periodical meetings with the partnerships and convening the OT Network meeting
- Work with and encourage partnerships to confirm some manageable evaluation processes to measure change, perhaps this could be an opportunity for a universal tool.
- Identify opportunities to capture and disseminate the achievements and enablers of change to support similar work in the future.
- Consider a more comprehensive evaluation of the funding implementation across the Loddon Mallee region.
- Encourage procedural documentation and explore alterations to PD's to include the demands of this role and provide effective orientation for new staff.
- Acknowledge the important role of Shire staff and utilise their skills and ability to be in the home, working with the clients. They are truly the eyes and ears of this projects development.
- Develop a shared Care Plan and common evaluation tool.

References

ASM Prepare, Victorian Government Department of Health, February 2010.

Appendix 1: Client Case Studies

Daisy – Buloke Shire Council

OT received a referral to see Daisy who had previously been discharged home with HACC services following a hospital admission. Prior to going to hospital Daisy was independent with personal care and house work. Daisy voiced that she would like to get back to her pre-morbid independence. OT liaised with Daisy's CCW about ideas to increase Daisy's independence with showering. In which Daisy progressed from assistance with showering and dressing to the CCW providing supervision only. Daisy also progressed from having her washing done for her, through to knowing how to work her new washing machine from practicing with her CCW, through to being able to complete the clothes washing and drying independently.

Case study prepared by Emma Moylan, OT. Bendigo Health

Irene – Gannawarra Shire Council

Irene* is a 58 year old lady who was referred to the OT LGA project as she was finding attending to heavy tasks difficult. This was further complicated by 3 herniated discs in her back and a long standing history of depression which also made it difficult to maintain a good routine at home. At the time of the initial consult Irene reported weighing 140kg and found walking out to the mail box and back exhausting. Irene was also living with a male housemate who was a heavy drinker. This housemate was very negative and unsupportive of Irene trying to improve her situation.

Initially Irene was receiving home help through post-acute care following a total knee replacement. Once post-acute care finished Irene stopped receiving assistance for three months but then contacted the shire to commence receiving home help again as she was finding it difficult to clean her home due to her back pain and shortness of breath.

At the initial consult Irene identified that she would like to improve her mobility and overall health and wellbeing. Irene also identified that it would not be ideal for her to become dependent on services at her age. Irene reported that she previously attended the exercise group at the local hospital, however struggled with motivation and the early start time.

Following the initial consult the OT contacted the physiotherapist and obtained a copy of the exercises Irene was completing at the exercise group. The OT then arranged through the shire for extra community care worker hours to be put in so that they could complete the exercises with Irene twice a week. The OT also provided Irene with a bariatric four wheel walker so she was able to complete the walking component of the exercise program but also give her the opportunity to be able to go for walks in her own time.

The OT worked closely with two CCW's to train them in completing the exercises with Irene. This involved demonstrating each exercise, discussing safety precautions and the importance of motivation, along with how to document Irene's progress. The OT also provided education around task analysis so that the CCW's could work alongside the OT to develop session plans for home help in order to enable Irene to assist with the housecleaning. Each session plan had a clear lay out of what Irene was expected to do and what the CCW would do during the allocated time for home help. The session plans were designed around working towards Irene achieving her goals, so each week Irene's workload would be increased or the number of rest breaks would be reduced in order to challenge Irene and improve her functional performance.

On the first session the CCW vacuumed the floors and cleaned the bathroom and toilet whilst Irene mopped the floors. Irene successfully mopped the house within 1 hour and had 12 rest breaks to complete the task. After 8 weeks Irene managed to cut down to taking 5 rest breaks and mopping the house within 40minutes. Irene is also cleaning the bathroom using a long handled aid which was prescribed to her by the OT.

Throughout my contact with Irene she expressed her frustration about living with her housemate and would like to be closer to her family. Irene has since looked at properties in Gippsland and is due to move in two weeks' time. Irene is looking forward to the change and she is planning on continuing to complete her exercises and attend a local art class in order to meet new people. Irene reports her new home in Gippsland is a small unit and she feels confident that she will be able to complete the housecleaning without assistance from local services.

Irene's* Goals

Aim: To improve mobility and overall health and wellbeing
Exercise Program

Long Term Goal:

Within four months, Irene will be able to successfully and independently complete her exercise regime, without becoming short of breath and requiring regular rest breaks.

Short term Goals:

Within one month, Irene will be able to successfully complete two prescribed exercises, without having to sit and rest between each exercise.
Within one month, Irene will be able to successfully walk to end of the court and back on a daily basis using her wheelie walker, without requiring a rest break.
Within two months, Irene will be able to successfully complete 3 reps of 10 step ups, without becoming tired and having to sit and rest between each set.

