

# Home and Community Care (HACC)

## Diversity planning and practice implementation review project

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The HACC program is jointly funded by the Commonwealth and Victorian governments.

## Key findings

The Home and Community Care (HACC) diversity planning and practice review provided the opportunity for the sector to provide extensive feedback on the implementation of diversity planning and practice in Victoria.

The sector consultation process was highly successful and generated a large volume of feedback for analysis. Approximately 300 participants from 250<sup>1</sup> agencies provided 269 individual written survey responses and 40 small group survey responses. An electronic survey generated an additional 43 responses. In total there was over 2,500 items of feedback, of which there were only three negative responses that indicated little benefit from diversity planning and practice.

The comprehensive feedback from the sector consultation, combined with the data analysis, provides clear priorities for continued implementation. (See section 5.12)

The review suggests that implementation of diversity planning and practice to date is viewed positively by the HACC sector. Continuation of diversity planning and practice will assist in supporting access to services by vulnerable people with diverse characteristics who experience barriers to accessing HACC services.

The key messages below summarise the findings of the review.

1. HACC diversity planning and practice appears to be well established in Victoria. Eighty-seven per cent of HACC funded agencies have developed and are implementing strategies to reduce barriers to access by HACC eligible people with diverse characteristics.
2. The HACC Diversity Adviser (HDA) roles are a critical success factor. HDAs have led and championed diversity planning in each region, influencing HACC funded agencies' commitment to and implementation of diversity planning and practice.
3. The sectoral development roles, such as those in peak organisations, the HDAs, regional networks and the statewide HACC Diversity Working Group have been instrumental in working together to provide a systemic approach to implementing diversity planning and practice.
4. There is an increase in organisational and workforce awareness and acceptance of diversity. For example, increasingly inclusive language, organisational culture, planning, service responses and practices, particularly in relation to Lesbian, gay, bisexual, transgender and intersex (LGBTI) and dementia.

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<sup>1</sup> N=250/434 HACC funded agencies

5. The Access and Support (A&S) activity is relatively new to the Victorian HACC program. A&S services engage with people with diverse characteristics who experience barriers to accessing HACC services, and support them to access services.
6. A&S workers are demonstrating success in engaging with, and linking vulnerable people to services. The majority of these people are new entrants to HACC.
7. A&S is still becoming known to organisations and communities as a new HACC service type, and has not yet reached maturity. There is the scope and capacity for implementation of A&S to be further progressed in the HACC sector, in the community and the service system as a whole.
8. Diversity planning and practice and the Active Service Model (ASM) are interrelated as they both encompass person-centred practice. A team approach between the HDA role and ASM Industry Consultant role is beneficial for HACC service outcomes.

An action plan outlining specific tasks to address the priorities listed in section 6.2, with ongoing leadership and input by the department, the Diversity Working Group and regional networks will support the continued successful implementation of diversity planning and practice in Victoria.

## Terminology

Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander.

## Abbreviations

A&S	Access and Support
AAV	Alzheimer's Australia Victoria
ACAS	Aged Care Assessment Service
ACCO	Aboriginal Community Controlled Organisation
APATT	Aged Psychiatry Assessment and Treatment Team
ASM	Active Service Model
CALD	Culturally and linguistically diverse
CCCS	Community Care Common Standards
CDAMS	Cognitive Dementia and Memory Service
DBMAS	Dementia Behaviour Management Advisory Service
ECCV	Ethnic Communities Council of Victoria
HACC	Home and Community Care
HAS	HACC Assessment Service
HDA	HACC Diversity Adviser
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MAV	Municipal Association of Victoria
MDS	Minimum data set
PAG	Planned Activity Group
RDNS	Royal District Nursing Service
VCAACD	Victorian Committee for Aboriginal Aged Care and Disability

## Acknowledgements

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The input of the HACC sector, the HACC Diversity Advisers and the statewide HACC Diversity Working Group is gratefully acknowledged. The Diversity Working Group comprises representatives from:

- Alzheimer's Australia Victoria
- Ethnic Communities Council of Victoria
- Municipal Association of Victoria
- Royal District Nursing Service
- Val's Cafe, Sexual Health & Ageing Program, (La Trobe University)
- Victorian Committee for Aboriginal Aged Care and Disability.

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# 1. Context

## 1.1 The Home and Community Care (HACC) program

The HACC program provides funding for services that support older and frail people with moderate, severe or profound disabilities and younger people with moderate, severe or profound disabilities and their unpaid carers. HACC services provide basic support and maintenance to people living at home to help avoid premature or inappropriate admission to long-term residential care.

The HACC program has a focus on five special-needs groups that may experience particular difficulty in gaining access to HACC services. The groups are:

- people from Aboriginal and Torres Strait Islander backgrounds
- people from culturally and linguistically diverse (CALD) backgrounds
- people with dementia
- people living in rural and remote areas
- people experiencing financial disadvantage (including people who experience or are at risk of homelessness).

## 1.2 The HACC program in transition

As part of the May 2013 agreement between the Victorian and Commonwealth Governments to implement the National Disability Insurance Scheme (NDIS), management of the HACC program will be split between the Victorian and Commonwealth Governments.

The effect of the split is that services for older people (people aged 65 and over and 50 and over for Aboriginal people) will be directly funded and managed by the Commonwealth Government. Services for younger people will be funded and managed solely by the Victorian Government, until the NDIS is in full operation.

The Commonwealth has committed to a three-year period of funds stability for Victorian organisations transitioning to the Commonwealth Home Support Programme.

Further details are available on the department's website <http://www.health.vic.gov.au/hacc/transition/index.htm>

### 1.3 What is diversity?

Diversity is a concept that recognises that each person is unique and has different beliefs, values, preferences and life experiences.

For some people these differences may result in barriers to accessing or using services. For example, barriers such as a lack of confidence, a lack of information or a belief that a service will not respond to their needs may impede a person's willingness or ability to access a service.

The HACC program has made a commitment to respect the diversity of the Victorian population and to work to remove perceived or actual barriers to access to necessary care and support for those who require it so that they can remain living independently in their homes and communities.

Diversity practice includes the HACC special needs groups and the characteristics within and across these groups. Diversity practice also addresses other characteristics that may be a barrier to accessing services such as age, socioeconomic status, gender, faith, spirituality and those who identify as LGBTI.

By taking into account the diversity characteristics of individuals and communities, HACC services can better respond to the needs of individuals and communities.

It is also important to recognise that diversity is not a static concept. The characteristics and needs of each group or person may change over time. For example, population demographics may change or people may become more experienced and confident service users so they no longer require assistance in accessing services, or carer's needs or circumstances may change.

Individuals represented in more than one HACC special needs group may have compounding factors that increase their barriers to accessing HACC services. For example a person who is non-English speaking and homeless.

All HACC funded organisations are required to provide person centred service responses to HACC eligible people, taking into consideration their diversity characteristics.

## 2. Project overview

### 2.1 About diversity planning and practice

In 2010 the Victorian Department of Health (now the Department of Health and Human Services) released a policy statement outlining its commitment to diversity planning and practice as a quality improvement strategy of the HACC Program in Victoria.

**Diversity planning and practice** sits within the context of the national HACC quality standards and is core business for all HACC funded organisations.

**Diversity planning** is a strategic population planning approach to HACC service delivery, with a focus on the five HACC groups described on page 1, that seeks to achieve:

- equitable access to services by eligible people regardless of their diversity, based upon assessed relative need
- planning that acknowledges the diversity of a community, group and/or individuals with complex needs due to their diverse characteristics
- informed practice that is responsive to differences between people and groups, and their diverse characteristics such as culture, age, gender identity, sexual orientation, faith and spirituality and socio-economic disadvantage.

Diversity planning involves agencies:

- gaining an understanding of the demographics of the HACC target population in their catchment
- understanding the diversity of their HACC client population
- comparing the catchment population with the client population
- identifying groups in their catchment who may not be accessing services equitably, and identifying barriers to access for these people
- setting priorities and developing a diversity plan
- implementing the plan.

In accordance with the intention of HACC diversity planning, HACC funded agencies in Victoria<sup>2</sup> were required to develop a diversity plan for the HACC triennium 2012-2015 and submit an annual review of the plan.

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<sup>2</sup> Around five per cent of HACC funded agencies in Victoria were exempt from this requirement.

A sector based **HACC Diversity Adviser** (HDA) role was introduced from July 2012 in each region to facilitate and support diversity planning and practice at the systemic level.

Diversity practice requires a service delivery approach that responds to the unique needs of groups and individuals with diverse characteristics. Introduced in 2012, the HACC **Access and Support** (A&S) activity is designed to provide short-term, episodic person centred assistance to HACC eligible people who experience barriers to accessing HACC services as a result of the person's diversity.

