Implementation of Occupational Therapy and Personal Care Growth Funding in the Southern 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 first 12 months of the implementation of funding to support local partnerships between Home and Community Care (HACC) service providers in the southern Loddon Mallee region of Victoria, with a focus on Occupational Therapy and Personal Care. The report considers both the work done by participating organisations, and the 12 month project that was funded to support the development of these local partnerships – the Occupational Therapy Support Project.

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 Active Service Model at a Glance
"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).

The core principles which underpin the ASM Approach are:

- People wish to remain **autonomous**
- People have the potential to **improve their capacity**
- People's needs should be viewed in a **holistic** way
- HACC services should be **organised around the person** and his or her carer
- A person's needs are best met where there are strong **partnerships and collaborative working relationships** between the person, their carers and family, support worker and between the service providers.

The HACC growth funding supporting the LGA partnerships was given as an additional resource to support organisations to further embed ASM approaches in their work with all clients. The intention of the funding was to improve client outcomes by building the capacity of the staff and services to work from an ASM perspective.

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 capcity, 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.

Supporting the establishment of the partnership work – a project approach

The **OT Support Project** (the project)) was established by the Department of Health in the Loddon Mallee region to support the implementation of a number of partnerships. 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 Southern Project Officer finished in July 2014.

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.

It is expected that the Project Officers work *with* partnerships and not *for* partnerships, assisting to build sustainable processes and plans that can continue beyond the end of the project – a capacity building approach.

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.

Introducing the Partnerships in the Southern Loddon Mallee Region

There are six partnerships across 5 Shires:

- Macedon Ranges Shire Council, Cobaw Community Health Service and Macedon Ranges Health Service
- Mount Alexander Shire Council and Castlemaine Health
- Central Goldfields Shire and Maryborough District Health Service
- City of Greater Bendigo and Bendigo Health Care Group
- Loddon Shire (South) and Bendigo Health Care Group
- Loddon Shire (North) and Northern District Community Health

Each Shire has a unique profile and the organisations involved had a varied history of working on joint projects together. At one end of the spectrum were organisations that had successfully implemented co-location approaches in HACC previously, and at the other were organisations that had not undertaken a partnership approach at an operational level such as this in the recent past.

The unique starting point for each organisation required a recognition from the outset that the implementation of the funding would look different in each shire.

Project Outcomes for the First 12 Months

Five broad outcomes 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 quarterly progress reports were provided to the Department of Health.

Key Project Activities

The following activities summarises the key elements of the work of the Project Officer over the 12 month period.

Communicating the intention of the funding and the Project Officer Role. The scope of the funding from the Department of Health was broadly stated. Clarifying these intentions then gave clearer direction to the role of the Project Officers. This information was communicated to the agencies through local meetings, and also through a presentation made at the "Partnerships and Possibilities" workshop in Castlemaine in December 2013.

Engaging stakeholders in the planning and implementation processes was an ongoing process. Building positive relationships between relevant stakeholders was seen as a key first step. As the opportunities for collaborative practice developed, so did the range of people who could contribute to the partnership approach. The Project Officer was actively engaged in these processes early on, however once the partnerships were established, organisational staff led the processes of involving others.

Supporting partnership development and local planning. A workshop for all participating organisations in the southern Loddon Mallee region was offered in December 2013. The purpose of this workshop was to provide information about the intention and possibilities of the funding, and to support partnering agencies to come together and consider the local outcomes they would like to see as a result of the joint work.
The Project Officer has then supported LGAs to meet together for planning both around their partnership and around the work on the ground. These 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.

Establishing the OT Network. The Project Officer established the OT Network meeting – a gathering of all of the southern co-located OTs. This group meets quarterly for 3 hours, providing the opportunity for OTs to share their approaches, troubleshoot, share resources, successes and general support.

Facilitating reflective processes. The Project Officer has approached the facilitation role with an emphasis on supporting local partnerships to notice change, consider what is working and why, and to identify and address challenges.

Capturing change: Supporting partnerships to notice their own achievements, and documenting the approach and outcomes of their work has been a key focus of the Project Officer's role.

Promoting sustainable practices. Supporting partnership to consider what they need to have in place to support the partnership and the joint work on the ground has been a frequent question posed at meetings. Partnership agreements, project plans, policies and procedures, role descriptions and communication pathways are some of the examples of work undertaken by agencies, supported and/or encouraged by the Project Officer.

Project Evaluation. The Southern Project Officer has undertaken a small evaluation process to capture some of the outcomes of the first 12 months – for clients, staff and partnerships. This report provides a summary of this activities undertaken including: documentation of all meetings throughout the year; client interviews; partnership review discussions; survey about partnerships; and feedback from OTs.

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 Consultant. Consultation around local approaches, and participating in broader planning have been two key (and valuable) activities supporting the work.

Summary

The first 12 months of the implementation of Department of Health growth funding in the southern 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. 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. Client stories and positive practice examples are also included to demonstrate the impact the partnership work is having for clients.

Section 2: PROGRESS TOWARDS OUTCOMES

Local partnership development and commencement of the OT roles on the ground have developed differently in each Shire – both in terms of local approaches and timelines. Two shires quickly commenced the work as soon as the funding was received, and have had OTs working with Council HACC services for 12 months. The other Shires have had a longer establishment phase (due to a range of reasons) and OTs have commenced in their roles within the last 4 to 6 months. Unique circumstance in one partnership have meant that that partnership work has been unable to commence as intended, however HACC OT services have continued to be provided by the health service as previously.

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. In addition to the progress documented through meeting minutes and project reports, data collected to inform this review includes: partnership evaluation discussions; staff survey; OT reflections; client interviews and case studies.

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

Developing a client outcomes measure and process has been beyond the scope of this project and remains a challenge for this sector. However, organisations have been able to identify a range of changes at a systems level that are (anecdotally) resulting in improved services to clients. The following table summarises some of these developments, and flow on effects for clients. Please note that all Shires have noticed positive changes, and these are given greater detail in the Section 3 of this report.

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.
Improvements in the development of client centred care plans – OTs have supported the development of more specific client goals and interventions.	Clients have more focused support plans to help them towards their goals of 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 and Community Support Workers and OT	Client planning and review is more frequent and results in concrete changes/improvements to care plans.
The co-location has **strengthened the links between council HACC services and other allied health disciplines** eg. Dietician	Clients are being referred in a timely manner to the range of services they need.

The survey conducted with organisations supported the above reflections, with 14 of the 16 respondents agreeing, or strongly agreeing that 'there have been improvements in our systems and processes around work with joint clients (eg. Referral pathways, joint assessments, care planning, client review). Please refer to Appendix 1 for a summary of the survey data and comments.