Increased Domestic Independence

Long Term Goal:

Within four months, Irene will successfully and independently clean the floors and bathroom of the house, taking short rest breaks as required.

Short Term Goals:

Within one month, Irene will independently clean the bathroom with the use of a long handled aid, taking only one rest break whilst completing the task.
Within one month, Irene will successfully mop the floors of the house, whilst the community care worker vacuums, taking only five rest breaks whilst completing the task.
Within two months, Irene will successfully vacuum the floors of the house and clean the bathroom, using a long handled aid, taking only 6 rest breaks to complete the entire task.

Irene's* Session Plans

Exercise Program

Community care worker to continue completing exercises with Irene on a Monday and Wednesday and work towards achieving goals. Irene to complete exercise regime on her own on the days that community care worker does not visit. Irene to try and increase the distance she is able to walk before having to stop and rest.

Domestic Independence

Session 1

- Irene to commence vacuuming bathroom prior to community care workers arrival.
- Once community care worker arrives they are to commence vacuuming the remainder of the house whilst Irene cleans the bathroom with a long handled aid.
- Once vacuuming completed community care worker is to complete mopping whilst Irene finishes cleaning bathroom and then commences on cleaning the toilet.
- Irene to allow herself 4 rest-breaks to complete the task. Irene to complete the task within 1 hour.

Session 2

- Community Care worker to complete vacuuming and clean the bathroom whilst Irene mops the floors.
- Irene to allow herself 7 rest breaks to complete the mopping of the floors. Irene to complete the mopping of the floors within 1 hour.

Session 3

- Irene to repeat session 1 but attempt to vacuum the hallway as well.
- Irene to complete the task within 1 hour and allow herself 3 rest-breaks to complete the task.

Session 4

- Irene to complete vacuuming of the floors whilst community care workers mops. Ideally, Irene is to begin vacuuming prior to community care workers arrival.
- Once vacuuming completed, Irene is to the then commence cleaning toilet whilst community care worker begins cleaning the bathroom.
- Irene to complete the task within 1 hour and allow herself 7 rest-breaks to complete the task.

Irene's* Checklist

Exercises

Task	No. of rest breaks Week 1	No. of rest breaks Week 2	No. of rest breaks Week 3	No. of rest breaks Week 4	No. of rest breaks Week 5	No. of rest breaks Week6	Target Goal
Warm/up walk							
Wall Push ups							
Heel/ Toe Raisers							
Step Ups							
Sit to Stand							
Bicep Curls							
Warm Down							

Domestic Independence

Task	No. of rest breaks Week 1	No. of rest breaks Week 2	No. of rest breaks Week 3	No. of rest breaks Week 4	No. of rest breaks Week 5	No. of rest breaks Week 6	Target Goal
Mopping the floors							
Cleaning Bathroom							
Vacuuming Floors							
Cleaning Toilet							

Observations and Progress were documented weekly.

Case study and Care Plan prepared by Amy Smith, OT, Northern District Community Health

Sally – Mildura Rural City Council

Sally is a 76 year old with Dementia who is quite agile. She has received Home Care services for a while now. She was referred back to the MRCC due to frequent calls to the police at night time reporting her husband missing – her husband has passed away.

During the joint assessment, we determined that Sally would both benefit and be able to increase her participation in house work.

The OT then attended Sally's home during a Home Care service. Working with Sally and the CCW, we negotiated some changes to the service plan. Instead of Sally having a cup of tea while the CCW worked, Sally now sweeps and mops while the CCW vacuums, and cleans the vanity basin while the CCW cleans the shower. They do dusting together while having a much enjoyed chat at the end of the service. Resulting in increased self-satisfaction, opportunity for socialisation and increased participation in meaningful activities, no change to services provided.

Case study prepared by Belinda Dixon, OT, Sunraysia Community Health Service

Betty – Mildura Rural City Council

Betty is a 57 year old with Bipolar and osteoarthritis. She was referred to MRCC for assistance with house work. During the joint assessment, Betty was in mental health crisis, had just moved house and had little furniture. The AO and OT were perplexed as how to assist Betty. A month later, the OT rang Betty and her condition was more stable. Betty and the OT determined she was having difficulty with making her bed because the mattress was too heavy, vacuuming because she experiences pain with pushing and pulling and difficulty scrubbing the shower tiles. She also had difficulty changing the doona cover and hanging wet bed linen.