The HACC diversity planning and practice reform therefore includes both an important planning function (that is, the development of regional and agency diversity plans) plus a practice function (that is, the HACC A&S service).

Diversity planning and practice complements HACC quality improvement initiatives such as the Active Service Model (ASM), the Assessment Framework, and Service Coordination practice, and is linked to standards that seek to ensure quality in HACC service design and delivery.

Within this context, the department engaged HDG Consulting Group to conduct a review of the implementation of HACC diversity planning and practice. The review findings will be used to inform the department and the sector in relation to ongoing implementation of diversity planning and practice.

## 2.2 Review aim and scope

The aim of the project was to review the implementation of diversity planning and practice in Victoria, across the three components of:

- diversity planning by HACC funded agencies
- the HDA role
- the A&S service.

The scope of the statewide review was to:

- identify the aspects of diversity planning and practice implementation that have worked well
- identify the aspects of diversity planning and practice implementation that have been challenging
- collate and analyse feedback and suggestions from the sector on how to continue to progress the implementation of diversity planning and practice.

Outside the scope of this review was funding and unit costs, targets, resource allocation, regional comparisons, performance review, evaluation and considerations or recommendations as to the transition of HACC services to the Commonwealth government.

## 2.3 Review method

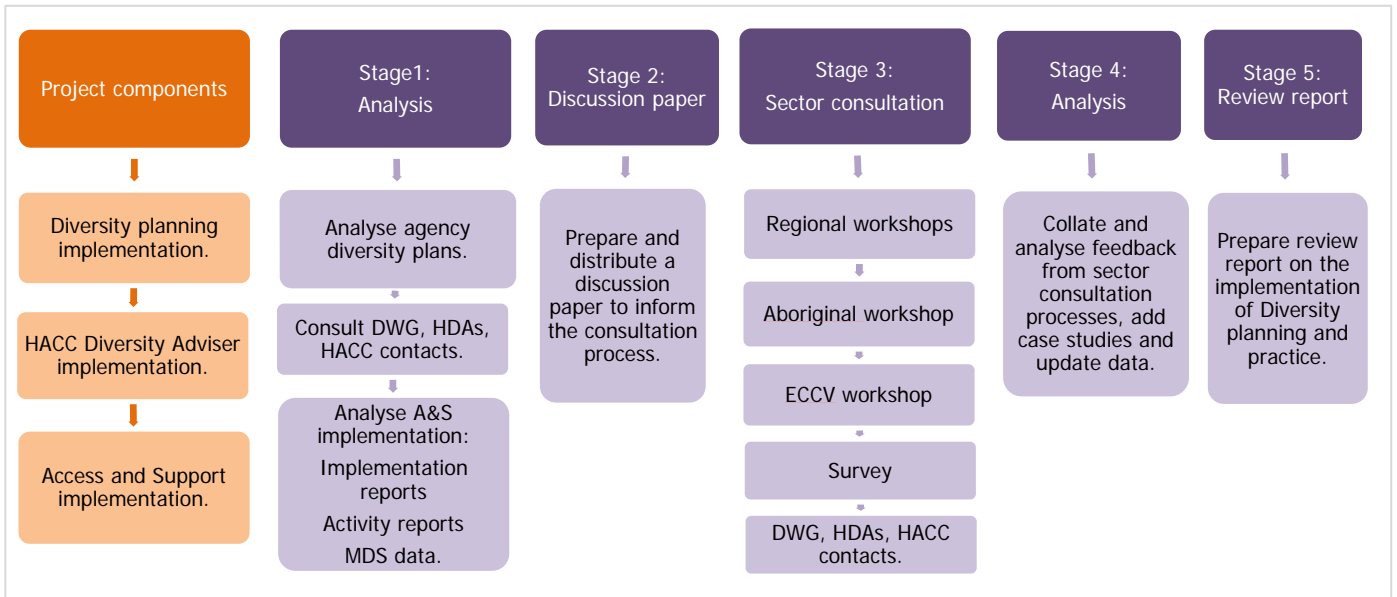
The project method was based on five key stages.

- Preliminary analysis: Analysis of agency diversity plans; consultation with the HACC Diversity Working Group, HDAs, and key stakeholders; analysis of HACC A&S Minimum Data Set (MDS), quarterly activity reports (July-September 2014) and annual implementation reports (May 2014)
- Discussion Paper: Development of a discussion paper as background information for the sector consultation process. (September 2014)
- Sector consultation: Conduct eight regional workshops, an Aboriginal<sup>3</sup> workshop and a workshop at the Ethnic Community Council of Victoria (ECCV); survey process; additional input by the HACC Diversity Working Group, the department regions and HDAs. (October - December 2014)
- Data analysis: Quantitative, content and thematic analysis. (December 2014)
- Reporting: Preparation of review report. (January – February 2015)

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<sup>3</sup> Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander

Figure 1: Project schema



The sector consultation process was highly successful. Approximately 300 participants provided 269 individual written responses and 40 small group responses. Seventy seven views of the electronic survey generated an additional 43 online survey responses. These processes provided over a large volume (over 2,500 items) of feedback for analysis.

## 2.4 Structure of report

**Chapter 3** focuses on **diversity planning**. Included is an overview of diversity plans developed by HACC funded agencies, the types of strategies identified and implemented, analysis of sector feedback about enablers and challenges of diversity planning, case studies, and suggestions for improvements.

**Chapter 4** outlines the role of the **HDAs** and feedback from the sector about the role and future support to agencies.

**Chapter 5** focuses on the implementation of the **A&S** service. Included is data from the HACC Minimum Data Set (MDS), analysis of narrative information contained in quarterly and annual reports, analysis of sector feedback about enablers and challenges, case studies, and suggestions for improvements.

**Chapter 6** concludes the review report with key messages and suggestions for continuing to progress the implementation of diversity planning and practice across Victoria.

## 3. Diversity planning implementation

### 3.1 Introduction

Regional diversity planning involves analysis of demographic and service provision data and interpretation of equity and access information as it applies to HACC special needs groups and people with diverse characteristics. Regional diversity plans specify regional priorities and actions and inform the development of HACC funded agency diversity plans.

Implementation of diversity planning by funded agencies commenced with notification by the department to agencies of the requirement to develop and submit a HACC diversity plan for the 2012-2015 triennium.

To facilitate and encourage this process, the department developed a range of implementation supports.

- A sector diversity planning forum was held in each region outlining the new HACC diversity planning and practice policy and requirements of regions and funded agencies.
- The department developed the [\*Strengthening diversity planning and practice: A guide for Victorian Home and Community Care Services \(2011\)\*](#) to support agencies in their diversity planning. The guide included a standard diversity planning template and links to a range of demographic and other relevant data sources for planning purposes
- MDS data was provided on HACC special needs groups.
- A sector based HDA role was allocated to each region, to lead, facilitate and support the implementation of diversity planning and practice with the sector.
- Input from the sectoral development roles located in peak bodies and reference groups – Alzheimer's Australia Victoria (AAV), Ethnic Communities Council of Victoria (ECCV), Municipal Association of Victoria (MAV), Victorian Committee for Aboriginal Aged Care and Disability (VCAACD), Royal District Nursing Service (RDNS) and Val's Cafe.

Additionally, collegiate working relationships commenced between the HDAs, ASM Industry Consultants and regional Program and Services Advisers. Diversity planning and practice was added as an agenda item to key network meetings and included in various communications by the department to the funded sector.

## Feedback about the information resource

As noted above, an information resource was developed to assist agency diversity planning: [\*Strengthening diversity planning and practice: A guide for Victorian Home and Community Care Services \(2011\)\*](#)

Sector feedback was invited (through the consultation forums and survey) as to the usefulness of this information resource.

Of the 60 comments made, all except one (that stated they were uncertain if it had been of use) were positive.

- *<sup>4</sup>Diversity Planning Practice Guide was informative and supportive of diversity planning.*
- *Yes. Diversity planning practice guide 2011- solid information about what the Department expected.*
- *Diversity planning practice guide is an excellent document to refer to as it encompasses the whole picture.*
- *The Diversity planning practice guide 2011 was useful due to being a new member to the team in 2011 and never having completed a diversity plan. The guide was extremely useful.*
- *We utilised the information resources to clarify what was required in the plan.*

This indicates that the information guide has been of assistance to funded agencies in outlining the expectations and requirements of diversity planning and in supporting the diversity planning process.

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<sup>4</sup> Comments in italics throughout the review document are direct quotes from participants at the sector consultation forums.



### 3.2 Diversity plans submitted by HACC funded agencies

HACC funded agencies were required to develop a diversity plan for the HACC triennium 2012-2015 and submit a review of the plan in 2013 and 2014.

