

Wellness and reablement in the Victorian home care sector

Statewide review of progress

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Statewide review of progress 2017

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Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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Executive summary

Wellness and reablement is an approach that builds on people's strengths and goals to promote independence and autonomy in home care. Evidence shows that this approach is effective in improving function, independence and quality of life for older people and younger people with disabilities.

In Victoria, the introduction of wellness and reablement approaches has involved a significant change management process as part of the introduction of the Active Service Model in 2010. To implement the model, funded organisations across the state have sought to embed wellness and reablement principles in everything they do.

This review of the service providers' 2017 implementation plans examines the positive achievements and areas for further improvement that Victorian service providers have identified during the 2017 calendar year, the sixth planning cycle in Victoria.

The report collects and analyses data from 334 Victorian organisations funded to deliver home care via the Commonwealth Home Support Programme (CHSP) and Home and Community Care Program for Younger People (HACC PYP). This represents 96 per cent of the funded organisations required to submit a plan, which is an excellent response rate, and shows a high level of engagement from Victoria's home care sector with wellness and reablement principles.

The data demonstrates that key wellness and reablement approaches are now embedded in CHSP and HACC PYP service provision in Victoria, particularly person-centred care approaches, goal-directed care planning practice and partnership work coordinating supports for clients.

Significant work to embed wellness and reablement approaches has progressed in the areas of communication, implementing systems to support person-centred practice, as well as workforce and volunteer development. A strong positive cultural shift has resulted in improvements to inclusive practices to support people with diverse needs.

Many of the key achievements build on work identified in previous planning cycles, and demonstrate the results of our efforts to undertake the long-term work involved in changing a model of care.

For many organisations, client engagement, co-design and co-production are in the early stages of implementation, with few organisations having progressed to applying co-design or co-production approaches.

Organisations' understanding of the value of and methods to measure and report on client outcomes is progressing but further work is required to increase the number of organisations and services collecting and reporting outcome measures.

The review also demonstrates the very valuable role that Wellness and Reablement Consultants (WRCs) play as drivers and enablers. In 2017, WRCs supported continued focus on client-centred practice during a significant period of transformational change in the sector.

Overall, the sector has shown significant progress and long-term change, and home care services in Victoria are now provided in a client-centred way that uses wellness and reablement approaches.

Background

Wellness and reablement approaches in the home-care sector have been shown to improve function, independence and quality of life for older people and younger people with disabilities.

This aligns directly with a key goal of the current suite of government-funded home-care programs, which aim to support people to maximise their independence and assist them to remain in their homes as long as they can and wish to do so. Embedding wellness and reablement within this sector therefore remains a key goal for both the government and the broader home-care sector.¹

Wellness and reablement began as a service model in Victoria with the first discussion paper published in May 2008, *The Active Service Model (ASM): a quality improvement initiative*. In 2010, the then Victorian Department of Health (now the Department of Health and Human Services) required Home and Community Care (HACC) funded agencies to participate in the ASM PREPARE practice review planning and reflection process. For this, agencies reviewed their assessment and service provision in relation to the ASM approach, and then identified actions required to adopt ASM. This work was supported by ASM industry consultants now known as Wellness and Reablement Consultants (WRCs). In 2017, the Victorian ASM approach was renamed 'wellness and reablement' to align it with the Department of Health's Commonwealth Home Support Programme (CHSP) approach.

Each funded organisation had to develop an implementation plan that set out strategies and actions specifically relevant for the service types delivered, the organisation type and the operational environment. This process encouraged organisations to incorporate wellness and reablement into organisational strategic and quality improvement plans aligned to the Community Care Common Standards and review process. Aligning the implementation planning with the standards and accreditation processes was considered an enabler to the implementation.

This is the sixth planning cycle for wellness and reablement (ASM) in Victoria. The change process is now at the stage of embedding new practice in the model of care for clients.

This statewide summary report summarises data and lessons from a review of the 2017 wellness and reablement plans provided by 334 organisations from across the state.

This report analyses data received from organisations across the state, as well as important information from the nine regional summary reports from the WRCs located in the nine aged-care planning regions in Victoria. The regional summary reports summarise review data reported and received in each region, with each WRC interpreting their regional data in light of their local knowledge.

¹ Department of Health 2017, *Review of wellness and reablement in the home care sector*, Commonwealth Government of Australia, Canberra.

Overview

Organisations across the state continued to demonstrate an impressive level of engagement with wellness and reablement change approaches, with 96 per cent of organisations participating in this review.

The high return rate and engagement is also due to the commitment of WRCs and sectoral development teams to supporting organisations, and their strong rapport with organisations' key representatives/managers.

The Department of Health and Human Services (DHHS) distributed a modified version of the previously used review template to facilitate a mid-term review.

The annual plan reviews are a critical element of the quality improvement planning cycle. They review progress made, and help inform planning for the next cycle. Reviews monitor and evaluate progress, including identifying significant learnings through achievements, common barriers and challenges as well as implementation enablers.

All Victorian organisations funded to deliver the Commonwealth Home Support Programme (CHSP) and Home and Community Care Program for Younger People (HACC PYP) were asked to complete a wellness and reablement mid-cycle report for actions completed in December 2016 through to December 2017.

The Commonwealth Government Department of Health (Department of Health) made it optional for CHSP-only funded organisations to submit a 2017 wellness and reablement plan. It was also optional for CHSP-only funded organisations to complete this current review and reporting process.

Of the 334 review reports received, the majority (308 or 92 per cent) came from agencies that receive both CHSP and HACC PYP funding. Thirteen (4 per cent) were received from HACC PYP-only funded organisations and 14 (4 per cent) from CHSP-only funded agencies. Funded organisations that do not provide direct client service provision were exempted from reporting.

Further analysis of the 14 CHSP-only funded organisations that submitted reviews identified that all 14 had transitioned from the previous HACC program. No newly funded CHSP-only organisations submitted review reports.

Information was collated, analysed and considered in light of the eight suggested planning priority areas outlined in the ASM and *Diversity planning resource kit* (September 2016), which informed the 2017 planning cycle:

- systems supporting person-centred service delivery
- workforce and volunteer development focusing on wellness and reablement
- goal-directed care planning (GDCCP)
- supporting partnerships
- communication and marketing inclusive of wellness and reablement approaches
- client engagement, co-design and co-production
- inclusive practices to support people with diverse needs
- measuring and collecting client and carer outcomes.

A ninth 'other' category was used to capture strategies and actions that fall outside these eight priority areas.

Organisations were specifically asked to report on:

- the strategies and actions proposed in the 2017 wellness and reablement plans that they developed and submitted in December 2016
- the stage of completion for each action, and how helpful each action was (self-rating)
- key achievements, barriers, challenges and to provide general comments on outcomes or progress.

New or other organisations that did not provide an implementation plan in December 2016 were asked to report on the progress of any wellness or reablement actions they had implemented in 2017.

Results

Key importance of the Wellness and Reablement Consultant role

The review highlights the important role that Wellness and Reablement Consultants play in the implementation of wellness and reablement in Victoria.

Wellness and Reablement Consultants support providers to gain a consistent understanding of wellness and reablement approaches, building their capacity to embed person centred approaches in service delivery promoting independence and autonomy.