Betty was in a position to purchase many items. The OT and Betty went shopping and purchased an upright vacuum cleaner and a lighter mattress. The OT demonstrated a tile scrubber and a long handled window cleaner which Betty also purchased. Betty now received a monthly home care service for assistance with hanging bed linen, scrubbing the shower tiles and making her bed. The outcome for Betty was increased participation and improved independence in house work, resulting in reduced hours of service.

Case study prepared by Belinda Dixon, OT, Sunraysia Community Health Service

Jenny – Mildura Rural City Council

Jenny is a 52 year old who experienced domestic violence, mental health issues and arthritis. She required personal care services because she could not wash her feet or her hair. In working with Jenny, the OT was able to organize a shower chair so that Jenny could sit to shower. Jenny purchased a foot stool so that she could put her foot on the foot stool to wash her feet, and a long handled sponge so she could reach her back. The OT also recommended Jenny sit at the laundry sink to wash her hair. Jenny does not require a personal care service at all now.

Case study prepared by Belinda Dixon, OT, Sunraysia Community Health Service

Vicki – Mildura Rural City Council

Vicki is a 44 year old lady who lives with her teenage children. She receives assistance with personal care due to shoulder pathology and poor balance. Vicki is not confident in showering by herself. She also enjoys the company of her personal carers. At the moment, Vicki receives a ½ hour service. Due to this limited time, the carer assists with the majority of the showering tasks. The carer reported if she had more time, she would encourage Vicki to perform more of the showering tasks. The OT is in the process of obtaining funding for a shower stool, hand held shower, long handled aids, and grab rails. By extending the service, and providing some aids and home modifications, the plan is that Vicki will increase her participation and require less assistance from her Carer. It is hoped, through encouragement and confidence building that Vicki will eventually become independent in showering.

Case study prepared by Belinda Dixon, OT, Sunraysia Community Health Service

Jodie – Mildura Rural City Council

Jodie is a 44 year old who lives also with teenage sons. She has bipolar and fibromyalgia. Jodie receives a fortnightly home care service for 1 ½ hours. Jodie is unable to sweep, mop, vacuum or clean the shower due to pain and fatigue. The OT is working with Jodie to engage her children in house work and increase her participation in every day meaningful activity, not service related. Another work in progress: Increased participation, lots of OT in-put, no change in service hours.

Case study prepared by Belinda Dixon, OT, Sunraysia Community Health Service

Case Study - Swan Hill Rural City Council

69 year old client who lives alone. She suffers from MS and recently lost her husband/carer within the last year. Receives home help weekly and also receives assistance with completing home exercise program twice weekly.

She was referred for review of home exercise program she is completing with CSW. Reviewed home exercise program with carer present and client explained that she no longer feels motivated to complete the program as since the physio updated her program she can no longer feel her muscles igniting with the movements and therefore feels the program is not working, she much preferred her old program. I referred to physio and liaised with them to determine if her old program was still suitable for what she required. They confirmed it was still suitable so the client was able to revert back to her old program which she felt more motivated to complete.

During general chit chat about other aspects of daily living it came up that she had some difficulty transferring on/off her shower bench onto her wheelchair post showering independently at home. She demonstrated her transfers with difficulty, taking up to 10minutes to transfer, however explained to the OT that it never usually took this long and it was just because she was tired. Upon conversing with the carer, the carer indicated that in fact she had visited multiple times and the client admitted to her that in fact it takes up to 30minutes each morning to build up the strength to transfer. She has a personal alarm however barely used this when she was stuck on her shower bench as she didn't want to be a hindrance to anyone.

The positioning of the rail was creating difficulty, so we therefore looked into swing down rails as this was the only option for rail solution. We determined that she would not have the strength to swing up the rail when not in use and she seemed against the option and declined as 'it would get in the way'.

Being quite an independent, determined and strong minded woman she seemed not open to suggestions. I decided to continue to partake in conversations with her regarding possible solutions and tried to allow her to come up with a solution as then she would be more open to the option. She eventually suggested a commode, which had been suggested in previous OT involvement but was declined by the client. Due to her providing the solution she was keen to follow through. We trialled a few options and sought case management funding to assist with purchase. She was independent with transfer's once right style and height was selected.

Outcome: Client remained independent with showering and avoided need for personal care assistance 3-5 times weekly. The client said she feels as though she avoided the need to go into permanent care as she has always said that once she needs help showering she would start to consider permanent care as an option. Great outcome with decreased need for services, increased client satisfaction and independence. Highlighted importance of acknowledging carer knowledge and value in input with client intervention (understanding the rapport the carers already have with clients- client did not disclose the severity of her difficulty upon first meeting with OT.

Case study prepared by Kellie Walker, OT, Swan Hill District Health