Analysis of 2014 diversity plan annual reviews indicated that at mid 2014 the vast majority, at 87 per cent<sup>5</sup> of HACC funded agencies in Victoria submitted an annual review.

The number of agencies that submitted diversity plan reviews in 2014, by agency type, is in Table 1.

Table 1: Proportion of HACC funded agencies by organisation type that submitted a diversity plan annual review 2014

Organisation type	Total agencies by type of agency	Number of agencies that submitted a diversity plan review in 2014	Agency type by per cent of total agencies by type that submitted a diversity plan review in 2014
ACCO	22	16	72%
Community health, health, nursing or multi-purpose service	129	116	90%
Local government	74	72	97%
Multicultural or ethnospecific	55	42	76%
Other non-government organisations	140	108	77%
Other/not stated	14	24*	NA
Total	434	378	87%

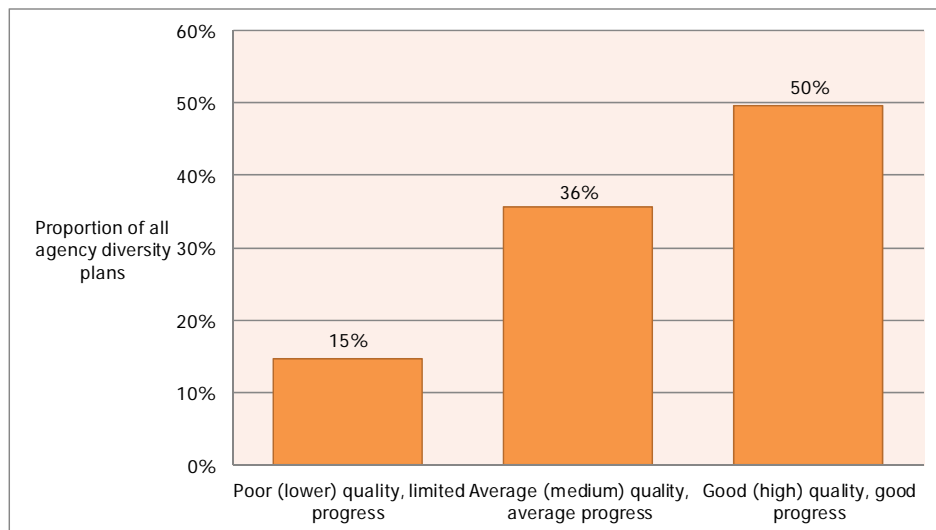
\*may include duplication due to cross-regional services

This data highlights the significant effort invested by the sector in submitting diversity plans to the department.

<sup>5</sup> 87 per cent (n=378/434 HACC funded agencies).

Based on an assessment of the quality of each agency diversity plan by the HDAs and department staff<sup>6</sup>, and using a three point scale of good, average or poor, about half of the plans were considered to be of good quality and showing good progress, and 36 per cent were considered to be of average or medium quality. Only 15 per cent of plans were considered to be of poor quality with limited or slow progress.

Figure 3: Quality of agency diversity plans



The content analysis of diversity plans detailed in the following sections indicates that funded agencies have used a range of diversity information about their catchment populations to inform their diversity planning. The agency 2014 diversity plan reviews include a variety of strategies designed to improve service access.

<sup>6</sup> Based on an agency diversity plan monitoring checklist that included factors such as alignment to the Regional diversity plan, clearly articulated and measurable actions, and appropriate timelines.

### 3.3 Types of strategies included in diversity plans

Collectively the agency diversity plan annual reviews submitted in 2014 contained over 3,750 strategies designed to improve service access and responsiveness to people with diverse characteristics. Analysis of these indicated the most common type of strategies as:

- the development of partnerships, links and Memorandums of Understanding (MOU) with new groups or organisations, accounting for 26 per cent of all strategies
- staff training and professional development, accounting for 22 per cent of all strategies
- updated information for clients accounted for 13 per cent and new or updated policies and procedures for 12 per cent of all strategies
- new service responses and new or revised practices each accounted for 11 per cent each of all strategies
- recruitment strategies were least common at three per cent of all strategies.

Figure 4 illustrates the proportion of strategies by strategy type.

Figure 4: Proportion of agency diversity plan strategies by strategy type

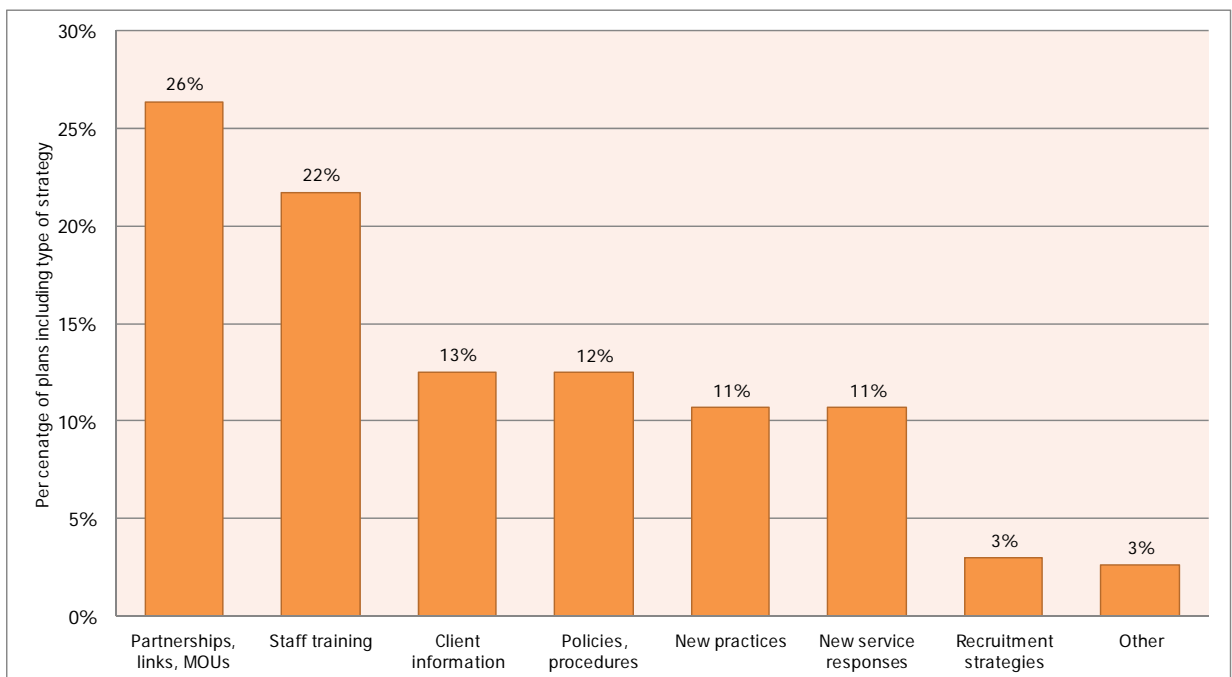


Table 2 indicates where agencies have targeted their effort to respond to diversity.<sup>7</sup> The highest number of strategies (20% and over) are shown in bold. Of note are the two largest percentages: partnerships in rural and remote areas, and staff training in relation to LGBTI.

Table 2: Proportion of diversity plan strategies by diversity characteristic and strategy type

Strategy / Organisation	Aboriginal	CALD	Dementia	Financial/housing	LGBTI	Rural and remote
Partnerships, links or MOUs	<b>29%</b>	<b>23%</b>	<b>23%</b>	<b>31%</b>	<b>24%</b>	<b>34%</b>
Recruitment strategies	5%	5%	2%	1%	1%	1%
Staff training	<b>22%</b>	<b>20%</b>	<b>25%</b>	17%	<b>33%</b>	7%
New or updated policies, procedures or tools	11%	13%	10%	15%	18%	10%
New or updated practices (e.g. service coordination)	10%	11%	11%	16%	8%	7%
New or updated client/community information materials	9%	16%	14%	8%	9%	15%
New or updated service responses	8%	11%	12%	12%	6%	<b>20%</b>
Other	6%	1%	3%	0%	1%	6%
Total	100%	100%	100%	100%	100%	100%

The strategies varied slightly across the diverse target groups. For example:

- partnerships, links or MOUs were the most common strategy in reducing barriers to access for Aboriginal people, people from CALD backgrounds, or those experiencing financial or housing insecurity, or from rural or remote areas
- staff training and professional development were the most common strategies in relation to reducing barriers to access for LGBTI people and people with dementia

<sup>7</sup> Percentage refers to the proportion of strategies within the particular category. For example, of the total strategies that target the rural and remote special needs group listed in all diversity plans, 34 per cent of the strategies are categorised as partnerships, links or MOUs.