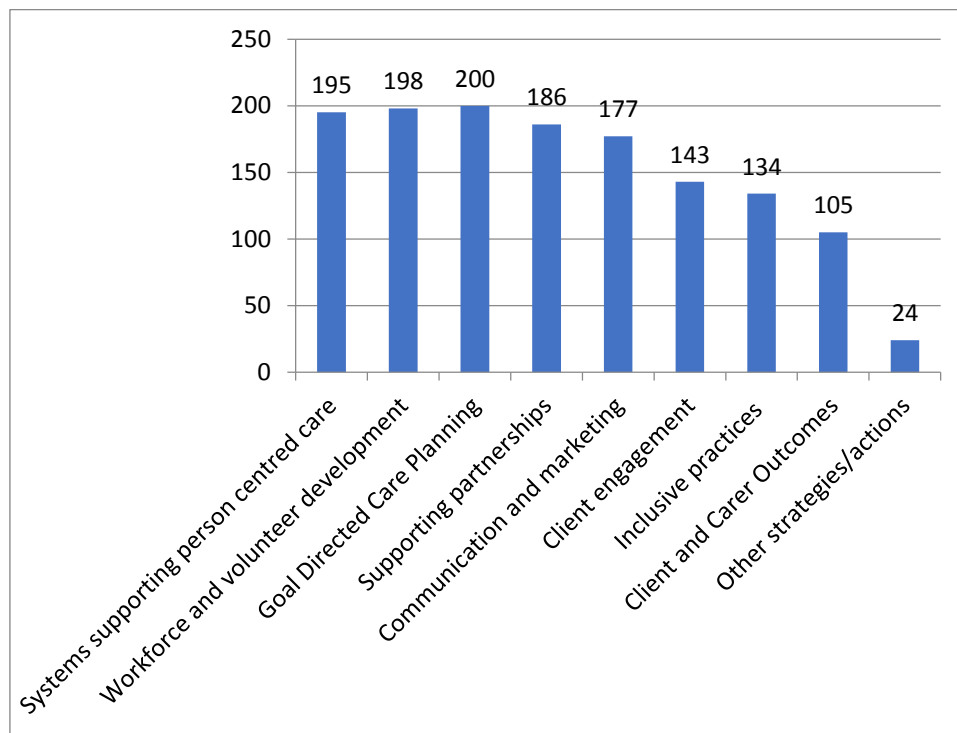
In particular, Wellness and Reablement Consultants assisted service providers by:

- Supporting organisations, networks and alliances to collaborate to progress wellness and reablement initiatives using action learning and co-design approaches.
- Supporting individual service providers with change management approaches required for the implementation of wellness and reablement.
- Supporting service providers in moving to outcomes based approaches and promoting the Data Exchange Partnership Approach as a mechanism for measuring outcomes for CHSP providers.
- Supporting service providers and alliances to understand how to effectively communicate wellness and reablement approaches to their workforce, management and leaders as well as to their clients/potential clients and their families/carers.
- Sharing examples of good practice, practice learnings and relevant resources, both locally and across the state.
- Supporting providers to meet planning and reporting requirements, including the development and review of Wellness and Reablement Implementation plans.
- Fostering 'Wellness and Reablement Champions' in service providers and networks.
- Facilitating planning forums, providing opportunities for collaboration, identification of local or provider priorities and providing practical guidance in the development of actions.
- Linking the wellness and reablement planning and quality improvement activities to the Home Care Standards for organisations.
- Identifying wellness and reablement training needs and promoting and supporting training where available.
- Collaborating with regional sectoral development team members (including Regional Development Coordinators, Diversity Advisers and Aboriginal Development Officers) and the Regional Assessment Services Coordinators to provide clear and consistent information to the sector.

Actions by priority area

Figure 1 shows the number of organisations across the state implementing action strategies that are either in progress or completed by priority area. This data does not include agencies that planned to work on a given priority but did not start work on that priority.

Figure 1: Organisations working on actions in progress or completed, by priority area, 2017

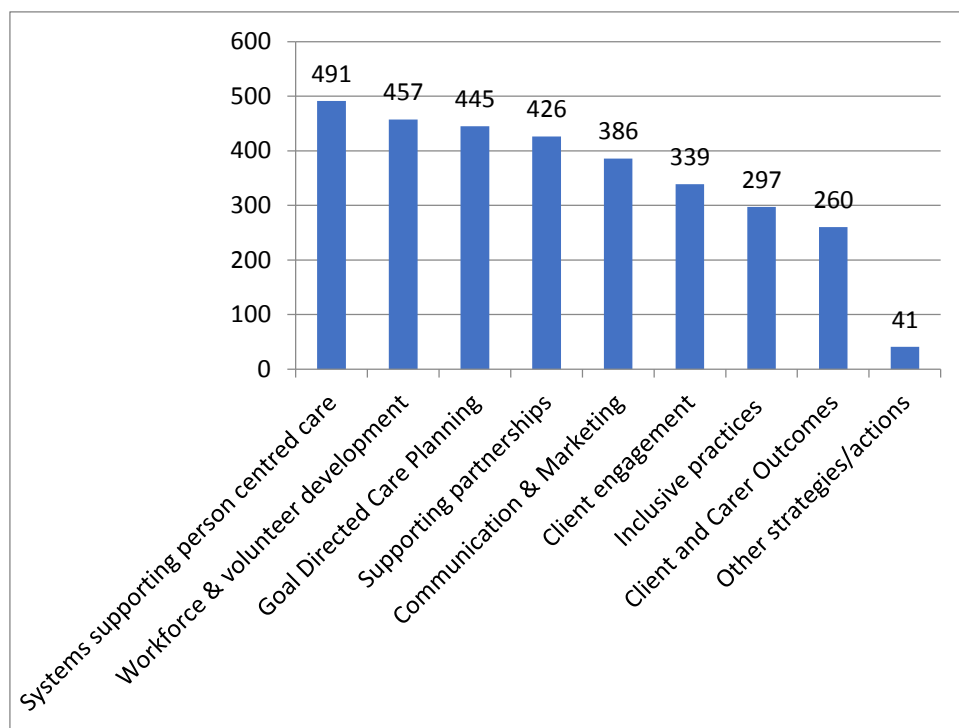


Number of action strategies implemented across the state

Figure 2 shows, by priority area, the total number of action strategies organisations reported implementing across the state that are either in progress or completed.

This data does not include priorities that were planned in 2016 that have not been actioned (have not started).

Figure 2: Total number of action strategies organisations were implementing or completed, by priority area across the state, 2017



Considerable work is in progress or has been completed across all eight planning priority areas.

The priority areas most commonly being worked on include:

- systems supporting person-centred service delivery
- workforce and volunteer development focusing on wellness and reablement
- supporting partnerships
- goal directed care planning (GDCP).

The areas where the least amount of strategy actions were in progress or completed in 2017 were:

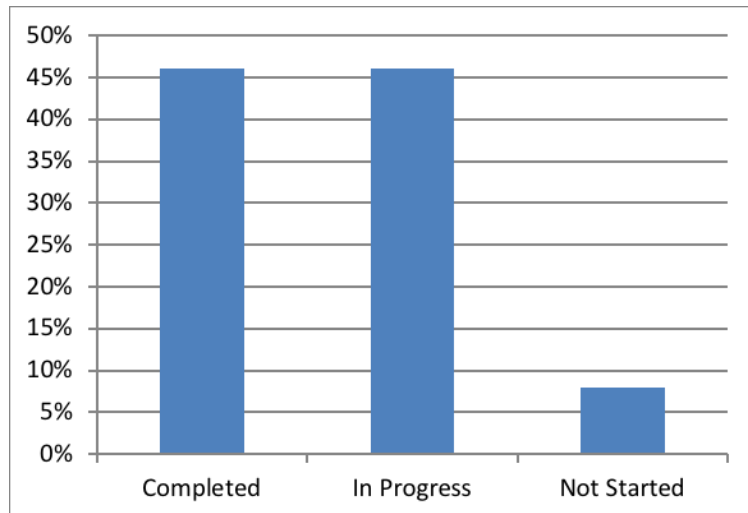
- measuring and collecting client and carer outcomes
- inclusive practices to support people with diverse needs and client engagement
- co-design and co-production.

Percentage of strategies completed, in progress or not started

Figure 3 shows the percentage of strategies completed, in progress or not started in 2017.

Overall, 92 per cent of actions were either in progress (46 per cent) or completed (46 per cent), with only 8 per cent of planned actions not started.

Figure 3: Percentage of strategies completed, in progress or not started, 2017



Organisations also rated 91 per cent of actions completed, and 71 percent of actions in progress, as helpful or very helpful, which shows the work has been valuable for the sector (Table 1).