Case specific feedback has also been noticed by the OTs, and captured in case studies or in discussions during meetings. Some of these case studies are included in Section 3 of this report or attached in Appendix 3. OTs have commented that there has been more holistic service provision to clients, focusing on a broader range of goals. They have also noted that the services provided by the partnering agencies are better coordinated, with feedback received from clients who had previous experience of HACC services supporting this observation.

> *"Clients have a clearer understanding of the role of different services and how these can support them. Less duplication of client perspective and information. Improved ability to modify/inform service provision to facilitate client independence and capacity." OT*

The funding is intended to progress the implementation of the ASM. The survey of staff asked whether people thought that the partnership approach was supporting staff to embed ASM approaches in practice. 11 of the 16 respondents agreed that this was happening, one was unsure and one felt that this was not happening. Comments reflected that the ASM approach was happening in many instances and that it may be happening more effectively with new clients rather than longer term clients.

The staff survey asked people about whether Community Care Worker feedback about clients they support is actively sought and informs care plan reviews. Comments reflected that where this had not already been happening effectively, it was beginning. Comments also highlighted the importance of this feedback in providing quality services.

> *"One of the best ways to improve care is through feedback from (community care) workers and a pro-active team leader who is able to manage the feedback by working in collaboration with the Assessment Officer, OT and others in the team." OT.*

In 4 of the 5 shires, the OTs have been using a range of opportunities to work in partnership with the Community Care Workers. Both formal and informal opportunities to build relationships, increase the Community Care Workers' understanding about the OT role and visa versa, and joint home visits have supported the sharing of ASM support ideas and skills. The development of care plans to include more specific, restorative care goals is also underway in some LGAs.

The Project Officer conducted 3 client interviews (summarised in Appendix 3). In all instances the clients were able to articulate positive outcomes contributing to increased independence as a result of the OT involvement with them. One of the questions that has been challenging to answer is: would this support have happened anyway prior to the funding? However it seems that the co-location 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.

Whilst it is early days in the commencement of this approach, qualitative data 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.

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 on the ground, support the co-located staff in their roles and are sustainable in environments of change.

The project has been focused on supporting organisations to plan for successful joint work. For some LGAs this has involved more frequent meetings and a more direct involvement by the Project Officer, and with others less formal meetings but involvement over the phone or via other relevant network meetings. LGAs have utilised the Project Officer in different ways, and to greater and lesser degrees.

In the first few months of the funding it became clear that there was the need to provide more information about the opportunities and expectations of the funding, along with some capacity building around partnership development and planning for local outcomes. In response to this need, 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 encouraged organisations to take an outcomes approach to their work – what will be different as a result of the funding? What does data and local knowledge tell us about the needs of HACC clients in our community?

Feedback from the workshops was largely positive. The presentation about the scope of the funding was well received, affirming that agencies had needed this information to progress their planning. In addition, participants appreciated the case presentation, as it demonstrated the potential for the funding. There was mixed feedback about the partnership sessions. Most people valued the session on effective partnerships but found that they did not progress their local planning. This feedback was noted and the workshop planned for the northern LGAs was adapted.

As part of the 12 month evaluation process, 5 of the 6 local partnerships participated in a review process that included consideration of the impact of the funding on the partnership. 4 of the 6 partnerships agreed that the joint work had strengthened the relationships between the organisations at both a management level and a service delivery level. Not only has this benefited 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 organisations.

The staff survey gathered feedback from people about progress in establishing the partnership approach. Of the 28 staff surveyed, there were 16 responses (57%). There was representation from OTs, Team Leaders, Coordinators and Managers along with one Assessment Officer. A detailed summary of the survey is attached in Appendix 1. Key points:

- All respondents answered that the growth funding had strengthened the partnership between HACC services in their LGA, with 9 of the 16 respondents strongly agreeing with this statement.
- Comments made about partnerships reflected that in some instances the funding was strengthening an existing partnership, however in others it had been a significant support in progressing partnerships.
- 12 of the 16 respondents felt that they were clear about what they were trying to achieve
- 13 of the 16 respondents agreed that they were clear about their roles and responsibilities in relationship to the co-located OT role.

- The survey indicated there is still work to be done around the various HACC roles in regard to client assessment, planning and review.
- It was also clear that there is ongoing work to be done in relation to documenting local approaches, roles and responsibilities in relation to sustainability of the initiative – with only 9 of the 16 respondents agreeing that they had done this work well.
- Overall, 14 of the 16 people who responded to the survey agreed or strongly agreed that the partnership approach is improving the services offered to clients.

> *"It is great having ready access to an OT without having to wait."*
> Assessment Officer

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 also demonstrated clarity around gaps in their joint work and opportunities for improvement.

Outcome 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.

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.

Barrier	**How barriers were addressed**
Staff knowledge around translating ASM into specific goals and support plans for clients	• Joint assessment processes or collaborative assessment processes • OT participation in case planning meetings • OT supporting development of care plans, and sharing skills and knowledge with the Assessment Staff • OT and Community Care Workers doing joint visits • Formal education sessions with HACC staff
Staff resistance to change	• Create opportunities for staff to build relationships and learn about one another's roles • Strong leadership from management about the purpose and value of change • Formal and informal opportunities for conversations between OT and Community Care Workers • 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, shared care planning and improved referrals • Increase sharing of client related documentation, • Positive client outcomes shared and build the momentum for change

	• Identifying joint client documentation opportunities.
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 • Involve Community Care workers in client review meetings
Increasing understanding about the roles of different staff and disciplines in HACC	• Referral quality improved • Secondary consultation opportunities have increased – formally and informally
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 OT being present at council, and not having to wait for telephone or email responses.

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.

Feedback from the OTs and through the partnership review discussions indicates that both formal and informal capacity building approaches have been used, and have been effective.

Co-location builds 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. And it is important to note that this relates to all staff involved. It has been recognised that the achievements so far in the project rely not on the OT coming in as an expert, but rather bringing all of the HACC roles together to learn about one another's work, and the approaches and systems of both organisations.

Both formal and informal opportunities for learning have been happening in most shires. Examples of formal learning opportunities include:

- 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

Examples of less formal opportunities include:

- Shadowing – Assessment Officers with OTs, OTs with Community Care Workers, Assessment Officers with other Allied Health staff
- Joint home visits
- Office conversations – that only happen because the OT is present at the council offices. Organisations report that this is perhaps the most valuable aspect of the work and has been the launching pad for a range of unanticipated outcomes.

OT Network Meeting
The establishment of the OT Network was seen as an important peer support opportunity for the OTs involved in the co-located roles. Three meetings have taken place and the intention is that these will continue in to the future.

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 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.

Reflective Practice
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 in 4 of the 5 shires 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 OTs commenced in their roles and started to have conversations with Council staff 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 OT focus to flex and change to meet the needs of clients and the organisation.

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. As such, it has been demonstrated in this project that the OT has been a helpful resource to both council staff and clients.