- new or updated policies or procedures were commonly listed for LGBTI than any other group
- new or updated practices were more likely to be identified as a strategy for those experiencing financial or housing insecurity in comparison to any other group.

It is interesting to note there has been considerable sector emphasis on diversity planning for the LGBTI community. Val's Cafe report that prior to 2012 they had few requests for LGBTI information or training. Val's Cafe credits HACC diversity planning in Victoria for the recent surge in requests for information and increased hits on their website. The increase in interest is most likely due to:

- the inclusion of LGBTI in the diversity planning guide
- the department's pilot project to increase HACC assessment staff LGBTI awareness including the printing of the Val's Café *Creating GLBTI inclusive HACC services* document
- including a Val's Cafe representative on the HACC Diversity Working Group
- the roll out of the Commonwealth's LGBTI training in Victoria.

As part of the consultation process, sector feedback was sought in relation to the types of strategies agencies might consider into the future. The strategies can be categorised into four key areas (see Table 3): capacity building – service delivery, capacity building – organisational, monitoring outcomes and integrated planning.

Table 3: Agency diversity plans - future strategies

Category	Description	Per cent
Capacity building – service delivery	Promotion of services, maintaining partnerships and links with other agencies and improvement in service delivery responses, including to specific groups e.g. LGBTI (Val's Café Rainbow Tick).	44%
Capacity building - organisational	Workforce development and training, policy development and information resources.	21%
Monitoring outcomes	Reviewing and evaluating implementation progress.	18%
Integrated planning	Broadening diversity planning to include a more integrated, whole of organisation approach.	10%
Other	Unspecified comments e.g. unsure at this stage	7%

The next sections of the report are based on sector feedback from the consultation forums and online survey. Approximately 300 participants from 250 agencies provided 269 individual written responses and 40 small group responses. Seventy seven views of the electronic survey generated an additional 43 online survey responses. These processes provided over 2,500 items of feedback for analysis.

The sector feedback detailed in the following pages (and case studies in the Appendices), provide compelling evidence about the planning and implementation of strategies by agencies to improve service access by people with diverse characteristics.

### 3.4 Enablers to diversity planning

The consultation process and review of the diversity plans indicate that a number of factors combine to create a productive and effective environment for diversity planning. These are:

- collaborative approaches to planning
- investment in workforce and professional development
- commitment across management levels and staff engagement
- accountability through monitoring and reporting
- revision to policies and practices.

These are further described below.

#### Collaboration and partnerships

The most common feedback (32 per cent of responses) about what had worked well for diversity planning, was a collaborative approach to planning across levels within and between organisations, the use of partnerships and the importance of communication structures. This applied to both large and smaller organisations.

- *As our organisation is relatively large and has various departments across different functional streams, diversity planning has brought all HACC funded services together to work on common goal/project.*
- *Having conversations about our diversity plan with all levels of staff from reception to the CEO and identifying key areas of focus.*
- *Having presentations at area meetings from guest speakers and allowing attendees to ask questions, etc. Attendees then returning to their own staff meetings and presenting feedback about the outcome of these meetings/forums.*

- *The aspects that have worked best are the networking, MOUs and opportunities to work together.*
- *Knowledge-sharing amongst HACC Aboriginal network members to develop plans; the region, the Active service model Industry Consultant (ASM IC), and the HDA work together to help us.*

### Workforce development

The second most common feedback (24 per cent of responses) about what worked well was the provision of professional development to enhance staff knowledge and skills, and staff engagement.

- *The process of creating a diversity plan in our organisation gets staff discussing diversity issues. It becomes a learning process as well as a collaborative process, hence improving our culture at work.*
- *This plan has given me personally an aim to work on. As a team leader I recruit and train staff. Having this plan to follow, I know what the department's expectations are and I will work towards having a diverse workforce, and train staff accordingly. LGBTI training is something I have never considered before.*

### Management commitment

This was followed by a commitment across management levels, the need for accountability through monitoring and reporting (13-14 per cent of responses each), and the revision of policies and practices (9 per cent).

- *Mapping what we do against outcomes and core business.*
- *Aspects of diversity planning that have worked best are setting goals, activating goals, reviewing and re-setting goals, building on outcomes and reflecting on difficulties in achieving outcomes, accountability embedded in practice.*

### Other

Other themes and comments (less than 10 per cent of responses each) included an improved understanding of diversity, use of information resources and the provision of support.

- *As a large organisation the diversity planning tool in particular has allowed for all the work and initiatives across different programs to come together. Recording and capturing this information in one place really shows the gaps and areas of improvement and of course achievements clearly.*
- *Access to research for example regional diversity plans, the guide to diversity planning and ABS for the purpose of identification of rural and social isolation.*

There were also positive comments about the role of the department:

- *Our organisation believes that the department is doing a great job in the implementation of the diversity planning and practice.*

### 3.5 Challenges to diversity planning

Feedback from the sector was also sought in relation to the aspects of diversity planning that had been most challenging. These challenges may be typical to any reform initiatives and the department and agencies may wish to consider how these may be ameliorated in future processes.

Analysis of feedback indicates these challenges as:

- allocation of adequate time and resources to undertake planning and implement strategies
- lack of staff understanding or capacity
- engaging communities
- trying to do too much
- evaluation of impact and outcomes.

#### Time and resources

The most common challenge, accounting for over one quarter of all feedback (27 per cent of responses) was having the time and resources to prepare a diversity plan, including time for consultation, collaboration and implementation of the strategies. Aboriginal Community Controlled Organisations (ACCOs) noted that generic organisations did not allow adequate time for consultation and communication with them about diversity planning and strategies.

- *Time for staff to think, reflect, get together, formulate a single plan (for a large organisation), coordinate the response.*
- *It takes time to develop partnerships, attend staff training, etc.*
- *Getting timely and appropriate feedback and support from stakeholders and partner agencies in the development and implementation of the plan.*
- *Funding, funding, funding ... in small organisation like ours it ends up being left to one person - me. Luckily I'm passionate about diversity.*



### Workforce understanding and capacity

The next challenge was the lack of staff understanding about diversity and achieving attitudinal changes, compounded by inadequate time or resources for staff for training and skills development, and staff turnover (25 per cent of responses).

- *The most challenging aspect of diversity planning has been the shift in attitude for staff who feel that they have always been diversity-aware and proactive. Some of the longer-term staff have shown an entrenched resistance to what they see as an imposed policy approach, even when colleagues have been positive and enthusiastic around involvement.*
- *Being aware and responsive to some people that may find information about diverse groups rather confronting and challenging.*

### Community engagement

Some agencies (18 per cent of responses) also identified challenges in engaging with diverse groups, and the time required to do so.

- *Identifying community members who identify [their diversity] - some people do not wish to disclose their cultural background or that they are LGBTI, etc.*
- *Engaging with the Indigenous community*
- *Challenge is accessing community groups which are not in contact with our services.*

### Fit with other plans and priorities

Thirteen per cent of agencies stated their 2012 diversity plan was overly ambitious, and that they needed to refine their plan to make it more realistic and achievable. Some commented on the need to link, or integrate HACC diversity planning with other agency planning processes.

- *Trying to find a place where this plan fits within broader agency plans- when it is only a small part of overall funding and other requirements to increase buy-in by management/staff.*
- *Working out what our priorities are for our agency.*
- *Coming up with strategies we can achieve.*

### Other

Some agencies (eight per cent of responses) identified challenges with data collection, evaluation of outcomes or reporting.

- *Having valid sources of information for reporting. There are plenty of indicators and this is not the issue. It is about having the tools/electronic systems to routinely collect information.*
- *The knock on impact of software system implementation delays across many diversity priorities.*
- *Measuring outcomes has been a challenge.*

### 3.6 Outcomes of diversity planning for agencies

Agencies were asked their views on the most useful outcomes of diversity planning.