Table 1: The value of strategy actions across all areas, 2017

Actions completed or in progress across all areas	Percentage helpful or very helpful
Completed actions	91%
Actions in progress	71%

Note that this is a funded organisation self-reported rating.

Data analysis and discussion

This section of the report provides an analysis of the data on the proportion of completed, in progress and not-started actions under each priority area. The self-rated measure of helpfulness is also included.

Systems supporting person-centred service delivery

This priority area focuses on organisations' work to ensure systems support person-centred service delivery. It includes actions to manage the impacts of the transformational change on client service provision.

It had the highest number of actions in progress or completed across Victoria (491), which shows the extent to which organisations have embedded systems to support person-centred service delivery during the transition.

In total, 48 per cent of actions were completed, 45 per cent were in progress, and only 7 per cent of planned actions were not started.

The bulk of actions completed in this priority area were rated as either helpful or very helpful, confirming the importance and the value of the work undertaken to support person-centred practices.

Organisations also reported that they have adapted processes and service models in response to the implementation of the My Aged Care portal, in particular:

- intake processes
- Regional Assessment Service (RAS) support plans and goals, which were translated into service-specific plans
- service-specific assessments and review processes, service transition and closure.

This work to adapt systems was most commonly reported where agencies were affected by the separation of assessment from service provision.

In addition, organisations reported that they had embedded wellness and reablement in their business and service plans, policies, procedures, position descriptions, electronic rostering systems and data collection/feedback systems.

Systems were also put in place to assist staff in person-centred services, including peer case review checklists and tools to guide good and consistent person-centred practice.

WRCs supported and enabled this work, which was also facilitated by training and resources for senior staff and managers. WRCs assisted organisations to develop service-specific assessment training, information and resources supporting processes and systems.

Agencies reported a number of specific barriers in implementing this priority area. The impacts of and time required to transition to the My Aged Care and CHSP systems was the most commonly reported barrier, with the separation of the RAS from service provision also reported as a related barrier.

Workforce and volunteer development

Priorities and actions identified in this area sought to build the capacity of staff and volunteers to provide wellness and reablement approaches.

This includes:

- training
- induction
- systems to transfer learning to service provision.

This priority area had the second highest number of actions in the state (457). In total, 48 per cent of actions were completed, 46 per cent were in progress and only 6 per cent of planned actions were not started.

Organisations reported that the vast majority of actions in this priority area were either helpful or very helpful. This shows that workforce and volunteer development is vital to implementing person-centred care and wellness and reablement approaches.

Many organisations reported developing wellness and reablement training and orientation for both staff and volunteers, and this was mandatory for some organisations. Some developed their own training and induction packages with a mix of training methods including face-to-face, e-learning packages and resources to support the transfer of learning.

Strategies and resources to support the transfer of learning included incorporating wellness and reablement into staff position descriptions, key selection criteria (for recruitment), volunteer handbooks, supervision and performance appraisals, peer education, support mentoring and peer reviews as well as reflective practice sessions. These strategies and structures helped to translate new learnings and skills into everyday service provision. In addition, some organisations also refreshed and reinforced wellness and reablement messages at staff and volunteer meetings, and put in place systems for ongoing training.

Goal-directed care planning (GDCCP) and strengths-based approaches were also common in relation to workforce development, and a large number of agencies reported that GDCCP was their primary workforce development strategy.

WRCs provided considerable support to agencies, especially in the area of wellness and reablement training as well as GDCCP training and resources.

One newly developed training resource is the Eastern Metropolitan Region Alliance *Connecting the pieces* resource on YouTube. The animated video and accompanying guide shows how diversity and person-centred care affects a client's journey. This resource was promoted and viewed by staff from multiple organisations in the Eastern Metropolitan Region and throughout other regions across the state.

The most commonly raised barrier to workforce and volunteer development was the reduced access to funded training.

Goal-directed care planning

GDCCP, including service-specific assessment, service planning and reviews, is a key element of person-centred care and the wellness and reablement approach. GDCCP places the person or client at the centre of support, and encourages collaboration between the client, their carer, the service provider and others. This also involves employing strengths-based approaches, and supporting clients to identify goals for their home-based support. This priority area had 445 actions in progress or completed across Victoria in 2017.

In total, 49 per cent of actions were completed, 45 per cent were in progress and only 6 per cent of planned actions were not started.

The review indicates that many organisations have progressed to the embedding and embedded stages for GDCCP. These agencies reported completing audits into the quality of their GDCCP, showing positive results and compliance with best practice GDCCP processes.

Many organisations are reviewing and modifying their GDCCP templates and tools with support from WRCs and utilising Victorian-developed resources including the Goal Directed Care Planning toolkit, the Barwon District Nursing Assessment and Care Planning Tool and the Making it Meaningful resource for social support. (See the resources and references section of this report for more links.)

Service-specific approaches are also being used to implement GDCP in allied health, nursing and social support services.

Work reported under this priority is also linked to the system changes associated with My Aged Care relating to aligning and translating the RAS support plan into goals for service plans, as well as systems to monitor and collect feedback.

The most common barriers to GDCP in 2017 were human resourcing issues, the impacts of the My Aged Care implementation, and reduced access to funded GDCP training.

Common enablers included support of senior management, workshop training and resources provided by the WRCs.

GDCP achievements have clearly built on gains and improvements reported in previous wellness and reablement (ASM) implementation planning cycles, and this has been a major achievement of the long-term change management processes associated with the new model.

Supporting partnerships

A person's needs are best met when there are strong partnerships and collaborative working relationships between the organisations providing their services. Funded agencies continue to build existing and new partnerships to embed the wellness and reablement approach. This priority area had 426 actions in progress or completed in 2017.

In total, 45 per cent of actions were completed, 47 per cent were in progress and only 8 per cent of planned actions were not started.

Organisations reported that partnership work was of high value, and that supporting partnerships strategies and actions helped to sustain partnerships and provide stability given the change underway in the sector.

Many organisations place a strong value on partnerships at all levels, including the local area, local government area and regional level.

Strong engagement of agencies in the newly formed alliances in two regional areas – the North and the West Metropolitan regions – is a key achievement.

Organisations valued participation in regional alliances, with benefits including developing resources such as the *Connecting the pieces* animated video and accompanying guide, and the *Connecting through inclusive communication practices* resource. This work was led by a region's sector development team in partnership with the alliance that provided vital and contextual input and direction.

Many organisations reported developing shared client pathways and protocols, as well as building workforce capacity to provide wellness and reablement approaches in service provision in partnership with allied health and colocated occupational therapists. Memoranda of understanding (MOUs) have been established, reviewed and updated to support this.

The value of participation in other networks or communities of practice was also commonly reported.

For a majority of funded organisations it is clearly apparent that the culture of partnering with other agencies remains strong in this time of transformational change.

Support and commitment from senior management and staff, as well as local provider networks being in place, were seen as enablers for partnership work.

Organisations reported a number of barriers and challenges specific to the partnership priority area. These included human resourcing (specifically staff changes impacting on partnerships and available staff given other business priorities) and the change environment reducing the time available for partnership participation.

Communication and marketing consistent with wellness and reablement

This priority focuses on strategies and actions to ensure the communication and marketing of services is consistent with wellness and reablement approaches.² This includes promoting inclusive and healthy active ageing messages to a range of audiences, and integrating wellness and diversity principles into communication materials and websites.

Given the reform in the sector and transition from the HACC program to the CHSP and HACC PYP program, plus the National Disability Insurance Scheme (NDIS) changes, many organisations are reviewing their communication material. This priority area had 395 actions in progress or completed in 2017.

In total, 45 per cent of actions were completed, 47 per cent were in progress and only 8 per cent of planned actions were not started.

Organisations reported that 90 per cent of actions completed in this priority area were rated as helpful or very helpful. In 2017, there was a significant focus on reviewing and revising websites, brochures, pamphlets and client information packs in line with wellness and reablement approaches. Organisations have also reported using Facebook and other forms of social media as a way to communicate with the local community and potential clients.