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 some 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 these services have worked as discrete entities. 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

Central Goldfields

The partnering organisations are Maryborough District Health Service and Central Goldfields Shire Council. Following some initial conversations, the organisations commenced formal planning in November 2013, and after some challenges in the recruiting process, the OT commenced in the position in March 2014.

The co-location approach

The OT started her work by making a presentation about the OT role to a staff meeting at Council, describing this as a very positive way to introduce herself and potential of her work with Council. Some initial joint assessments then commenced, opening the door to the development of a range of opportunities for her role. The OT attends the weekly client planning meetings, during which new referrals re discussed, client reviews are initiated and roles are allocated. Decisions about the need for joint assessments are made at this meeting. The OT also has a presence on Thursday when the Community Care Workers come in to collect their rosters – an opportunity to meet people and discuss any client issues.

Progress Highlights

A broad range of work has happened in a very short time in Central Goldfields Shire, and the partnership agencies are positive about progress. Some highlights of the work to date:

- Client planning is more coordinated, with a documented planning/communication system in place to record progress
- Shared documentation systems are being developed, including the shared use of the SCTT tool, decreasing duplication of information collection from the client
- Formal and informal training opportunities are taking place with Community Care Workers, including session in the home with clients
- OT is having involvement in the Planned Activity Groups, developing individual support plans for clients, with an indirect benefit of capacity building for staff
- Staff from both organisations have a better understanding one another's roles. Systems and processes
- There is improved communication between intake staff from both organisations
- Clients are benefiting from improved communication between organisations eg. increased referrals to other Allied Health services.

Enablers of change

- Positive attitudes of staff
- Access by the OT to the Council data management system
- OT havingtime to listen to Council staff in the first few weeks
- Having permission to spend time building relationships (indirect client time)

Challenges

- Managing workload demand
- Client reluctance towards the ASM approach, or to see an OT
- Managing the needs and expectations of younger clients
- Having a mobile office can be time consuming and adds a complexity to the role

Some future priorities and ideas

- Promote the partnership work more broadly across the organisations and engage all relevant HACC staff
- Develop a joint procedure manual around the work and finalise partnership agreement
- Explore opportunity to involve an Allied Health Assistant in the work
- Consider opportunity to engage with District Nursing and PAG coordinators
- OT to continue 1:1 training with Community Care Workers.

Positive Practice Example

The OT identified the need for some training around the use of a wheelchair– both for the client, Beth, and for the Community Care staff. With Beth's permission, the OT organised a training session in the client's home, attended by the 14 community care workers involved with the client! Everyone received the same information around road safety, operating the chair, safe transfers and they all had a go in the wheelchair. The OT also talked about Beth's capacity to do things for herself and the importance of supporting her to maintain, and even increase her independence. Beth prepared a lovely afternoon tea for everyone. With the help of the support workers, Beth now has the confidence to operate the wheel chair herself, with supervision as needed, and is able to be actively involved in her own shopping, banking and other social activities that support her independence, health and wellbeing.

Loddon Shire

The agencies involved in the partnership work are Loddon Shire Council, Bendigo Health (southern part of the Shire) and Northern District Community Health (northern part of the Shire). Due to a range of factors, the work in the northern area of the shire has not fully commenced. This summary page relates to the work of Bendigo Health with Loddon Shire Council.

The co-location approach

The OT is based at the Serpentine Council offices two days per week, with the other half day of her role spent at Bendigo Health on administration and client follow up. The OT commenced the work with some broad ideas about the role, but found that as she had conversations with staff and started with joint assessments, the possibilities of the role emerged. Communication and planning processes are established; the OT attends monthly Community Care Worker meetings; formal training sessions are taking place. The OT describes feeling very welcome by council staff and is like one of the team.

Progress Highlights

- **Co-location has been successfully established**
- Assessment Officers have a good understanding of the OT role and visa versa, supporting appropriate referrals to the OT.
- Formal and informal capacity building with staff is happening
- Two way flow of information about services – building capacity at both organisations
- Community Care Workers are providing feedback about their clients and changes are being made to improve support provided to clients
- The OT has made presentations at staff meetings about the ASM approach and had the opportunity to talk through some people's concerns about this way of working
- OT involvement and feedback is adding depth to the care provided and is upskilling staff
- Council staff feel more confident in care planning around client capacity and safety
- Service provision is being individualised to a greater degree
- The OT position has supported bringing other allied health disciplines to Loddon.

Enablers of change

- Having a consistent OT presence builds relationships and enables informal, timely conversations to happen with a range of staff.
- Loddon Shire Council has been actively advocating for the co-location from the outset.
- Access to council systems supports access to information and shared documentation
- The initiative, skills and leadership of the OT
- Getting started even though the approach was not clear helped to identify opportunities and build the role in a way that is relevant to the needs of clients and staff
- Letting go of what is not working and trying something new.

Challenges

- Collecting meaningful data that reflects the indirect client work of the OT – conversations and capacity building with staff
- The initial information and lack of clarity about the intention of the funding and the OT role
- Coordinating the OT role given the North/South divide

Some future priorities and ideas

- Continue to document processes and approach to support sustainability
- Strengthen multi-disciplinary approach in Loddon Shire
- Consider how all HACC OTs could work in a similar way
- Continue to gather case studies to capture the work.

Positive Practice Example

The Loddon Shire holds monthly team meetings with teams of Community Care Workers supporting clients in the same geographical area. These meetings offer time for staff to review their work with their clients, and were identified as a key opportunity for the newly appointed OT.

The OT started to attend these meetings to let the Community Care Workers hear about her role and to be a resource to their planning conversations about their clients. The OT was able to offer some general suggestions in the first meetings and provide some practical examples about the OT role and how it could resource their work. The OT also presented at meeting of all council HACC staff about her role and the ASM approach, building opportunities for people to get to know her.

It wasn't long before the Community Care Workers started to bring some of the challenges to their meetings for OT input. The story of Mrs Shopley is included in Appendix 3 and is an example of how the OT can support the Community Care Workers in their role, without even needing to meet the client.

City of Greater Bendigo

The City of Greater Bendigo and Bendigo Health are the agencies involved in the partnership work, and had a unique context for the start of the work. HACC Assessment Services transferred from Bendigo Health to City of Greater Bendigo in January 2014, creating a significant environment of change for both organisations.

The co-location approach

The LGA received the same amount of funding as all LGAS, enabling the employment of a 0.5 EFT OT position. The OT commenced in the role in February 2014, with an initial idea of focusing on reviewing HACC clients in receipt of Meals on Wheels. It quickly became evident that initial energy needed to focus on building relationships between staff and increasing understanding about one another's roles and organisational processes. The client group the OT is now focusing on tends to be clients receiving multiple services, and often the clients with more complex needs.