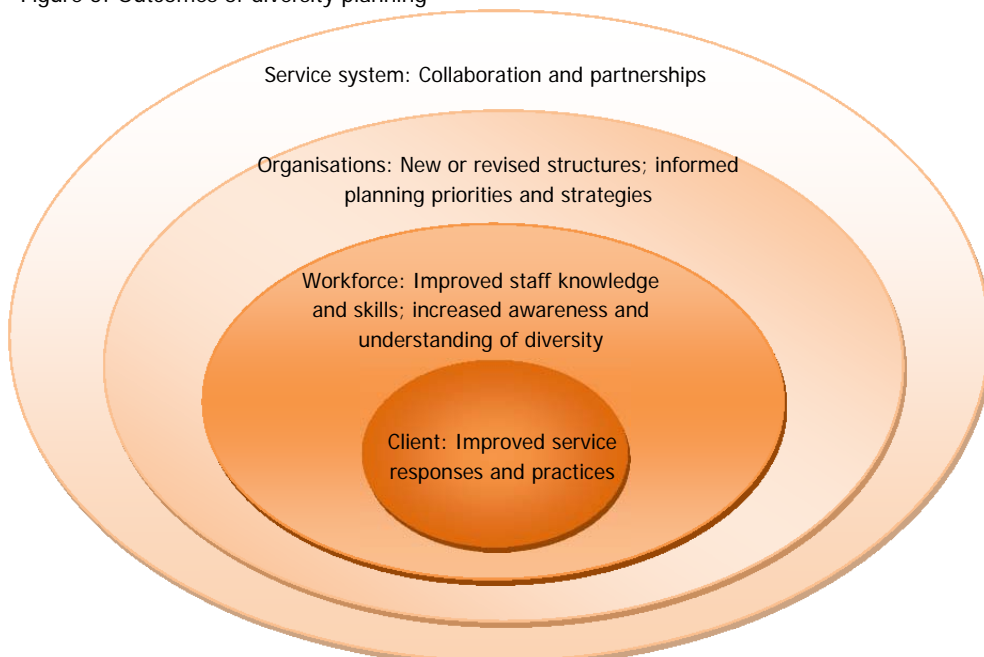
A wide range of achievements are evident from both the analysis of the diversity plans, and from the feedback gained through the sector consultation and the survey processes.

Overall, feedback was extremely positive about the insights and benefits gained from diversity planning. Analysis of feedback indicates the following outcomes from most to least common:

- improved awareness and understanding of diversity
- improved workforce knowledge and skills
- development of collaboration and partnerships
- program planning
- informed priorities and resource allocations
- improved service responsiveness and practices
- influenced new or revised structures.

These are further described below.

Figure 5: Outcomes of diversity planning



### Improved awareness and understanding of diversity

The most commonly reported outcome (30 per cent of responses), was that diversity planning created an improved awareness, identification and understanding of diverse groups within the community, which in turn informed service provision.

- *Identifies that some clients are underrepresented in HACC services, that there are gaps that need to be addressed and to think about ways to address those gaps.*
- *Diversity planning has assisted our organisation in: highlighting what diversity is, defining it and getting people thinking about it; recognising diversity within groups e.g. Aboriginal people with dementia.*
- *Kept diversity on our radar so to speak.*

### Improved workforce knowledge and skills

The next most commonly reported outcome (14 per cent of responses), was related to the workforce – including recognition and prioritising of staff training needs (e.g. dementia, cultural awareness, diversity, LGBTI) and subsequent access to professional education. The raised profile of diversity and the development of staff skills and knowledge contributed to improved service delivery responses (this is congruent with previous commentary regarding staff training as a key enabler).

- *The development of a diversity plan has placed a focus on specific groups - education and training was structured around this.*
- *Staff interest was heightened and through education staff had a greater sense of desire, interest and commitment to improving their practice and meeting client needs.*
- *Allowed staff to attend training as diversity now part of quality plan.*

### Development of collaboration and partnerships

Partnerships, links and the development of MOUs were common strategies included in agency diversity plans (14 per cent of responses). Enhanced communication, collaboration and partnerships were identified as outcomes that resulted from this focus. This includes relationship building, collaboration and partnerships (formal and informal) between organisations; as well as communication and sharing of ideas within and across different levels or programs within organisations.

Analysis indicates that the sector thought that outcomes were:

- beneficial to service provision because they had achieved an increased awareness of services, sharing of common goals or improved practice (e.g. referrals, service provision, secondary consultation)
- beneficial to working relationships (between and within services) because they had achieved increased trust, openness, collaboration, training and sharing of information.

Examples provided in the feedback suggest that the development of new links and partnerships were most often developed in relation to services (in order of frequency) for people with dementia, Aboriginal people, people from CALD backgrounds, people who identify as LGBTI and people with insecure housing/financial disadvantage.

- *The most useful outcome of diversity planning for our organisation has been strengthening the partnerships between ourselves and the other agencies in our area.*
- *Diversity planning has encouraged staff to actively seek out further partnerships and innovative opportunities. Richer variety of programs/activities offered to clients. Secondary consultations/shared knowledge around specific target groups/specialities.*
- *Joint partnership with [agency] to educate the community on memory loss. An extremely successful forum was held for 120 community members.*
- *MOU with an Aboriginal agency has definitely increased our level and comfort to contact each other if and when required. Also we now collaborate in everyday ways that never happened before. Increased trust; increased openness.*
- *We need to do more with this area but so far we have found partnerships allow for a larger scope of responses to clients and a more rapid engagement process.*

However, some people reported variable outcomes and challenges with partnering due to time constraints, lack of ongoing support or maintenance of the partnership, or other issues.

- *Everyone wants a partnership – some of these are not genuine and are just ‘ticking the box based on quick conversations that are not genuine.*

The feedback reflects partnership literature<sup>8</sup> which indicates that effort is required not only in the establishment of partnerships and links, but also in their ongoing maintenance and effectiveness.

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<sup>8</sup> See Partnership Practice Guide. Guide 3: Sustaining the Partnership, Victorian Council of Social Services at <http://www.health.vic.gov.au/pcps/partnerships/index.htm>

## Program planning

Another outcomes of diversity planning was informing program planning and the consideration of service gaps (13 per cent of responses). This included input into other organisational plans. These in turn contributed to improved service practice responsiveness.

- *Ability to come together, reflect and plan.*
- *Has assisted in organisation's strategic planning - organisation wide principles have been adopted.*

## Informed priorities and resource allocation

Some people also identified that diversity planning had influenced the allocation of resources, and informed the development and coordination of priorities and strategies for specific client groups (10 per cent of responses).

- *Identifying and analysing the data regarding diversity locally. Great reflective exercise which does not occur as often as it should.*
- *It has facilitated discussion where there is clarity and agreement about priority areas particularly in relation to CALD, Aboriginal clients, homelessness and clients with dementia.*

## Service responses

Similarly, improved service responsiveness and practices (10 per cent of responses) were also identified as outcomes. Examples included development or revision of referral pathways, assessment, service coordination, referral, guidelines, policies/procedures or tools (e.g. intake, assessment, priority of access, fees policy, staff performance review) and the development of new or updated information resources or promotional materials for specific groups (e.g. brochures or newsletters).

- *We now ask clients and families if there are any diversity issues which may impact on our ability to deliver care.*
- *Developing templates to capture better information.*
- *Provides better person centred individual care, as well as more considered planning for larger groups.*

## Structures

The remaining outcome (seven per cent of responses) was in relation new or revised structures. This included examples of organisational structures such as diversity action teams, working groups, committees, or champions that led and influenced diversity planning within an organisation or unit and contributed to the organisational culture regarding diversity.

- *Supporting Board and Management to establish strategic directions regarding diversity.*
- *It has taken time but we are just getting staff more engaged by having working parties develop for each diverse group we want to work with.*

## Other

There was one negative comment questioning the need for HACCC diversity planning:

- *I think HACCC should butt out where accreditation processes are already in place with clear standards for diversity and a requirement to fulfill these standards. This HACCC initiative is a duplication which is wasted and would be better used to target smaller organisations.*

Overall, these outcomes suggest that diversity planning has generated a range of benefits for the sector, the workforce and service users with diverse characteristics.

Interestingly, many of these factors (e.g. workforce development, structures, policies/procedures, partnerships and so forth) have been well documented in change management and integrated health promotion literature<sup>9</sup>, suggesting that the implementation to date has increased and effectively contributed to the capacity of the sector to respond to diversity.

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<sup>9</sup> See <http://www.health.vic.gov.au/pccps/hp/>

### 3.7 Measuring the impact for consumers

Whilst the previous section documents the outcomes of diversity planning as reported by agencies (i.e. organisational level), this section considers agencies' suggestions about evaluating the impact for consumers (i.e. client level).

The most common suggestions were the use of quantitative data about services usage and consumer feedback. Also suggested was the development of an overall evaluation framework (with associated tools and guidelines) to allow for flexible, multi-faceted evaluation approaches, incorporating both impact and process measures.

- *Measures that clearly identified what diversity planning has delivered for individual clients – that is, how has it improved service in tangible terms. Focus on using client information and demographic data to highlight where there are gaps in service provision to certain groups and what practical, measurable actions are going to be taken – these need to be measures that clearly demonstrate what has been achieved for individuals - not booklets, frameworks etc – but what has changed for clients.*
- *Doing some region wide analysis of the plans and writing in a report - for example it's interesting in the discussion paper to hear what types of strategies are being written and which organisations are putting those strategies in their plans.*

#### Service usage data

Agencies noted that the collection and analysis of quantitative data enabled the measurement and comparison of service usage rates for diverse groups (29 per cent of responses). Some people also noted that data would be useful for benchmarking purposes (e.g. comparison across time periods, or by like agencies).