Many organisations now prepare communications in line with health literacy guidelines, ensuring appropriate readability for the audience. Some organisations used community advisory committees, volunteers and clients to review their communication materials to ensure they are clear and easily understood.

Some organisations reported offering community information sessions to help clients understand how to navigate the service system, given the reform in the sector.

Inclusive communications practices were supported with access to the *Connecting through inclusive communication practices* resource, and promoted and used by regional WRCs.

Barriers and challenges specific to communications included human resourcing, specifically staff restructures, turnover and vacancies affecting the availability of staff. A number of organisations reported the impacts of mergers and amalgamations as another barrier.

Enablers included workshops and support provided by WRCs, including health literacy and readability resources and the inclusive communication resource referenced above.

Client engagement, co-design and co-production

This area focuses on engaging with consumers/clients and organisations proactively working with clients to improve services. This approach aims to deliver services that are more relevant because clients have been actively involved in their design and implementation.

This priority area had 339 actions in progress or completed across Victoria in 2017. In total, 47 per cent of actions were completed, 43 per cent were in progress and 10 per cent were not started. Organisations regarded this work as of high value.

Organisations report evolving their structures and methods to engage and involve clients in decision making, and in the planning, design, provision and evaluation of services to improve the wellness and reablement focus of services and programs. This included establishing consumer advisory committees and other groups, and policies and procedures to support this work. One example is involving clients in interview and selection panels to recruit new home support workers.

² In line with known wellness and reablement information in the CHSP: programme manual and Living well at home: CHSP good practice guide.

Some organisations reported working on co-design and co-production projects, with most happening in the Southern Metropolitan Region where the most support for this approach has been provided.

The focus of many organisations remains on client feedback and client satisfaction surveys as their primary form of client engagement, and it appears a significant number of agencies still have a limited understanding of co-design and co-production.

Some agencies identified their limited understanding of co-design and co-production as a barrier to work in this area. Other barriers include a lack of human resource time, given that client engagement activities can be time consuming.

A significant number of organisations reported attending consumer feedback and co-production workshops organised by WRCs, and identified this as a significant enabler to work under this priority.

Inclusive practices to support people with diverse needs

This priority relates to the best practice of being responsive to people with diverse needs at all stages of assessment and service delivery. This priority is related to and works in synergy with Victoria's Diversity Planning initiative by working to ensure clients with diverse needs receive supportive and inclusive service-specific assessment and service provision.

This priority area had 297 actions in progress or completed across Victoria in 2017.

In total, 43 per cent of actions were completed, 49 per cent were in progress and only 8 per cent of planned actions were not started.

Organisations reported the value of completed inclusive practices to support people with diverse needs actions.

The most common actions were diversity awareness and cultural awareness training, with a strong focus on lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ) inclusivity training and Aboriginal cultural competency training.

A number of organisations reported positive cultural changes in providing services to people with diverse needs, with several completing the Rainbow Tick accreditation. There was also a strong focus on improving services for people living with dementia across the state including improving activities for people living with dementia and the use of the *Dementia-friendly toolkit* in social support settings.

A number of systems approaches were also used to improve services for people with diverse needs, which included an annual cultural audit conducted to identify gaps in service provision and feedback mechanisms to capture information about the needs of people with diverse needs being met.

Several organisations also reported improved representation from diverse groups on committees and advisory groups. Some organisations also reported implementing strategies to recruit staff and volunteers from specific communities to align with the organisation's client base.

The Eastern Metropolitan Region piloted an integrated approach to diversity planning and wellness and reablement planning in 2016, which highlighted where these two areas intersect.

Resources such as *Connecting through inclusive communication practices* and the *Connecting the pieces* animated video also seek to improve understanding of how wellness and reablement and diversity intersect, as well as strengthening understanding of inclusive communication practices.

It is clear that there has been a positive cultural shift for many organisations in the way they support and manage clients with diverse needs. WRCs and Diversity Advisors have been significant enablers of this cultural shift, along with management support and partnerships with stakeholders.

Reported barriers to actions in this priority area included reduced access to funded training.

Measuring and collecting client and carer outcomes

Measuring and collecting client and carer outcomes is a priority of both the CHSP and HACC PYP funded programs. This priority area focuses on measuring, collecting and reporting outcomes.

This priority area had 260 actions in progress or completed across Victoria, the fewest of the eight priority areas in 2017.

In total, 40 per cent of actions were completed, 45 per cent were in progress and 15 per cent of planned actions were not started. This was the lowest completion rate and highest not-started rate of all priority areas.

Organisations reported that 90 per cent of actions completed in this priority area were rated as helpful or very helpful, indicating the value of completed actions in measuring and collecting outcomes.

While a proportion of organisations reported that they had started to collect client (and carer) outcome measures, the majority said they were still exploring the best way to collect and report on these. It is also clear that some organisations still have a poor understanding of what collecting client and carer outcomes means.

Organisations report using a variety of tools to collect and report on outcomes. These include the ASM client and carer outcomes tools, the Goal Attainment Scale, the Outcome Star tool, the Euro QOL, the Canadian Occupational Performance Measures (COPM), Personal Outcome Measures and the Victorian Health Experience Survey (VHES).

A variety of the ASM client and carer outcomes tools are in use, predominantly by organisations involved in piloting the tools. One organisation is embedding the pre–post outcome measure in its Ezitracker client data management system.

Some organisations have confused conducting audits of client care plans to measure compliance in care planning, a process measure, with collecting client outcome measures.

The largest number of barriers for any of the priority areas was reported in this priority and these help explain why this priority area had the lowest completion rate and highest not-started rate.

Several organisations involved in the pilot of the ASM client and care outcomes tools reported not starting their Wellness and Reablement measuring outcomes actions because they were intending to use outcome tools developed by the DHHS. These tools were not endorsed by the Department of Health as CHSP providers should be considering the Data Exchange (DEX) Partnership Approach. Providers were given the opportunity to use the tools developed by DHHS for understanding their outcomes and to assist with using the Partnership Approach.

WRCs reported in their regional summaries that while many organisations had considered the DEX Partnership Approach to collecting and reporting outcomes, most needed more information. Barriers included organisations having a limited understanding of how to collect outcomes, and what tools to use. The lack of human resources and prioritisation of activities given time constraints in the current reform/change environment were also mentioned as barriers to progressing work on this priority.

WRCs reported that organisations are seeking further clarification and support in relation to engaging with the DEX Partnership Approach, and that at present it is seen as too time consuming and requires additional tools and resources to support the process. They also reported that service providers wanted support to embed a tool that can capture client and carer feedback and for DEX reporting.

It was noted however, in several regions information has been provided to organisations at alliance meetings and through individual visits about the DEX Partnership Approach.

Further coordinated work is needed to assist and engage service providers in reporting outcomes to ensure they have the knowledge, skills and tools to capture outcomes that meet outcome reporting requirements.

The main enablers included support of WRCs and senior management.

Other actions/strategies

This category captures strategies and actions that fell outside the eight priority areas. There were 41 actions in progress or completed across the state that could not be categorised according to the priority areas.

Actions reported as achievements were mixed in type. A number of organisations reported undertaking work to support clients in understanding, accessing and transitioning to the NDIS.

A number of new or pilot wellness and reablement service initiatives were captured in plans.

The transition to the My Aged Care portal was reported by some organisations as a barrier to implementing actions in the 'other' category.

Barriers and challenges

Commonly reported barriers and challenges related to transformational change and reform in the sector, specifically the transition from HACC to CHSP and HACC PYP and the NDIS. These included:

- needing to focus resources on implementing My Aged Care as a priority ahead of wellness and reablement implementation actions
- challenges due to the impacts of separating the RAS from service provision
- limited access to funded training and development opportunities for staff and volunteers.
- internal changes including restructures, agency mergers, workforce reviews, staff changes and the resultant impacts on the need to train and support new staff.

Wellness and reablement case study examples

Agencies provided many case and service studies as part of the 2017 wellness and reablement review report in January 2018.