Progress Highlights

- Co-location successfully established
- Care coordination meetings have commenced, attended by the OT
- Review meetings around complex clients are attended by all relevant staff, including the Community Care Workers.
- Relationship building between OT and the Community Care Workers (150 staff!) underway – both formal and informal opportunities to share skills and knowledge
- Increased understanding about respective roles
- OT has supported the new Assessment Officers with information about Bendigo Health services and systems, and Assessment Officers are shadowing members of the Rural Health team.
- Clients are proving positive feedback about services

What is different as a result of the co-located OT and partnership work?

- The co-location supports more timely responses, with decision being made on the spot as relevant people share the same space
- Improved consistency and coordination of client support
- Shared access to client documentation supports communication and coordination
- Co-location supports conversations, supporting client work and learning opportunities for staff
- Increase in staff knowledge from both organisations around services and support ideas – capacity building that staff can use in their future work with clients.
- Coordinators from both organisations meet regularly, supporting joint planning and timely progress of work
- OT a helpful conduit of information between the organisations

Challenges

The Bendigo OT noted some similar challenges to the other OTs. However the organisations reflected on the unique challenges for the City of Greater Bendigo due to the population. There are more clients and therefore more staff. With the same EFT allocated to the co-located OT as in other Shires, particular strategies and approaches have been needed to manage the workload and target the OT work.

Some future priorities and ideas

- Continue to engage with the Community Care Workers
- Explore the opportunity for other allied health involvement in care coordination meetings
- Continue to document processes to support sustainability and support OT staff rotation.

Positive Practice Example

A referral was received from HACC Assessment Officer for a joint assessment with OT for an elderly man at home alone with limited social supports. Mr Woods was receiving meals on wheels five days a week through Council however it was found he was eating the meals cold as he had no safe way of heating them. OT input was requested to assess the safety of Mr Woods' home environment and the suitability of the meals on wheels he was receiving.

Mr Woods was enjoying the meals he received from CoGB however was eating them (and most other food) cold. A microwave was discussed with Mr Woods. He was hesitant to purchase a microwave as he didn't feel confident to use it. It was discovered that Mr Woods had a positive relationship with the meals on wheels volunteer who delivered his meals. Following liaison with the volunteer it was offered that they could assist Mr Woods to heat his meals in the microwave over the next two weeks. Mr Woods was now happy to go ahead with the purchase of the microwave. HACC Assessment Officer included this in their service delivery plan.

Mr Woods is now able to confidently use the microwave to heat his meals on wheels and manage other easy meals such as frozen dinners and soups.

(See Appendices for full case study)

Mount Alexander

Mount Alexander Shire Council and Castlemaine Health partnered to support the establishment of the co-location. The two organisations have a significant positive history of partnering around the provision of HACC and other health and wellbeing initiatives. As such, they commenced the co-location more than 12 months ago, building on prior joint projects and partnership approaches..

The co-location approach

Whilst the OT does not have a dedicated work space at the Shire offices, she attends the office each week for the Care Coordination meeting, and is present at other times following up on client issues and communication with relevant team members. She is also available via mobile phone and email. The weekly Care Coordination meeting was the key to establishing the OT role, and remains the central communication and planning opportunity for all staff.

Progress Highlights

- Initially joint assessments between OT and Assessment Officers were undertaken – a good way to establish relationships and understand one another's role.
- Now the Assessment Officers make relevant referrals to the OT (usually around complex clients)
- OT works with all teams, including HACC, Access and Support, Planned Activity Groups, exercise programs, HARP program and sharing information and approach with the Rehabilitation team at Castlemaine Health
- Formal and informal training is happening with Direct Care Workers in groups and on a 1:1 basis
- OT has supported Assessment Officers in refining care plans, developing more specific goals that then translate into more meaningful support for clients
- OT well established as a resource for all staff supporting client assessment, planning and review.

What is different as a result of the co-location?

- A better understanding of roles has supported improvement in referrals.
- Goal directed care planning is happening in a concrete manner
- Policies are being developed
- Direct Care Workers are providing more feedback about clients
- OT is supporting client reviews, adding to robust decision making about transitioning from short term to longer term support services.

What has helped?

- Joint assessments were helpful in the first instance to develop a good understanding of roles and build relationships
- Understanding that the work is about joint collaboration, not joint assessment for assessment's sake.
- Good working relationship between the organisations prior to the work commencing and strong leadership from managers
- Individual approach, skills and experience of the OT, taking leadership and developing the role in response to the opportunities that presented.

Challenges

- Accounting for indirect client work and staff capacity building
- Managing work load within a part time load
- Establishing remote computer access for the OT role

Some future priorities and ideas

- Explore opportunity for an Allied Health Assistant to support the OT work
- Develop an OT position manual
- Plan for other OT team members to be able to work in the role
- Explore outcomes measures
- Joint meetings with District Nursing

Positive Practice Example

One of the significant contributions of the OT noted by Mount Alexander Shire Council was the support she has given staff in developing their knowledge and skills around Individual Support Plans. The OT has shifted goal setting from broader goals, to more specific goals/strategies to support the client to maintain or improve their independence. This in turn results in a more prescriptive care plan that the Direct Care Workers can put into practice. Feedback from the Direct Care Workers has been positive.

Macedon Ranges

Cobaw Community Health and Macedon Ranges Shire Council have partnered to establish the OT partnership role in the Macedon Ranges Shire. The OT has been employed for 12 months, working 0.5 EFT.

The co-location approach

The OT works from the Shire offices each Tuesday, and is available for phone and email contact on Mondays and Wednesdays. Initially OT and AOs completed a number of joint assessments as a way to become familiar with one another's approaches. Now these are less frequent as staff identify when joint or separate assessments will be the most beneficial. Largely the client focus has been on new clients, and those who can benefit from a targeted, time limited intervention (restorative care).

Progress Highlights

- Provides a quick OT response to those clients identified as urgent by AOs
- OT getting to know council staff and visa versa
- Communication and planning opportunities: monthly assessment and review team meetings; informal conversations around the office; client review meetings planned as needed; feedback following home visits; attendance at community support worker team meetings
- The OT also established an OT Network in the Macedon Ranges Shire which has supported communication, professional development and process troubleshooting eg. Waiting list management

What is different as a result of the joint work?

- Improvements to referral processes and response times between Council and Cobaw
- Joint/collaborative assessment processes are leading to positive client outcomes - eg quicker equipment installation and more immediate OT follow up post assessment, supporting the ASM approach
- Review of the home maintenance system
- Helpful to run potential OT referrals past the OT - appropriate or not?
- The broad range of knowledge and experience of the OT has added to the breadth of the assessment process
- OT supports communication with families, particularly around complex supports needs
- Increased understanding of the OT role and visa versa
- OT has supported the identification of new support strategies that staff were not aware of

Challenges and barriers

- Initial lack of information about the purpose of the funding and expectations of the role
- Starting without documentation supporting the work – roles; processes; communication pathways etc
- Different understanding about ASM practice – is it about reducing the amount of services to people, or offering similar levels of service in different ways?
- The challenge of change – takes time, uncomfortable for some staff
- Lack of funding to support purchase of OT equipment for clients
- Separate care planning processes between agencies can be a barrier to collaborative practice. The OT plan is not readily accessible to council staff and visa versa.