Comments were made in relation to limitations of the current MDS items regarding accurate data about diversity characteristics.

- *Compare client data (demographics). If collated annually could compare if there is an increase or decrease in the number of people from [diverse] groups accessing services.*
- *Number of clients accessing service. Number of referrals from external agencies.*

### Consumer feedback

This was followed by suggestions for using community and consumer feedback, such as client satisfaction surveys, case studies, care plan outcomes and so forth (also 29 per cent of responses).

- *Only feedback from the clients would measure the impact and outcomes.*
- *Measure impacts by service users exiting services and case study examples.*
- *Participation, feedback from consumers on increased wellbeing.*

### Evaluation framework

Some suggestions (20 per cent of responses) noted the need for an overall evaluation of impact and outcomes using a multi-method approach.

- *Framework for evaluation; measures for impacts; baseline data; pre and post measure.*
- *We audit outcomes and measure impacts now but most of the data is quantitative - qualitative outcome frameworks could be expanded.*
- *Future measurement is likely to be addressed through requirements to collect information for indicators related to priority groups (and health) as well as accreditation. There is no need for more indicators, instead, those proposed by Department of Health could be used as relevant, to report on priority groups.*
- *By completing our plans every year and filling out the final column indicating 'complete' or due date we get a good idea/good measure of our outcomes.*
- *Guidance from the Department would be appreciated.*

There was also commentary that evaluation should have clear links to relevant standards with flexibility across agencies in how outcomes are measured.

### Workforce

Other suggestions (7 per cent of responses) related to workforce skills and values in relation to diversity, such as participation rates in training.

- *Staff skills and knowledge – partnerships - referrals.*
- *Staff education, complaints and compliments.*

Overall, the feedback about measuring impact for consumers highlights the need for a systematic approach that provides for consistency, as well as the capacity for flexibility between agencies when measuring outcomes.



### 3.8 Suggestions for improvements

Feedback from the sector was sought on suggestions for improvements to diversity planning.

#### Integrated planning

Analysis indicates the most common feedback (22 per cent of responses) was to increase ownership or 'buy-in' and participation across the whole organisation, including non-HACC services.

Whole of organisation diversity planning was seen as requiring improved communication both by senior management and 'grass roots' levels, as well as better links and integration with other planning processes (e.g. strategic plans, program plans, ASM plans).

Feedback indicates that whilst diversity planning is well accepted at coordinator and middle management level in many organisations, vertical integration (that is, up to senior and executives levels, and to direct care staff) would be beneficial.

- *Diversity plans need to be linked to other organisational plans eg. strategic plan, operational plan, work plans. It should not be a stand-alone plan if wanting to implement organisational change.*
- *Too many plans - they sit on my shelf and are not read or disseminated to the coalface.*
- *The organisation can improve its diversity planning by continuing to implement diversity policies and practices across other programs (not HACC funded) and Committee of Management level.*
- *Some A&S workers may not be familiar with the diversity plans – the A&S workers should be consulted during the development and review of the plans.*

#### Catchment planning

This was followed by suggestions for developing collaborative, accountable, inter-agency, or catchment-wide approaches (19 per cent of responses) particularly in rural areas.

- *I would welcome cross agency/facilitated conversations about the demographics of our region and discussion about strategies to engage.*
- *Diversity planning needs to be more action orientated, action that can be measured. HDA or the department should help in setting targets rather than just up to agencies to act or plan according to their discretion.*

## Planning template and timeline

Some suggestions reflected the need for improved information or changes to submission timelines, whilst others were about improvements to the planning or annual review template (12-13 per cent of responses each).

- *Having a diversity plan due before end of financial year but reporting on the full financial year is ridiculous. Make plan due in September reporting on previous financial year.*
- *A better more iterative template that allows for ongoing change.*
- *Template could be more user friendly, work instructions in use of template could be clearer.*
- *A better live or cloud-based template for interagency access with ability to update progressively - a live document.*
- *The guidelines, templates etc provided have been extremely useful tools when developing our plan.*
- *No suggestions as the regional office level of support was responsive to our needs and the templates provided both guidance and method.*

## Support

Other suggestions (approximately ten per cent of responses) related to planning skills development.

- *More education and support on how to write and implement effective diversity plan.*
- *Agencies need more practical regional workshops or individual assistance to develop their plan. Because there is a tendency to have too broad strategies and too many.*
- *Develop an orientation kit/training kit for in-house training for new staff.*
- *Improved training calendar - [the provider] is not meeting needs of professional staff, case managers and direct care workers.*
- *The provision of continued opportunities for staff to undertake training on areas and topics relating to diversity including but not limited to LGBTI, financial hardship, CALD non-English speaking background (NESB), Aboriginal communities and other groups.*

### 3.9 Priorities

Feedback from the sector was invited in relation to future priorities for diversity planning and practice.

Responses focussed on similar themes to the previous feedback. The most frequent feedback was collaborative working arrangements with other agencies, integration of diversity planning into the organisational structure, the impact of the HDAs and diversity planning timelines.

- *Networking/planning across "like" agencies; sharing of plans/ideas.*
- *To maintain communication and opportunities for networking.*
- *Similar organisations to get together to work together.*
- *Ongoing consideration for place based approaches - particularly in the diverse area of rural.*
- *Continue partnership development with other service providers.*
- *Schedule discussions by HDAs to Boards of agencies to assist with promotion of diversity at senior end.*
- *Engaging the whole organisation in diversity awareness and planning.*
- *Roll diversity planning and practice into whole agency/multiple funding streams and services approach - not specific to HACC only.*
- *HACC Diversity planning and practice needs to be embedded in the organisational strategic and business plans, rather than an add-on plan.*
- *Keep HDA officer if you want diversity to be a priority in agencies - important for agency support. Change due date for diversity plan.*
- *Reviewing the timeline [for submission of the plan] as we tend to get quite a few requests etc all around the same time, and like some other organisations we are limited in staff and time availability.*

This was followed by ongoing opportunities for professional development and staff training.

- *Priorities would include the continuation of relevant training and information sessions.*
- *Diversity plan examples. Ongoing training, e-learning regarding diverse groups and issues.*
- *These forums are useful and diversity planning regional meetings were very useful last year.*
- *HACC training on Aboriginal diversity issues (not currently available on training calendar).*

Comments also highlighted the need for a future focus on evaluation and monitoring of outcomes.

- *Doing some region wide analysis of the plans and writing in a report - for e.g. It's interesting in the discussion paper to hear what types of strategies are being written and which organisations are putting those strategies in their plans.*
- *Measuring client outcomes effectively using quantifiable and qualitative data.*
- *Measures that clearly identified what diversity planning has delivered for individual clients – such as how has it improved service in tangible terms.*
- *Focus on using client information and demographic data to highlight where there are gaps in service provision to certain groups and what practical, measurable actions are going to be taken – these need to be measures that clearly demonstrate what has been achieved for individuals - not booklets, frameworks etc – but what has changed for clients.*

### 3.10 Summary – diversity planning

The information presented in the previous sections provides clear evidence that HACC diversity planning in Victoria has been embraced by the sector.

HACC funded agencies have contributed a significant amount of time, effort and action in the process of diversity planning and implementation. They report that it has been effective in developing strategies to understand and improve access for people with diverse characteristics.

Evidence for this includes the:

- number of diversity plans and annual reviews submitted
- high percentage (85 per cent) of diversity plans that were rated by the HDAs/regions as being of medium or good/high quality (only 15 per cent were rated as poor quality)
- improvement of diversity plans over time with strategies becomingly increasingly focussed and measureable
- positive feedback provided by the vast majority of participants during the sector consultation process.

The review consultants, who were involved with diversity planning during its introduction into the Victorian HACC program 2012, have observed that the acceptance of diversity planning by the sector, and the appreciation of the benefits and outcomes, has significantly increased since its inception.

This is likely to be the result of the combination of implementation supports such as strong leadership and support provided through the department's central office and regions, resourcing of the HDA roles, periodic diversity forums, the diversity planning information resources and access to diversity related training (in particular dementia and LGBTI).

The continuation of these implementation supports, in conjunction with actioning the various suggestions for improvement made in the previous section (that is, an organisation-wide approach to ensure diversity planning is integrated with other planning processes, facilitated collaborative inter-agency planning and ongoing workforce skills development) will support the ongoing improvement of diversity planning and practice implementation.

## 4. HACC Diversity Adviser implementation

### 4.1 About the HACC Diversity Adviser role

The HACC Diversity Adviser (HDA) role operates on a region-wide systemic basis to support regional and agency diversity planning and implementation.