WRCs in the nine aged-care planning regions reviewed all case studies received, and forwarded a selection of 43 case studies with their regional summaries to the DHHS central team coordinating sector development.

The case studies demonstrate that wellness and reablement implementation is progressing well across all priority areas and is being embedded.

A selection of eight case studies and service initiative studies have been included as appendices. They show how the implementation is taking place and the positive impacts on clients. Case studies have been re-formatted for inclusion in this report.

Case study appendices

1. Service initiative Case study 1: Building culturally inclusive social support groups' demonstrates client engagement, co-design and inclusive practices to support people with diverse needs in action, underpinned by principles of client centeredness, flexibility and creativity in social support settings (Eastern Metropolitan Region).
2. Service initiative Case study 2: Embedding the client monitoring systems into the service delivery system' demonstrates a service initiative to provide daily monitoring and reporting on client wellbeing to ensure that critical information to the planning and delivery of services is communicated to team leaders. It supports effective communication between clients, direct care workers, team leaders and family to ensure support plans are appropriate, relevant and responsive to the changing needs and circumstances of clients (Barwon South-West Region).

3. Service initiative Case study 3: Implementing a competency framework for person-centred practice in allied health' demonstrates the systems approach one agency is taking to embedding person-centred care by implementing a competency framework for person-centred practice in allied health service provision (Northern Metropolitan Region).
4. Service initiative Case study 4: Service initiative GDCP' demonstrates the background, context, process and outcomes in embedding GDCP in a large community health service (Western Metro Region).
5. Client Case study 5: Inclusive practices, holistic, person-centred approaches, strong networks and partnerships' demonstrates how a holistic, person-centred approach combined with strong networks and partnerships assisted a man from the Stolen Generation and his wife with a navigating the service system. With the help of an access and support worker, services were put in place to not only keep them connected to their community but to help remain independent (Loddon Mallee Region).
6. Service initiative Case study 6: Outcomes measures' demonstrates one organisation's approach to collecting, collating and utilising outcome measures for their allied health service clients. It gives insight into the complexity for the organisation in selecting the measures and right tools to collect. (Grampians Region).
7. Client communication Case study 7: Communicating wellness and reablement approaches to the community' is an excerpt from Orbost Regional Health's *Quality account report* and informs the local community of the organisation's services achievements in safety and quality. The client's story serves as a great example of how wellness and reablement services can be communicated to clients in a simple and easily understood way without jargon (Gippsland Region).
8. Service collaboration Case study 8: Partnership for inclusive practices' demonstrates how organisations can work together to improve inclusive practice as well as efficiencies. This service collaboration study outlines the benefits of working together and using a tailored person-centred care approach for the benefits of clients (Hume Region).

Resources and references

Resources developed in Victoria in 2017

The two most significant resources developed in Victoria and shared in 2017 are described below, with hyperlinks included.

Connecting the pieces video and guide

These resources articulate the unique aspects of diversity and person-centred care (wellness and reablement) and, importantly, the relationship between these approaches, how they influence each other and the need for diversity and person-centred care to be understood throughout the continuum of the client's journey.

[View the film](https://www.emralliance.org/uploads/9/7/7/9/97794766/video_-_connecting_the_pieces_1080_hd.mp4) <https://www.emralliance.org/uploads/9/7/7/9/97794766/video_-_connecting_the_pieces_1080_hd.mp4> or [visit the website](https://www.emralliance.org/connecting-the-pieces.html) <https://www.emralliance.org/connecting-the-pieces.html>.

Connecting through inclusive communication practices

This resource contains information, tools and good practice examples that organisations can use with their staff, volunteers and consumers to develop new communication materials, or when reviewing existing communication materials.

It focuses on the use of inclusive language and communication practices that are meaningful and relevant to potential and current consumers.

It also has useful information and links to other resources that will support organisations to have meaningful conversations that are person-centred and consider each person's diversity.

[Visit the website](https://www.emralliance.org/connecting-through-inclusive-communication-practices.html) <https://www.emralliance.org/connecting-through-inclusive-communication-practices.html>.

Resources and references used in the implementation

Key CHSP references

[Commonwealth Home Support Programme – programme manual 2017](https://agedcare.health.gov.au/news-and-resources/publications/fact-sheets/commonwealth-home-support-programme-programme-manual-2017)

<https://agedcare.health.gov.au/news-and-resources/publications/fact-sheets/commonwealth-home-support-programme-programme-manual-2017>

[Living well at home: CHSP good practice guide](https://agedcare.health.gov.au/programs-services/commonwealth-home-support-programme/living-well-at-home-chsp-good-practice-guide) <https://agedcare.health.gov.au/programs-services/commonwealth-home-support-programme/living-well-at-home-chsp-good-practice-guide>

[A partnership approach to reporting outcomes](https://dex.dss.gov.au/about/a_partnership_approach_to_reporting_outcomes)

<https://dex.dss.gov.au/about/a_partnership_approach_to_reporting_outcomes>

Key HACC PYP references

[HACC PYP guides](https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines) <https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines>

Other key resources developed in Victoria

[Goal-directed care planning toolkit](https://www.emralliance.org/goal-directed-care-planning-toolkit.html) <https://www.emralliance.org/goal-directed-care-planning-toolkit.html>

[Planned activity groups – Making it Meaningful: Assessment and care planning guidelines and tools](https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines)
<<https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines>>

[Enabling the use of easy living equipment for everyday activities – guidelines and training package](http://www.mav.asn.au/search/Results.aspx?k=easy%20living)
<<http://www.mav.asn.au/search/Results.aspx?k=easy%20living>>

[Consumer feedback toolkit](https://www.emralliance.org/uploads/9/7/7/9/97794766/consumer_feedback_toolkit_-_1.1_introducing_the_emr_hacc_alliance_consumer_feedback_toolkit.pdf)
<https://www.emralliance.org/uploads/9/7/7/9/97794766/consumer_feedback_toolkit_-_1.1_introducing_the_emr_hacc_alliance_consumer_feedback_toolkit.pdf>

[The support loop resource](http://www.hwpcp.org.au/wp-content/uploads/2016/06/The-Support-Loop-Resource-1.pdf) <<http://www.hwpcp.org.au/wp-content/uploads/2016/06/The-Support-Loop-Resource-1.pdf>>

[Supporting older people living well at home: understanding the role of OT](https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines/hacc-quality-and-service-development/active-service-model/putting-asm-into-practice)
<<https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines/hacc-quality-and-service-development/active-service-model/putting-asm-into-practice>>

[Dementia-friendly social support – checklist](http://www.g21hwbpillar.com.au/resources/dementia-friendly-social-support-%E2%80%93-checklist-report) <<http://www.g21hwbpillar.com.au/resources/dementia-friendly-social-support-%E2%80%93-checklist-report>>

[Supporting volunteers to take an active service approach: a resource kit for managers and coordinators of volunteers](https://www.emralliance.org/supporting-volunteers-to-take-an-active-service-approach.html) <<https://www.emralliance.org/supporting-volunteers-to-take-an-active-service-approach.html>>

[Barwon assessment and care planning guidelines and tools](http://centralvicpcp.com.au/hacc/wp-content/uploads/2015/10/Barwon-Ax-Tool-guidelines-post-trial.doc) <<http://centralvicpcp.com.au/hacc/wp-content/uploads/2015/10/Barwon-Ax-Tool-guidelines-post-trial.doc>>

[Physical activity in planned activity groups](http://www.nari.net.au/elearning/story.html) <<http://www.nari.net.au/elearning/story.html>>

[Plan, do, study, act \(PDSA\) – a model for improvement](https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines/hacc-quality-and-service-development/active-service-model/putting-asm-into-practice) <<https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines/hacc-quality-and-service-development/active-service-model/putting-asm-into-practice>>

[Partnership analysis tool \(VicHealth\)](https://www.vichealth.vic.gov.au/search/the-partnerships-analysis-tool) <<https://www.vichealth.vic.gov.au/search/the-partnerships-analysis-tool>>

Eating for independence: A training program for the nutrition care of older people living in the community (not available online)

Key resources developed outside Victoria

The [Step forward together toolkit](https://homecaretoday.org.au/provider/consumer-engagement/co-production) <<https://homecaretoday.org.au/provider/consumer-engagement/co-production>> (WA) for community aged care providers who want to implement or improve the wellness and reablement focus of services and programs.