Some future priorities and ideas

- Support the work with relevant documentation
- Consider opportunity to develop one client care plan that is shared amongst organisations
- OT to work more directly with the service provision team in the future
- Increase collaboration with all OTs – could there be periodical joint meetings between OTs (Cobaw and MRH), Assessment and Community Care teams?
- Find some simple evaluation processes.
- Involve community care workers in client review processes

Positive Practice Example

The co-located OT responded to a request from a persistent client who wanted to regain his independence and had previously been assessed as not being suitable for a scooter. The OT visited the client and his family to explore the needs and opportunities. A new support plan was developed, including the introduction of a scooter, safe scooter training and addressing home access issues. The client can now be seen out and about, heading down the street to buy his paper and enjoying the independence he wanted.

Section 4: Project 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 – building staff and service capacity for the benefit of 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 initial client feedback, case study examples and staff feedback. 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 staff knowledge about roles increased, so has their skill and confidence in being able to make appropriate referrals and initiate conversations about their client work. Staff commented that they 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 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 created a barrier 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 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 the OTs, some assessment staff and organisational leaders involved with a co-location approach to the work 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, 2 of the 6 partnerships have finalised partnering agreements, 3 have a draft started, and one Shire has not progressed this work beyond an initial template provided by the Project Officer.
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.

The reasons? 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. The Project Officer has also taken an encouraging approach rather than an authoritative approach to the task – perhaps a stick may have been more effective than a carrot?

The learning? The initial intention to have partnerships complete the relevant planning and partnering documentation prior to commencing the work on the ground has been noted by organisations and the Project Officer as an unmet, and perhaps unhelpful goal. As noted in Section 3 of the report, in all instances, 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.

The goal from here? 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 Project Officer role was a Department of Health position sub-contracted to Cobaw Community Health. Some broad objectives for the role were provided which the Project Officer further developed into a work plan, including detailing the project outcomes. 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 Consultant. 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.

As to the value of the project, from the Project Officer's perspective, the key contribution has been in supporting the partnership 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 and notice (and document) change.

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, and the commitment of HACC staff in local government have been the critical factors in the progress of the work.

Looking Ahead

With the local HACC partnerships established in 5 of the 6 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. The Department of Health will continue to support the final partnership to establish their work.

Key recommendations for future action:

- 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 – District Nursing and Planned Activity Groups.
- Consider the role of Allied Health Assistants in the work
- Department of Health to continue to support the partnership work through periodical meetings with the partnerships and convening the OT Network meeting
- Partnerships to confirm some manageable evaluation processes to measure change.
- 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.

References

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

Appendix 1: Staff Survey Summary

Respondents: 16 from 28 invitations to participate in an on-line, anonymous survey using the Survey Monkey tool.

	1 Strongly Disagree	2	3	4	5 Strongly Agree
1. The Occupational Therapy (OT) and Personal Care (PC) growth funding has strengthened the partnership between HACC organisations in our Shire.			2	5	9

Comments:

- *Greater trust between assessment staff and OT*
- *I haven't been able to see any recognisable difference.*
- *Greater collaboration and communication between HACC services and OT resulting in clear understanding and better outcomes for clients.*
- *Existing strong partnership has been further strengthened*
- *We have seen significant improvement*
- *Better understanding of the roles, responsibilities of each other and improved communication.*
- *Clear communication and greater understanding of roles and responsibilities. Greater number of referrals being received now.*
- *I considered the Partnerships to already be quite strong.*
- *Existing partnerships have been further developed and strengthened*
- *There is still a fair way to go but the direction we need to make is clear*

	1 Strongly Disagree	2	3	4	5 Strongly Agree
2. Our partnership is clear about what we are trying to achieve in relation to the OT and PC Growth funding			4	8	4

Comments:

- *I am clear on what was envisioned with this partnership, but I cannot agree that this is consistent across the organisations.*
- *This is becoming clearer as role is established within the LGA. Was initially too focused on a specific area of personal care however has been expanded to allow best use of OT approach/skills with clients.*
- *Senior Management may need reminding about this.*
- *Still some confusion at times between agencies*
- *still progressing and evolving*
- *Still some exploration of appropriate referrals happening*

	1 Strongly Disagree	2	3	4	5 Strongly Agree
3. Our organisation is clear about our roles and responsibilities in relation to the co-located OT role.		1	2	10	3

Comments:

- *Unfortunately I never saw any final documentation on what the roles and responsibilities were. A draft was circulated early on to provide feedback on, but I never received any final docs and there was no meetings to provide clarity to the role or develop linking work plans*
- *Well supported by organisation in terms of supervision and support for emerging OT role. Organisation is clear about capacity building focus of OT role and for this to expand to all HACC OT's working within the organisation.*
- *Community sector of organisation has gained knowledge but probably not the organisation/health service as a whole, although information has been provided in newsletter etc.*
- *As it's a new role, still improving*
- *Some ongoing discussions occur as situations arise, but staff are aware when these discussions need to occur. This is part of the evolution of the role.*

	1 Strongly Disagree	2	3	4	5 Strongly Agree
4. Staff from both organisations are clear about the roles of the OT, Assessment Officers and Community Care staff in client assessment, planning, service provision and review.			6	6	4

Comments:

- *There are some differences in expectations at times*
- *I tend to agree with this statement; however I have found the understanding of the changes in the HACC sector to be at very different stages across individuals and organisations. This makes it increasingly difficult to get consistency of planning and client engagement.*
- *Staff from LGA have been unclear at times about focus of co-located OT on capacity building and the need to refer on to more appropriate/other allied health services. OT has felt at times as though has been a back up to assessment decisions surrounding*

eligibility for HACC services.