The HDA role is based on a common position description and includes:

- promoting HACC diversity planning through leading and facilitating change and practice improvement
- promoting the development of diversity planning and practice through information provision, advice and support
- developing positive relationships with the range of HACC funded agencies and other key stakeholders to achieve a collaborative approach to implementing diversity planning and practice
- addressing issues and seeking out new opportunities to facilitate diversity planning and practice
- providing implementation support and facilitating partnerships between organisations to respond to diversity issues
- using diversity knowledge to facilitate networking, forums, and partnerships
- working with the department's regional staff to ensure sharing of diversity planning and practice knowledge
- providing advice to the regional office and central office on barriers and enablers, risks and solutions and practice learnings
- working within the context of HACC program quality improvement initiatives, such as the ASM, and Service Coordination practices
- providing information on training and professional development and facilitating diversity training for the sector (but not delivering training)
- strengthening the capacity of the HACC service system to deliver quality services that respond to diversity.

The commencement date of the HDA role in each region varied with the earliest commencing in late 2012 and the last in December 2013).<sup>10</sup>

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<sup>10</sup> Three regions have experienced turnover of HDA staff.

The roles are employed in the funded sector and have a close working relationship with departmental staff and ASM ICs.<sup>11</sup> This close communication enables a collegiate team approach to supporting agencies and facilitating links, connections and partnerships, and information sharing through networks and forums.

## 4.2 Feedback about the HDA role

Feedback was sought through the sector forums and survey process as to whether funded agencies had received information, assistance or advice from their regional HDA, and if so, how it had influenced their diversity planning and practice.

Fifty-one per cent of respondents to this question reported they had received information, assistance or advice from the HDA, 42 per cent did not answer this question, were unsure, or stated that the question was not relevant, and seven per cent stated that they had not. It is noted that many of the forum's attendees may not be the agency contact for the HDA.

Of the respondents who had received information, assistance or advice from the HDA in their region, the majority (76 per cent) had found it useful. Of the remainder, 16 per cent made no comment, five per cent were unsure, and two per cent had not found it useful. The HDAs are acknowledged by the majority of respondents as being instrumental in the successful implementation of diversity planning and practice.

- *Provided good feedback about our most recent diversity review and plan.*
- *Provides suggestions about different ways we can approach challenges for [people] accessing services.*

Feedback indicates that input from the HDA roles has influenced diversity planning or practice in four key dimensions.

### Expertise about diversity planning

Firstly, HDAs are viewed as a useful resource to provide guidance, expertise, constructive feedback and suggestions about diversity planning and practice.

- *I think the success and quality of Diversity Plans in the region is largely due to the commitment, expertise and support of the HDA.*
- *The HDA has a wealth of knowledge and experience of both the sector and region.*

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<sup>11</sup> In most regions the HDA is co-located with the Department of Health regional HACC team (e.g. Program and Services Adviser and Active Service Model Industry Consultant).

- *The HDA role has been a great resource for the agency and the sector as a whole.*

### Information and links

Secondly, HDAs are seen as an accessible avenue for providing information, resources and links. This HDA support is particularly important when considering sector feedback that organisations lack time to do diversity planning.

- *The HDA provided a profile for each local government area with the number of Aboriginal people – this was very useful as we do not have the expertise or capacity within our organisation.*
- *Note the trends, make links and join the dots [that is, interpret information] e.g. information about catchments and what the data means.*
- *Our HDA ... has been very supportive, providing suggestions, resources and advice.*

### Collaboration

Thirdly, HDAs are perceived as supporting collaboration, and in some cases, facilitating opportunities for staff training. As these are both common strategies in agency diversity plans, this role assists agencies to achieve these strategies.

- *Supports organisational practices e.g. provided advice about where to access training and helps achieve some of the identified actions on our plan e.g. the HACC Alliance regularly has speakers present on different topics, some of which relate to diversity.*

### Support to A&S

Some respondents also commented on the support provided by the HDA to A&S workers and networks as beneficial.

- *Establishing a network for A&S and providing a platform to exchange and hear about other organisation's practices and issues.*
- *Excellent support provided to our A&S workers in the region.*

There was also positive feedback about the 'great work' of the HDA role and importance of its continued funding.

- *Continue with the great work and support that has currently been given.*
- *Keep up the good work!*



### 4.3 Implementation of the HDA role

Feedback from regions, HDAs and a small number of comments from the sector noted points of differentiation on how the HDA role is implemented across key dimensions.

The table below provides a summary of the key differences in how the HDA role is implemented in different regions.

Table 4: Differences in HDA role implementation

Role dimension	Points of difference
Diversity planning guidance and feedback	Some HDAs provide a critique and feedback on the quality of a diversity plan to each individual organisation, whilst others present feedback via a catchment wide snapshot at a forum or network meeting. This is in part influenced by the size of the region and number of funded agencies. For example, in a rural region with around 40 funded agencies there is the capacity for site visits to each agency and the provision of individual agency support and feedback. Whereas in a large metropolitan region with the same level of HDA resource and around 90 funded agencies, there is clearly less capacity for this to occur.
Resourcing organisations	This may be at an individual organisation level or at a network level, or both. For example, discussion about demographic data or MDS results to inform and assist individual organisations, whereas others provide information at a sub-regional level.
Collaboration and facilitation of training	Some HDAs actively identify training opportunities and organise training sessions, or facilitate collaborative projects, whereas others have less active involvement.
Support to A&S workers.	In some regions the HDA has a key role in the support of A&S networks. Some HDAs lead, resource and/or participate in regular support meetings with A&S workers, as a form of intelligence gathering, capacity building and information dissemination, whilst others have less direct involvement. This may be influenced by the number of A&S auspice agencies and A&S workers (e.g. one region has one A&S worker; while another region has 17) and need and capacity for HDA involvement in A&S network meetings.

- *HDA role across regions needs to be standardised and be consistent.*
- *The inclusion of the A&S portfolio as part of the HDA role in the [region] has been a very useful inclusion. It would be great to see this aspect statewide.*

## 4.4 Suggestions for improvement

Around 30 per cent of participants provided suggestions about how the HDA role could further support diversity planning and practice. Analysis revealed the following themes (in order of frequency, most to least).

### Support, encouragement and feedback

Firstly, to continue to provide support and feedback, and review and critique diversity plans.

- *More on-site meetings.*
- *Providing practical support/advice on strategies, and what is most effective and realistic to implement.*
- *Provide practical advice to agencies where they are unsure how to proceed.*
- *Assist smaller agencies where possible.*

### Information on diversity

Secondly, to continue to provide data, information and updates, through agency and network meetings and through other channels such as email and newsletters.

- *Provide data and feedback - about needs and gaps in regards to the diverse communities.*
- *Continual attendance at HACC Assessment Service network.*

### Capacity building and collaboration

Thirdly, to continue to support collaboration between agencies and workforce capacity building and training.

### Other

There were also some comments about the opportunity to better link diversity planning with the A&S service. For example, through catchment wide diversity planning strategies linked to the delivery of A&S.

## 4.5 Summary – HDA role

The HDA role has been instrumental in leading and supporting the implementation of diversity planning and practice.

The HDA role appears to be one of the critical success factors in the successful implementation of diversity planning and practice by funded agencies.

The HDA connections with statewide sectoral development roles (such as at the ECCV), and with regional roles such as the ASM IC, and the department's regional HACC staff is a key enabler to the effectiveness of the role in leading and promoting the implementation of diversity planning and practice in the sector. This collegiate relationship provides for consistent messaging to agencies, coordinated support and clear expectations in relation to the implementation of HACC diversity planning and practice.

There are differences in how the HDA role is implemented in each region. This may be because there is one HDA for each region regardless of the number of funded agencies the role supports.

The focus should therefore be on continuing to achieve the following core functions:

- provision of support to HACC funded agencies in the development and continual quality improvement of diversity planning, including commentary and feedback on individual agency diversity plans
- promotion of diversity planning to agencies senior management, to support and integrate diversity planning as part of organisation planning processes
- contribution to the support processes for A&S workers
- continued capacity building support for agencies, such as inter-agency planning and supporting access to diversity related professional development.

In future this could also include:

- support for evaluation of diversity planning and practice in accordance with an agreed statewide approach (e.g. evaluation framework and tools)
- closer linking of A&S to agency diversity planning across catchments, population planning and target areas.

The continuation of the HDA role and key functions is likely to remain a critical success factor in contributing to the ongoing success of the implementation of diversity planning and practice.

## 5. Access and Support implementation

### 5.1 About Access and Support

The Access and Support (A&S) activity was introduced into the Victorian HACC program in 2012 and is integral to diversity planning and practice and the ASM.