References

Australian Healthcare Associates 2015, *ASM PREPARE 3 Year Review, Final report, March 2015*, <<http://www.hwpcp.org.au/wp-content/uploads/2015/04/ASM-report-Final-march-2015.pdf>>.

Department of Health 2017, *Commonwealth Home Support Programme – programme manual 2017*, <<https://agedcare.health.gov.au/news-and-resources/publications/fact-sheets/commonwealth-home-support-programme-programme-manual-2017>>.

Department of Health 2017, *Review of wellness and reablement in the home care sector*, <<https://agedcare.health.gov.au/programs/review-of-wellness-and-reablement-in-the-home-care-sector>>.

Appendix 1: Mountain View Cottage case study

Use the reflective questions at the end of the case study to help you assess whether your service is able to take on some of the initiatives put in place at Mountain View Cottage, whether they are suitable for your group and what needs to happen for these changes to be possible.

Figure 4: Mountain View Cottage case study illustration



CASE STUDY: MOUNTAIN VIEW COTTAGE, LEARNING TO LET GO.

This case study illustrates the principles of client-centeredness, flexibility and creativity.

Case study

Sussy Vasquez-Lozano, Coordinator of Community Programs (HACC PYP and CHSP) for the City of Whitehorse and her team are leading a small revolution. The fifteen Social Support Groups (SSG) run by the local council under her coordination are empowering clients to plan activities, ensure affordability and participate in risk assessments for the programs. This is regardless of the clients' cultural background, their English-language proficiency or whether they are experiencing dementia.

Identifying the need for change

It all started in 2012: participant numbers were low and the team were planning to implement the Active Service Model. Sussy and her team, with the assistance of Anna Makedonskaya (Service Development, Business Quality and Training Coordinator for City of Whitehorse) initiated a review of the programs and consulted current and potential participants and staff.

The review was conducted over five months and included surveys, questionnaires, workshops and focus groups. More than 200 people were consulted, from HACC staff, existing clients and local senior groups.

An important aspect of the review was consultation with potential clients (through senior groups) about their experience accessing services and what may interest them in the future.

What surfaced was the great diversity of older people in the area – not just of cultural backgrounds but also of interests. HACC programs at the time were traditionally developed with a service focus, rather than the diverse needs and interest of clients.

The review led to wide-ranging changes to the way services were designed and delivered. Amongst many improvements, the phone system was re-designed to improve responsiveness; a community transport framework was developed; staff position descriptions were reviewed; training and resources in person-centred practice developed and provided; and a risk management strategy designed and implemented.

At the core of the review's recommendations was the desire to respect 'clients' rights to make their own decision and lifestyle choices'. Over the course of three years, the team developed and implemented Service Principles, 'balancing risk-management with flexibility and dignity of choice'. Anchored in State and Federal Acts and Charters (eg the Age Discrimination Act 2004), they have given Whitehorse City Council HACC Community Programs focus and direction, and a framework to evaluate their practice.

The Service Principles are provided to clients joining the programs as a document outlining their rights and responsibilities, as well as ways to provide feedback.

The client planning element was introduced mid-2015, and, while it is still a continuous improvement process, it sees clients meeting every two months to develop a schedule of activities for their group, ensuring they are affordable, checking staff availability, and assessing general feasibility. A schedule is then produced for each group, allowing for possible changes in mind, mood and weather.

Outcomes of the review in practice

Today, Mountain View Cottage is bright and beautifully decorated, with fresh flowers, new garden settings and colourful cushions throughout, but more importantly with no separation between staff and client areas, and few office spaces. Clients can choose between three outdoors areas, a quiet room, an arts room, a domestic kitchen and a commercial kitchen to prepare meals, and meeting areas for activities. The fifteen SSGs are at full capacity and the staff form a cohesive team, dedicated to a person-centred approach that builds on clients' and staffs' strengths and clients' wishes.

While this could seem costly, it has in fact enabled the programs to achieve efficiencies. As Sussy explains: 'We only purchase what is needed for each activity, which has reduced program costs. Other benefits are that we have increased client's satisfaction and introduced new programs within the same budget allocation.'

As for cultural diversity and language proficiency, they are accommodated in the groups and treated like any other individual trait. 'When you look at affinities' says Sussy, 'language is secondary because you are focusing on what people have in common rather than their differences'.

Recently, a Montessori trainer visited from Dementia Australia and made some recommendations that will be implemented over the next few months. 'What Montessori has done' explains Sussy, 'is reinforce the message that the setting up and preparation are as much part of the activity as the outcome'.

If people want to create something as an activity, planning and buying materials are just as part of the activity as creating the final product. And if it takes time and they cannot start on their craft work on the day, then so be it, they will do it the following week. In the meantime, they will have been shopping, on an outing, managing expenses and interacting with others – each of these an activity in itself.

Managing risk and duty of care

In the past three years, Mountain View Cottage has developed a tight process for risk assessment, with a series of 'checkpoints' at the intake, care plan and program delivery stages. This is complemented by a reflective practice approach where positive and negative incidents are examined and learnings are drawn for future practice.

An example of the involvement of clients in the management of risk can be found in the planning of outings. In a recent instance, clients were discussing the possibility of going to a venue that presented physical challenges, as accessing the site could only be done by walking on gravel - this would have been difficult for client with walkers. Staff had concerns about the outing. Clients were able to explore this outing as an option and while doing the risk assessment, arrived at the conclusion that it was not suitable.

Clients reported feeling fully informed and supported making the decision and an alternative venue was found by them. In the past if this had been a decision made by staff, clients may have expressed dissatisfaction at not knowing how the decision was made and the factors that were considered.

Reflections

The journey undertaken by Mountain View Cottage to maximise clients' autonomy and decision making includes considering the following:

- Project environment – how might the room/s best be set up for multiple activities to be conducted concurrently? Are there quiet areas? Are there safety issues for people who do not speak English, and how will you address them?
- Program planning – how do you engage people in program planning at present? In which area might you increase their involvement and maximise their level of decision making in the planning process (e.g. activities, physical environment, how to be inclusive of new participants)? What costs will be associated with a change of approach? There are many areas worth exploring and adapting at no or low cost to agencies.
- Risk management – how does your service's risk management strategy incorporate clients making decisions about planning and delivery? What risks does this pose and how can they be mitigated? Think of who you need to discuss this with in your agency.
- Areas can include: practical risks such as using utensils during food preparation and safety during outings; psychological risks such as conflict resolution and negotiating disagreements between clients involved in decision making.
- Communication – such changes cannot happen without the support of the whole organisation, and of families and carers. Within your organisation, how will you consult and publicise what you are doing? Are there concerns that you need to address? How will you do this? With families and carers, how will you explain your new approach? How will you address their possible apprehension about the level of autonomy granted to their family member? Do you have examples you can use in your communication with them to demonstrate the benefits of your approach.

Recommended resources

- The [Centre for Culture, Ethnicity and Health at the North Richmond Community Health Centre](http://www.cah.org.au/training/) <<http://www.cah.org.au/training/>> offers practical and specialist training to help organisations and individuals start to be more responsive to clients from migrant backgrounds.
- [Connecting the pieces](http://www.emralliance.org/connecting-the-pieces.html) <<http://www.emralliance.org/connecting-the-pieces.html>> is video and reflective resource explaining how diversity, person-centred care and the relationship between them.
- [Pathway of the Innovative Multicultural PAG partnership](http://www.ahaconsulting.com.au/wp-content/uploads/2016/06/Multicultural-Planned-Activity-Group.pdf) <<http://www.ahaconsulting.com.au/wp-content/uploads/2016/06/Multicultural-Planned-Activity-Group.pdf>> in Brimbank.
- The [Centre for Cultural Diversity in Ageing](http://www.culturaldiversity.com.au) <<http://www.culturaldiversity.com.au>> offers a range of resources, from practice guides to census data and multicultural resources.
- The [Ethnic Communities Council of Australia's Aged Care Policy Committee](http://www.eccv.org.au/policy/committees/aged-care-committee/) <<http://www.eccv.org.au/policy/committees/aged-care-committee/>> can be contacted for policy advice.
- The [Montessori method](http://montessorifordementia.com.au) <<http://montessorifordementia.com.au>>, with its focus on independence, is increasingly applied as a model of care in the aged care sector.