- *Is a need to clarify and inform on regular basis - perhaps increase contact between eg. intake workers across orgs.*
- *There is still some way to go in some areas but OT and assessment work very well together*
- *Improving through the link that the new OT role has brought in.*
- *Still some ongoing clarification as situations arise. This is part of the evolution of the role.*

	1 Strongly Disagree	2	3	4	5 Strongly Agree
5. Over the past 12 months there have been improvements in our systems and processes around work with joint clients (eg. Referral pathways, joint assessments, care planning, client review)		1	1	11	3

Comments:

- *Needs more work but definitely improving*
- *Although the partnerships have been strengthened, I have not seen any evidence of any improvements to client outcomes. This is often due to a lack of continuous communication between the agencies as to the progress towards client outcomes. Something is happening, but we are not kept up to date as to what.*
- *Improvements to quality and nature of referrals to OT. Joint assessments frequently conducted, improved and extensive collaboration surrounding care planning for complex clients.*
- *Technology agreement still lagging behind i.e. not in place. Useful support from PCP.*
- *Again sometimes there is still confusion as to who should refer to whom*
- *Yes, more streamlined and more clear.*
- *this has always occurred, however it is now happening more often and happening with greater ease*

	1 Strongly Disagree	2	3	4	5 Strongly Agree
6. The partnership work is supporting staff from our organisation to embed ASM approaches in their practice.	1		4	6	5

Comments:

- *Starting to.*
- *I have not seen any evidence of this partnership supporting an ASM approach*
- *OT frequently provides support and advice re: active service principles and that it is an approach to enable clients and carers. Education frequently provided about how best to explain these principles to clients.*
- *Better results with new clients onto the system and not existing clients.*
- *Visible examples and CCWs are involved*
- *There is still quite a lot of work to be done with care staff*
- *ASM has been part of our service delivery framework prior to the partnership work. it has probably increased the number of referrals for clients where an ASM approach is relevant.*

	1 Strongly Disagree	2	3	4	5 Strongly Agree
7. Community Care Worker feedback about clients they support is actively sought and informs care plan reviews.		1	4	5	6

Comments:

- *I do not know if this happens*
- *CCW feedback is always actively sought, but the impact this has on care plan reviews is limited as the goals are not adequately reflected to allow for useful feedback.*
- *Processes surrounding CCW feedback is now established. OT frequently engages with CCW's re: concerns with clients which informs modification to client care plans. OT has been involved in training with CCW's re: using different approaches with particular clients. Increased CCW input is essential for further development.*
- *Get fantastic feedback from our CCW's*
- *One of the beast ways to improve care is through feedback from workers and a pro active team leader who is able to manage the same by working in collaboration with the Assessment Officer, OT and others in the team.*
- *Work has commenced need further work on this*
- *This has been occurring prior to the partnership work. it appears that we are now getting more direct feedback from the CCW and their confidence is increasing in having these discussions.*

	1 Strongly Disagree	2	3	4	5 Strongly Agree
8. Our partnership has documented our approach, roles and responsibilities to ensure continuity of service in the event of staff changes.		4	3	3	6

Comments:

- *Not there yet but this work is planned*
- *Some parts of the role are well documented, others will need to be clarified and formalised to ensure continuity of service.*
- *Not sure on that one.*
- *We need to work on roles, responsibilities -both overarching and region specific to be able to have some kind of measurement for us to improve our quality and standard of practice-for OTs-as it is a very new and unique role.*
- *Plan for process driven rather than person driven, already have flow charts and guide lines in place*

	1 Strongly Disagree	2	3	4	5 Strongly Agree
9. The partnership approach is improving the services we offer to clients.		**1**	**1**	**8**	**6**

Comments:

- *More opportunities to reduce duplication but not quite embedded in all practice*
- *Given that we had access to OT's previously, I do not see any difference to what the situation was like 12 months ago.*
- *Clients have a clearer understanding of the role of different services and how these can support them. Less duplication of client perspective and information. Improved ability to modify/inform service provision to facilitate client independence and capacity.*
- *It is great to have ready access to an O.T. without having to wait.*
- *not for younger disabled*

10. What is your job role?	Team Leader	3
	Coordinator	4
	Manager	1
	Occupational Therapist	5
	Assessment Officer	1
	Senior Manager	1

Appendix 2: Client Interview Summaries

Interview 1

Background
The client, Mrs J, started to receive HACC services several months ago following a stroke. She was assessed by the council for home help following rehabilitation and had been received support with house cleaning once per fortnight for an initial period.

Prior to her stroke, Mrs J had been independent and managed the household for herself and her son, doing all of the cooking, cleaning and general household management. Since the stroke, her son has become her carer, whilst also working full time. Both Mrs J and her son were feeling stressed about the situation. Mrs J had been resistant to some suggestions for other support.

The OT working with the council HACC services undertook an assessment with a restorative care focus. With an initial focus around safety, the support opportunities broadened to include a range of other strategies to support Mrs J to become more independent and to start to do some of the tasks she enjoyed in the past.

These included:

- Cooking support – menu planning, remembering recipes she liked in the past, support with simplifying cooking tasks, cooking soups, snack preparation, printing off shopping lists (Mrs J's eyesight and writing had been affected by the stroke)
- Connecting with old hobbies – the OT identified that Mrs J had enjoyed knitting previously. Whilst fine knitting may have been a little too tricky, Mrs J has been supported to knit using large needles
- Connecting with others – Mrs J has been linked into the local PAG group. Mrs J started to go a couple of weeks ago, and the OT has supported her to link in. Mrs J is picked up by a bus to attend this group, and this is her only regular social outing. Mrs J goes shopping with her son once per fortnight.
- Safety – Mrs J now has a personal alarm – a helpful safety strategy for her, and provides some peace of mind for her son.

Mrs J reported that she felt that the support was built around her goals, as defined by her and not the OT. She said she felt listened to. Mrs J said that she has found the OT support very helpful. She feels confident with her writing and can now complete her shopping list and write down other information as she needs to.

Reflections from the Project Officer:
The OT support has been highly valued by Mrs J, who notes increased skills and confidence with regard to her speech and writing and also she is very pleased about the link in with the PAG group.

Mrs J was not able to provide a large amount of detail about her experience of services, but felt positive about the relationship with the OT and the quality of the support being provided. The OT support has "been helpful. Means that I can do more things that I couldn't do before".

This is a type of support that would most likely not have been offered prior to the co-located OT being involved.

Interview 2

Background
The client Mrs G was referred for HACC in home support services due to chronic pain in her back and the impact this was having on her mobility and capacity to clean her home. In addition Mrs G experiences dizzy spells that cause her to lose balance. She has fallen due to these spells in recent times.

Following a review of the referral by the OT and Assessment Officers at council it was agreed that joint AO/OT assessment would be valuable. The OT and AO attended Mrs G's house to complete the assessment.

The HACC staff were met with a very motivated woman highly frustrated by her limited capacity. Mrs G said she wasn't sure what to expect from the visit but had assumed it may end up with someone coming to clean her home. The Assessment involved both a conversation and a tour around the home. The OT immediately identified opportunities to both support Mrs G's safety and assist her to regain some independence.

Key goals agreed to initially:

- Support to maintain her ability to complete household tasks by herself
- Safe transfers – bed, bathroom, car

The first issues addressed were in the bathroom. A toilet seat riser was an immediate provision that instantly supported Mrs G's independence and pain management. In addition, the three panelled shower door was replaced with a shower curtain to help ease of access and also to remove the risk of shattered glass in the event of a dizzy spell. Rails were also installed in the bathroom.

Mrs G was having difficulty getting up out of bed. A bed pole was installed – a small intervention that Mrs G identifies as making a huge difference both to the time it takes her to get out of bed and to the pain levels.