Appendix 2: Warrnambool City Council case study

Warrnambool City Council (WCC) uses Ezitracker, which is a remote workforce management solution.

All community care workers have iPhones and access to Ezitracker is via a mobile phone app.

A function within Ezitracker has been identified by WCC as an opportunity to make improvements to its client monitoring and feedback systems that will enhance both the responsiveness to client care needs and deliver a more efficient service delivery model.

The Support Loop resource was developed and launched during the same timeframe and WCC have undertaken to adapt this paper-based tool to an electronic resource within Ezitracker.

Client feedback and monitoring systems had traditionally focused on a deficit model of care where by direct care workers would report issues of concern to the team leaders.

The former system and practices did not provide or encourage direct care workers to monitor and feedback information about client general wellbeing or observed changes to client health in relation to memory and cognition, goals, mobility, nutrition and cognitive function in a timely manner.

All these elements are fundamental to working with clients from a wellness perspective and to supporting them to maintain their independent living skills.

The Ezitracker and Support Loop client monitoring system will:

- be conducted at every episode of care in a client's home
- provide daily monitoring and reporting on client wellbeing
- ensure that information that is critical to the planning and delivery of services is communicated to team leaders
- support effective communication between clients, direct care workers, team leaders and family
- ensure that care plans are appropriate, relevant and responsive to the changing needs and circumstances of the client.

The IT system build is almost complete, and a trial will commence in 2018.

Appendix 3: Banyule Community Health case study

Banyule Community Health has developed and is implementing a competency framework for person-centred practice in allied health service provision. To ensure optimal client outcomes and to further build the capacity of the workforce, the goal of the project was to develop a framework of person centred core competencies to inform work performance and to identify the training needs of the staff.

The process

Following staff and consumer focus groups and a literature review, 57 competencies were identified as important for the delivery of person centred care in a community health setting. These competencies were incorporated into a Self-Assessment tool. The Person-Centred Care Competency Self-Assessment tool sets out the 57 competencies under seven domains:

- communication and interpersonal skills
- understanding client values and beliefs
- shared decision making
- multidisciplinary teamwork
- coordination of care
- supporting self-care and self-management
- problem solving and negotiation skills.

The self-assessment tool has been implemented with all existing and new allied health staff to establish a baseline of knowledge and skills and to identify training and support needs for each staff member. The tool will be re-issued to all team members after two years as part of the quality improvement cycle.

Outcomes

The implementation of the competency framework for person centred practice in allied health at Banyule Community Health service has provided the organisation with a greater understanding of the staff's learning needs and organisational training needs.

This has resulted in targeted, team-based training. Through supervision, staff are reporting increased levels of confidence and a wellness approach is embedded into service delivery practices through:

- Active listening – using strategies that indicate you have heard and understood what the client has said; feeding back to the client through acknowledging, restating or paraphrasing, questioning and reflecting.
- Holistic assessment – focusing on a client's overall wellbeing by asking questions on broad topics including the physical, emotional, mental, social and environmental wellbeing of the client.
- Strength based assessment – focusing on the client's strengths and abilities rather than their deficits or problems.
- Service specific care planning – a living, written document, developed collaboratively with the client and driven by the client's needs, goals, preferences, choices and priorities.
- Health and lifestyle coaching – supporting clients to gain the knowledge, skills and tools to make changes in their health or lifestyle behaviours and to support them to regain skills and to increase their confidence and independence.

Appendix 4: cohealth goal-directed care planning case study

cohealth's goal directed care planning (GDPC) or person-centred planning is endorsed as a key component of a person-centred approach and is integrated into cohealth policies and practice guidelines. While care planning is new for some staff, many have been setting goals and developing care plans for years. Traditionally the focus has been on creating care plans that provide staff with information and the intervention or services being delivered. A goal directed approach to care planning requires staff to shift focus and develop care plans that are meaningful and useful tools for clients. GDPC are strengths based, individualised and reviewed regularly to ensure they remain relevant and useful.

Background and context

Goal-directed care planning is one of the foundations of person-centred care, and is embedded as core practice across health and community service in policy and practice guidelines. It requires staff to plan collaboratively with clients about how they will work together to meet each person's individual goals and document care plans that are meaningful and useful tools for clients. Because of this care planning is prioritised by cohealth.

Aim

cohealth recognised the need to undertake a change management process with all service delivery staff to embed a client centred approach and to work collaboratively with clients on their goals. cohealth seeks to improve the consumer's experience and outcomes by developing a consistent, integrated approach to person-centred care planning practice.

As a result, our clients will be empowered, engaged and in control, our staff will be confident and consistent in undertaking care planning. We set a target of; a minimum of 90 per cent of all clients will be offered a goal-directed care plan, which will be developed in collaboration and shared with the client, and reviewed as agreed during the episode of care.

Process

A Senior Manager led the initiative, and consultant Kate Pascale provided strategic support and advice for the review and development of tools and systems to support the implementation of effective care planning across cohealth. Kate Pascale also undertook a series of full day interactive workshops with the service delivery workforce, to establish a common understanding of ways of working that support GDPC.

Individual teams then created team action plans, care plan templates and work instructions that aligned with their population cohorts and used health literacy and strength based care principles to ensure appropriate language was used. Teams also chose a GDPC Champion, who attended monthly Champions sessions to support their knowledge, skills and confidence in implementing GDPC within their team. The Champion role was to bring that learning and change in practice back to their teams, help the team solve problems and celebrate good practice. GDPC is a standing agenda item on team meeting agendas.

There is a steering group which meets bimonthly to further support the implementation of the initiative and activities of this group are broad including strategy planning and evaluation, auditing, governance and quality.

Resources utilised

- Kate Pascale was engaged to deliver training which was rolled out to all clinical staff. This included a practical, comprehensive manual for every participant.
- Senior Manager leadership as part of the steering group, GDPC Champions and Program Managers from each team.

- Communications plans, evaluation framework and auditing templates, development of a cohealth care planning policy.

Enablers

- Our cohealth values are courage, respect, inquiry and innovation and social justice. Employees at cohealth have a very strong connection to our values which align with the purpose and process of goal-directed care planning.
- Goal-directed care planning is core practice in cohealth's health and community services, it is evidenced based and it aligns with other cohealth service initiatives such as inter-professional practice, self-management, early intervention, holistic, client centred and coordinated healthcare which is collaborative and strengths based.
- A committed senior leadership team which is able to continue to drive the implementation of GDCP; promoting training attendance, communicating with relevant stakeholders, undertake evaluation and policy development.
- Program managers who have embedded GDCP supporting structures with teams and individuals such as case conferencing, client review meetings, GDCP discussions, celebrated good practice, included it as part of the professional development review process and have coached staff. In addition, the teams were able to implement GDCP in a flexible way that worked for their team. A change management lens was overlaid with the GDCP implementation to support teams to be engaged in the process.
- Consumers were engaged to assist with developing resources and promotional materials. Evidence of the consumer's high level of engagement and also client surveys data highlighting that clients valued care plans improved the legitimacy of this approach with staff.

Challenges

- Consistent and timely messaging through to all teams. A communications plan was developed and regular communications were tailored to all levels and at teams within the organisation. Communications to teams was able to be tailored as required to meet the needs of the team.
- Multiple organisational and sector wide changes occurring at the same time as implementing this initiative resulted in a slower and less even implementation of GDCP.

Outcomes

- Staff thought the GDCP full day training was valuable and practical. Staff reported increased knowledge of the cohealth care planning strategy and core practices of GDCP.
- Increased number of care plans used within teams which achieve best practice indicators
- The number of completed care plans has increased over time.
- The number of reviewed care plans has increased over time.
- Consumers' feedback was sought and used to inform GDCP practice. Consumers are engaged and have a positive experience with goal directed care planning.
- Client directed care, self-management and care planning phrases are included on care provider position descriptions.

The difference the initiative has made to the way staff work

- Care providers have an increased level of commitment to working in a client centred way.
- Care providers have increased confidence with completing care plans. Care planning is now a common approach across the agency.
- It has provided a meaningful way to adopt interprofessional practice, self-management and client directed care into standard practice at cohealth.

Client and carer benefits

Clients feel more included in their care, they feel they are more in control and have more choices. They have reported that they feel involved in decisions about their care, the care plans were helpful and receiving a copy of their care plan helps them stay on track and committed to achieving the goals.

On reflection

Future and key areas for continued development include continuing to engage the care plan working group and continue to support teams to strengthen care planning within teams, including the importance of reviewing care plans.

Appendix 5: Bendigo and District Aboriginal Corporation case study

The situation and the client

A man came to Bendigo & District Aboriginal Corporation through the 'Bringing them Home' (Stolen Generation) program. The man and his wife wanted to connect with the community. Through the Planned Activity Group (Social Support) assessment health issues were identified.

Actions taken, referrals made

The client was referred to the Access and Support worker to assist navigate the system for housing relocation, occupational therapy assessment, assessment with home care services and for an Aged Care Assessment.

Outcomes

The man is now waiting on a Home Care Package. He is currently being provided with local home care services through the local council. His wife has received respite through the carer's support program and future/ongoing respite is being planned.

The man now is attending and enjoying the Planned Activity Group (Social Support) regularly. Major health and housing issues are being addressed.

The benefit of partnerships and using a client centred approach

All of these services were brought together by networking, meetings, community gatherings and sharing of appropriate service information.

On reflection

This man and his wife only presented as wanting connection to the local community. Through discussion and referrals major health and accommodation issues were identified and addressed.

Appendix 6: Djerriwarrh Health Service case study

Background

The identification of outcome measures has been a challenge for staff as no single measure is appropriate to capture the diversity of conditions that clients present with.

Action

In response to this, the teams have implemented and revised a variety of outcome measures following a set trial period. Where possible, staff have been encouraged to identify outcome measures which are relevant to most health conditions. Where this is not possible, selected measures may be used for specific conditions.

The selection of measures has been determined based on their relevance to the clinical condition, the ability to capture data in the primary care setting and the specificity of the measure in demonstrating an effect as a result of a particular intervention.

Results

To date, each allied health discipline has identified key outcome measures to evaluate the effectiveness of therapeutic interventions. Results have demonstrated positive outcomes with client improvement shown across a variety of allied health disciplines.

The collection of client outcome measures remains reliant on manual processes such as the completion of file audits for individual client interventions. Where group programs are delivered, specific survey measures are collected to monitor client satisfaction and clinical outcomes.

Outcome measures reports are compiled and presented back to allied health and management teams to monitor the quality of programs.

As part of the governance structure, these reports are tabled at relevant committees and fed up to the Board to facilitate transparency at all levels of the organization.

Conclusion

Specific reporting templates have been developed for use across the organization. Outcome measure reports form part of the organizational quality plan which contributes to organizational accreditation requirements.

Appendix 7: Orbst Regional Health case study

Consumer, carer and community participation – doing it with us, not for us

Advancing age, a health setback, or disability can pose real challenges for maintaining an independent active life. We expect to be able to manage and may feel embarrassed or even a bit ashamed of asking for help. In some cases, reduced capacity can contribute to depression when the activities that used to provide interest are no longer accessible. Physical and social therapies help people remain as active and engaged as possible. This story is a great example of how a bit of well-targeted help can make a difference.

Our home-based care services have helped around 250 people this year to lead an active life.

Alan's story

I collapsed at home and fractured my back. I had surgery and from then on, I was useless. I was doing everything beforehand and lost 12 kgs as I found I couldn't bend over or stand too long, to peel spuds for example. It was terrible.

When I returned home I had six weeks home help with cleaning and found out I could get meals cooked for me. Home-based services provided a worker twice a week to help with housekeeping and cooking.

The first two weeks was trial and error, as we got used to each other. We started off going shopping together, doing a big shop. I pick my own recipes now and write my own shopping list. I prepare and pre-bag the vegetables and put them in the freezer ready to cook when I need them. When I am feeling really good I do my own shopping. But if I don't get to do the shopping, I have enough food because there is plenty in the pantry and freezer now as we have stocked them up.

Our staff member said, 'When I first came here Alan needed help and over time we have worked out different ways so he can still do things. He can prep up the vegetables and we work together to create nutritious meals. I am only guiding him now and monitoring how he is going'.

Appendix 8: Lower Hume Primary Care Partnership case study

Principles showcased

- Provide tailored services to the unique circumstances and cultural preference of each client family and carers
- Develop and promote strong partnerships and collaborative working relationships between the person, their carers and family, and support workers.

Background

Over the past seven years HACC (now CHSP and HACC PYP) funded organisations across Victoria have been required to submit a Wellness and Reablement Plan (previously known as Active Service Model ASM) and a Diversity Plan. The plans identify priorities that organisations implement to build more person centred and inclusive practices across the organisation and for their clients.

In July 2015, members of the Lower Hume Primary Care Partnership (PCP) Service Development Collaborative agreed to collaborate on the development, implementation and evaluation of their 2015-2016 Diversity plans.

After the success of the initial joint plan, in July 2016, the same members also agreed to collaborate on the new cycle of planning for Diversity Plans as well as including a collaborative approach to Wellness and Reablement Plans

Aim of the collaboration

- Improve access to community aged and disability services by eligible people who are marginalised or disadvantaged, and
- Increase the capacity of the service system to appropriately respond to their needs.

Joint action plan

Agreed actions identified. Diversity, and Wellness and Reablement plans developed and lead agencies for each target/priority group delegated.

Evaluation

- Monthly progress reporting and discussion on the implementation of the plan is a standing item on the Service Development Collaborative meeting agenda.
- Regular attendance at Service Development Collaborative meeting of regional Diversity Advisor and Wellness and Reablement Consultant to support planning and implementation of priorities.
- Monthly reports summarised into annual evaluation and review of plan for the Department of Health and Human Services (DHHS) and more recently the Department of Health (DoH).
- A survey was undertaken to identify strengths and areas for improvement.

Results (so far)

- Collaborative work is enabling a sharing and a more efficient use of resources to achieve common goals.
- Increased peer support for the small rural health services and local governments with limited resources resulted in the plan became a living document.
- Reduction in siloed and duplication of work between and within organisations.
- DHHS identified this work as a model for future collaborative initiatives and has asked the collaborative to present learnings.

Benefits for clients and potential clients

- Increased awareness by the community of the health services as an accessible and inclusive place to visit and obtain health support.
- Helped to identify new engagement and inclusive strategies for groups that we have found difficult to plan for.
- More holistic approach to service delivery
- Increased knowledge of how to work with diverse communities using person centred practices that we are experiencing
- Better understanding to the needs of a diverse range of clients.

Learnings

- Much more is achieved by working together and sharing resources and knowledge as well as sharing responsibility for implementation.
- Needs to have executive level support and not be confined to only DHHS funded programs.
- PCP is well placed to facilitate collaborative planning, implementation and reporting.

Challenges

- In smaller agencies responsibility is often tacked onto some other person's role
- In larger agencies Managers often have responsibility but their clinical responsibilities often take precedence
- Aged Care Reforms and National Disability Insurance Scheme have been and still are for many the primary focus
- To embed within the organisations quality improvement processes