Mrs G said that the OT also provided lots of helpful tips about managing housework and cooking. Examples included learning how to vacuum more efficiently and safely; putting a stool in the kitchen to reduce fatigue whilst preparing food; cooking larger quantities of food and freezing portions.

Mrs G said that she appreciated the emphasis on being supported to remain independent. She said she felt listened to and that the support she was being given was in line with her needs.

Future goals: Mrs G wants to get to the bottom of the dizzy spells so that she can feel safe and confident to go on outings in her car and sit by the river fishing. She is also having an aid installed in her car to assist her to get in and out, which will support her to make more frequent car trips once the cause of her dizziness is addressed.

Reflections of the Project Officer:
The written support agreement was not very meaningful for the client (she couldn't find it and noted that there was too much paper!) but she was able to talk about the support being offered to her. Is there a more meaningful way that support goals could be captured?

Client is highly motivated to make change and simply needed the many strategies that the OT has offered. Support has meant that Mrs G does not need to receive any home help at this stage.

Mrs G is well connected socially and reflected that without these social connections and support, she suspects she would be much worse off. The conversation highlighted the importance of supporting clients to maintain or build their social opportunities.

Interview 3

Background
Jane has been living with a range of chronic health conditions for most of her adult life. Now in her fifties, Jane's health has been impacting on her capacity to live as independently as she would like. With chronic pain and decreased mobility, Jane's reliance on services has been increasing over the last 10 years.
With a robust sense of humour, Jane speaks light heartedly about the many challenges she faces on a daily basis – not only due to her physical health issues, but also financial pressures, living in housing that is both expensive and not adapted to her mobility issues and social isolation. Jane speaks about the frustration of not being able to live independently and the impact this has on her sense of happiness and wellbeing.

OT Support
Jane has been receiving services from her local council on and off for about 10 years. She has help with cleaning once a fortnight and shopping support weekly. More recently council has also been helping her take her bins out, and back in. With a care plan review due, the co-located OT was requested to do a joint visit to Jane's house with the Assessment Officer due to the current complex issues getting in the way of her independence.

Jane said that she appreciated the services that council provided, but that she felt that a 'breath of fresh air' walked in the door when the 'council OT' arrived for the first home visit. When asked what had made such an impact, she said that the OT had taken time to listen to her story and to what she needed; to really identify what was important to her, and had made concrete changes to improve her life.

Some examples of this assistance:

- Jane had been unable to clean out her cat's litter tray. The OT provided some simple equipment that means Jane can now do this for herself in a safe manner.
- OT provided a simple loop to secure Jane's walker when she is transferring it in and out of the car, making this a safer task.
- The OT is looking at sourcing a bed for Jane, as her current bed exacerbates her pain.
- The OT is exploring a tailored set up to support Jane to work on her laptop comfortably and safely, meaning that Jane is able to write and can consider continuing her study on-line.
- The OT has linked Jane up with some support to look at more suitable and affordable housing options.

The current focus of support is on de-cluttering the house. The pockets of clutter are creating barriers to progressing some other goals. For example, once the kitchen is cleared, some 1:1 cooking support is planned to support Jane to prepare more meals for herself, and rely less on frozen meals from the supermarket. This will then impact on her overall health and finances. Jane will also be supported by the OT to develop some systems to maintain the house once decluttered.

In the future, Jane would like some assistance with getting on top of the additional cleaning jobs that are required in homes from time to time, as she feels she has 'pockets of mess', and cobwebs and dust that are inaccessible. She also hopes to finish her study. Jane does not want to be treated like an old person, and wants to maximise her health and independence to live a long and satisfying life.

Jane described the support offered by the OT as life changing and she believes that the OT is advocating for her back with council. Jane has felt that the domestic assistance she receives is a service offered without any extra interest in her wellbeing (staff come in and out), and that the OT

has added a dimension of care to her experience. She also stated that the OT had supported her to become more independent.
Jane's closing statement about her support from the OT – "An angel descended from another planet, bringing a care factor that I really needed."

Reflections from the OT
Building rapport and trust with Jane was a key aspect of the approach that the OT highlighted. In the past, OT support that had moved too quickly onto actions and 'fixing' things had not worked with Jane. The OT spent significant time establishing the support relationship and allowing Jane to tell her story. It was only once this relationship was established that progress could begin on talking about some of Jane's goals and strategies to get there. The OT commented that had this approach not been taken, it is likely that the OT intervention would have been unsuccessful.

Reflections of the Project Officer
The conversation with Jane highlighted a number of things:

- Jane noticed a real change in her experience of support with the OT, indicating that the inclusion of the OT in the range of support offered in conjunction with Council HACC services is benefiting this client.
- Jane sees the OT as a council employee, but not necessarily clear about the connection between the OT and other council staff, indicating there may be a need for some further information about staff roles.
- Taking time to establish the support relationship with clients with complex needs can be the difference between engaging the client with the support they need, and not.

Appendix 3: Client Case Studies

Mrs Shopley

A Community Care Worker (CCW) requested discussion of a client at their bimonthly meeting. They reported that providing shopping assistance for Mrs Shopley, an elderly lady with dementia, was particularly difficult as she would often buy items she already had 2 or 3 of at home ie. orange juice, milk or butter. This was presenting issues for storage of the food items and disposing of expired food items.

When at the shops this client would become quite distressed if her usual items weren't purchased, despite repeated attempts to explain why she didn't need the items.

Recommendation:
OT recommended developing a regular shopping list that could be laminated for repeated use. The CCW could then go through the shopping list with Mrs Shopley before leaving the house to cross off any items that weren't needed that week. CCW could then refer to the list at the shop to provide Mrs Shopley with the visual cue as to why that item is not required.

HACC Assessment and Service Delivery staff agreed to allocate an extra 15 minutes to each shopping assistance service to allow time for the list to be reviewed before going to the shop.

Outcome:
CCWs report that Mrs Shopley is much calmer when shopping and instances of multiple food items have decreased. Use of the shopping list and including Mrs Shopley in reviewing this list promotes her engagement and participation in a meaningful task in line with the principles of ASM.

Case Study prepared by Sarah Gallagher, OT, Bendigo Health.

Mr Landry

Mr Landry is a 77 year old man living on his own in a unit just out of town. He has a lot of difficulty with back pain which he is currently seeing a specialist to manage.

OT attended a review of this gentleman with a HACC Assessment Officer. At the time of review, Mr Landry was receiving general home care to assist with cleaning bathroom, vacuuming, mopping and hanging out laundry.

After discussion with Mr Landry at the review, he identified that the reason he couldn't hang his laundry was due to the distance to the clothesline and the height of the clothesline.

Recommendation:
OT recommended Mr Landry use a clotheshorse in the undercover area outside of his unit.

Outcomes:
Mr Landry returned to being independent with his laundry and called the council himself to reduce his home care once he was confident he no longer required assistance. He also reported that he is going for regular walks to maintain his health and walks to the local school to volunteer with one of their programs.

Case Study prepared by Sarah Gallagher, OT, Bendigo Health.

Mr Woods

A referral was received from the HACC Assessment Officer for a joint assessment with OT for an elderly man at home alone with limited social supports. The initial referral was received by Council from Mr Woods' previous neighbour and was for a HACC assessment for assistance with personal care, shopping, meal preparation and general home care.

Mr Woods was receiving Meals on Wheels five days a week through Council however it was found he was eating the meals cold as he had no safe way of heating them. OT input was requested to assess the safety of Mr Woods' home environment and the suitability of the meals on wheels he was receiving.

A joint visit was completed with Mr Woods, Mr Woods' previous neighbour, the Council HACC Assessment Officer and the OT. At the visit Mr Woods presented as a proud man who had lived alone in the same house since his childhood. Mr Woods had no children or family in the area. He described his previous neighbour as his main social support. Mr Woods' health had recently deteriorated following a TIA ('mini stroke') however he was very hesitant to admit he required any extra support. Mr Woods' previous neighbour was very concerned about his safety at home and explained that he became easily overwhelmed by new people/services.

A number of occupational performance issues were identified:

- High falls risk, particularly when accessing the outdoor toilet and clothesline via the back ramp. Falls risk was increased given Mr Woods had no home phone or mobile or method of contacting others in an emergency.
- Decreased safety washing and drying in bath with current set-up (no shower available).
- Decreased safety managing transfers in current lounge chair. Mr Woods was also sleeping in his lounge chair which was impacting on the quality of his sleep and resulting in increased fatigue.
- Decreased safety when accessing toilet and transferring on and off the toilet.
- Decreased safety managing heating of Meals on Wheels and meal preparation (on alternate days) using current oven/stovetop.
- Decreased ability to manage home care tasks secondary to reduced mobility and endurance.
- Decreased safety when driving.

Mr Woods' main goal was to: "Stay living in my own home"

As evident above, a number of issues were identified upon assessment. It was very important for Mr Woods that gradual, achievable steps were taken to prevent him from becoming overwhelmed with numerous recommendations and ensure that he felt empowered through the process. A number of visits were conducted with Mr Woods and his previous neighbour to build rapport and one recommendation was focused on per visit.

Recommendations:

- Meals: Mr Woods was enjoying the meals he received from Council however was eating them (and most other food) cold. A microwave was discussed with Mr Woods. He was hesitant to purchase a microwave as he didn't feel confident to use it. It was discovered that Mr Woods had a positive relationship with the Meals on Wheels volunteer who delivered his meals. Following liaison with the volunteer it was offered that they could assist Mr Woods to heat his meals in the microwave over the next two weeks if he purchased a microwave. Mr Woods was happy to go ahead with the purchase of the microwave. HACC Assessment Officer included this in their service delivery plan.

- Falls Risk: After a number of visits with the OT Mr Woods was happy for a rail to be installed at his back ramp (leading to the outdoor toilet). Mr Woods was happy for this to be done by Council property maintenance service. He is considering the purchase of a mobile phone with an emergency button to assist him in case of an emergency.
- Bathing: After a number of visits with the OT Mr Woods was happy for a rail and a hand held shower hose to be installed to assist him to get in and out of the bath. Mr Woods was happy for this to be done by Council property maintenance service.
- Seating/Sleeping: Mr Woods was happy to trial an electric lift chair with the OT and his previous neighbour to assist with his transfers and the quality of his sleep. Electric lift chairs were trialled and a funding application is currently in progress.
- Home Care: Mr Woods declined home care assistance offered by the HACC Assessment Officer. OT continues to feedback to HACC Assessment Officer re: above outcomes and if Mr Woods would like to be re-assessed in the future.

Outcomes:

- Mr Woods is able to confidently use the microwave to heat his Meals on Wheels and manage other easy meals such as frozen dinners and soups.
- Existing resources of the clients and at Council (i.e. Meals on Wheels volunteer) were utilised to support Mr Woods.
- Mr Woods is able to independently manage his personal care in his bath at home with the new equipment.
- Mr Woods' falls risk has been reduced and he is considering further steps to keep himself safe at home.
- Mr Woods was able to actively participate in the process and the services were delivered in an individualised manner.
- Mr Woods is more aware and open to services available to support him to remain at home safely.
- Feedback from Mr Woods' previous neighbour was extremely positive about the level of collaboration and communication between the OT and Council HACC services. She reported Mr Woods and herself had felt well supported and informed which reduced her level of stress and concern.

Case Study prepared by Sarah Green, OT, Bendigo Health.

Sue

Sue is a 67 year old woman, jointly assessed at home by the Occupational Therapist (OT) and Council HACC Assessment Officer, with a return visit the next day.

Background

- Sue (not her real name) was admitted to hospital with Shingles and while there developed a breathing disorder requiring her to be discharged on a concentrator. Sue's two daughters instigated moves to a new living situation - either to down size or to move to aged care. Pre admission she was receiving no services, was out and about visiting a number of people and provided a private ironing service to 5 people.
- During the initial assessment visits, a male friend turned up but Sue refused to see him due to her perception that her shingles on her face disfigured her and made her ugly. Sue had also cancelled the private ironing work and contacted an estate agent to sell her home.
- Early discussions with Sue indicated that she was not ready to make the decision about selling her house or moving into aged care.

Supports

- Daughters were supportive but focused on moving and down sizing. One daughter had a plan for her mother to move into a rented unit that she owned, but this was in a cul-de-sac and allowed for no observation of the street - something she enjoyed where she currently lived.
- OT was involved, and HACC carer staff from the shire were engaged to provide home help once per fortnight

Goals

- Short term goal: wait and see how her recovery progressed, but still to obtain quotes for her house if she were to sell.
- Longer term goal: to make decision to remain or to move (as per her daughters advice) once her recovery could be reviewed.

Outcomes

- Short term equipment loan organised for her with shower stool, over the toilet aid and walking frame.
- Client improved and found she did not need the concentrator. Through some conversations with the OT, the appearance of her shingles did not cause her concern with any friends calling by or taking her out.
- A number of visits to support her in her decision about housing. Her daughters had made a decision about her housing but had not really reviewed their mothers needs with her. Sue clearly did not want to be in care or move once she improved
- She returned to doing all her past ironing jobs for the 5 clients, and has a new relationship with her daughters, in that they need to ask her first and not make decisions without her.
- Sue thanked OT for the support, and indicated that the Community Support Worker from Council was no longer needed to help with her house cleaning.
- Sue remains in her own home

The joint visit by the OT and Assessment Officer at the very start of the support period allowed for early intervention and contact to resolve some issues quickly and provide minimal service within a 3 month period.

Case Study prepared by Robert Haughton, OT, Cobaw Community Health