A&S services provide short-term, episodic person centred assistance to HACC eligible people who experience barriers to accessing HACC services as a result of the person's diversity.

The A&S role works with the person to improve their knowledge about the service system, increase their confidence in using services, and improve their access to HACC services through linking them to appropriate services. It has been described by some service providers as a 'soft entry point' for the most vulnerable people.

A range of actions facilitated the introduction of the A&S activity.

The department conducted a process to transition organisations with previous 'access' type funding to the new A&S service type. Information was provided to HACC funded agencies about designation criteria for approval as an A&S service provider. Key criteria included an appropriate organisational context for the A&S activity, links with the service system, use of service coordination practices and resources, appropriate staff training and skills development, and regular supervision for the A&S worker.

The department developed the following information resources to support A&S services:

- [\*Diversity planning and practice in Home and Community Care services in Victoria: A practice guide for Access and Support roles \(2013\)\*](#) The practice guide provides a detailed description about the A&S activity, including scope, day-to-day practice requirements, skill requirements and management considerations.
- [\*Diversity planning and practice in Home and Community Care services in Victoria: Working with HACC Access and Support services \(2013\)\*](#) The guide provides information about the A&S activity for organisations that are not funded to deliver A&S.

## Feedback about the A&S information resources

Sector feedback was invited (through the consultation forums and survey) on the usefulness of the A&S information resources.

There were around 30 comments made regarding each A&S resource. The comments were typically positive. An additional ten people stated they were not familiar with the resources, however these were mainly people who worked in locations without A&S workers.

- *The [A&S practice guide] contains very detailed and useful information regarding the role.*
- *The A&S practice guide ... informative and supports us in our work.*
- *I have used all resources available and give them out when meeting all organisations and promoting A&S.*

There was one negative comment, requesting more concise information.

## Reporting processes

Three reporting processes were developed to provide comprehensive information about the progress of A&S implementation, from both an organisational and service level.

- Implementation report – submitted annually by the A&S manager. This is a narrative report that describes the implementation of the A&S activity from an organisational perspective such as the development of partnerships, service coordination practices and A&S professional development needs.
- Activity report – submitted quarterly by the A&S worker. This is primarily a narrative report that describes the activity undertaken by the A&S worker including promotional activities, working with the service system, the number of secondary consultations, referrals made and received, challenges and good practice.
- Minimum Data Set (MDS) – submitted quarterly by the A&S worker. This includes client demographic information and client service hours.

## 5.2 A&S funded agencies

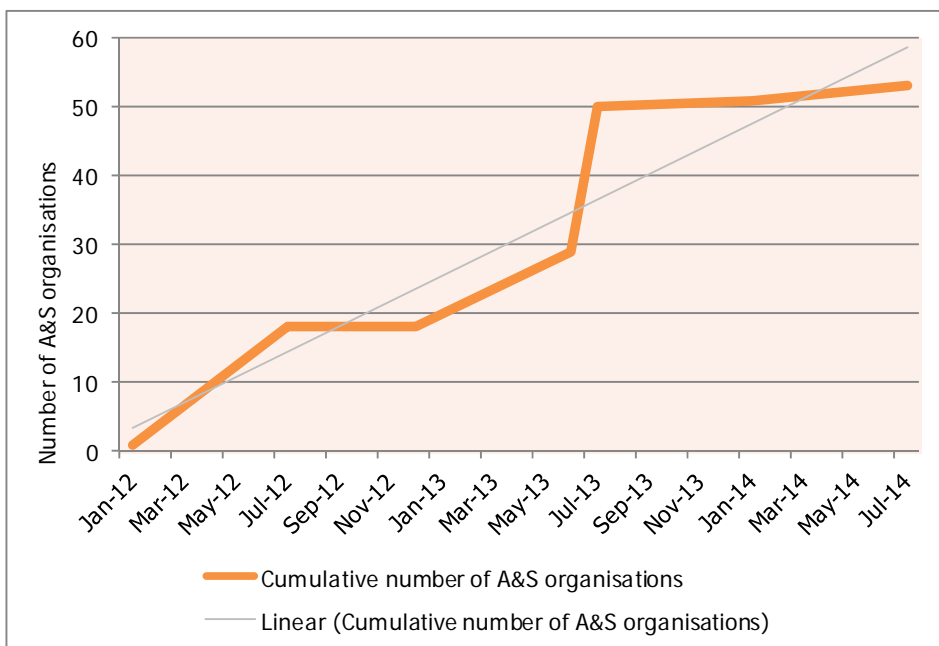
Between January 2012 and July 2014, A&S services were progressively established in 52 HACC funded agencies. As shown in the table below, these included a mix of organisation types.

Table 5: A&S organisation type

Organisation type	Number of agencies funded to provide A&S
CALD	17
Health service	9
Council	8
ACCO	6
Community health service	6
Other non-government organisation	6
Total	52

Within the first seven months to July 2012, around 35 per cent of agencies had transitioned to A&S services. One year later, at July 2013, around 94 per cent of A&S services had commenced, with all having commenced by July 2014.

Figure 6: Cumulative number of A&S services established, January 2012 – July 2014



Each A&S auspice agency was required to nominate the **primary** focus (diverse group) for the A&S service – refer to Table 6.

Table 6: Primary focus of A&S service by group

Group	Number of A&S services with this focus
CALD	24
Aboriginal	13
Insecure housing/financial disadvantage	5
Dementia	3
Rural and remote	0
All of the above groups	7
Total	52

As mentioned in the overview in section 1, there is diversity within and across the HACC special needs groups and some individuals may be represented in more than one HACC special needs group.

The following sections of the report use three different data sources to analyse A&S implementation. These are:

- HACC MDS data for the 2013-2014 year
- annual implementation reports submitted in May 2014
- quarterly activity report for the sample three month period of April-June 2014.

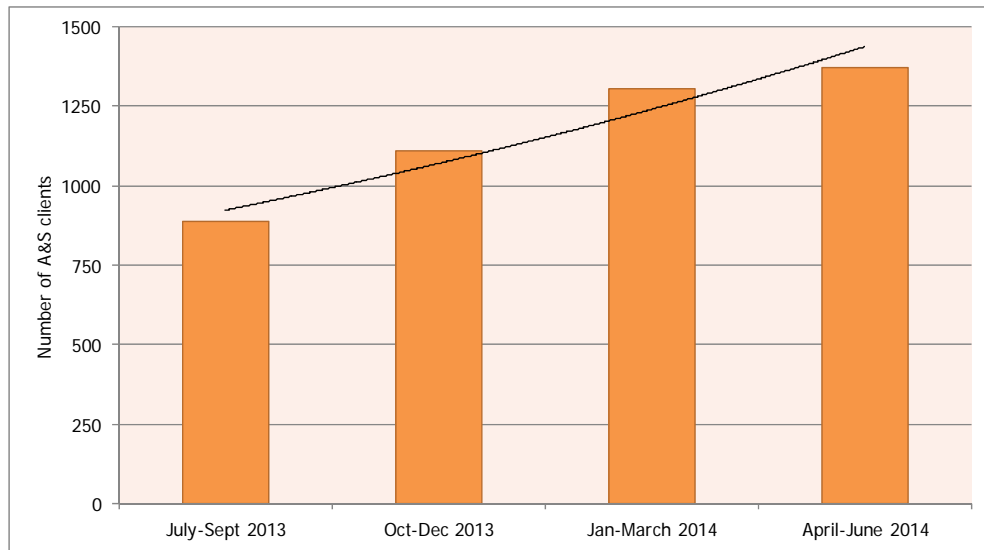
### 5.3 HACCC MDS A&S data

A&S services are funded on the basis of annual client care target hours which are reported through the HACCC MDS. Across Victoria, there were around 83,651 A&S target hours in 2013-2014.

#### Number of A&S service users

HACCC MDS data indicates there were a total of **3,143** individual A&S clients in the 2013-2014 year.

Figure 7: Number of A&S clients by quarter



The number of A&S clients per quarter increased substantially<sup>12</sup> from the first quarter (886 clients) to the fourth quarter (1,373 clients) likely reflecting the increasing implementation of the A&S service by funded agencies. (Note that A&S clients may appear in more than one quarter).

The 3,143 A&S clients included:

- 295 people (nine per cent) who identified as Aboriginal
- 1,764 people (56 per cent) from CALD backgrounds.

Feedback from the sector has highlighted the need for improvements to MDS categories to enable reporting against diversity characteristics (such as dementia and financial disadvantage).

<sup>12</sup> A&S is a short term service so that clients in the first quarter are not necessarily the same people as the clients in the last quarter.



### A&S service duration

The A&S role is designed to work with people on a short term episodic basis and link the person to relevant services. The A&S practice guide identifies eight weeks as an indicative length of time in which this should occur.

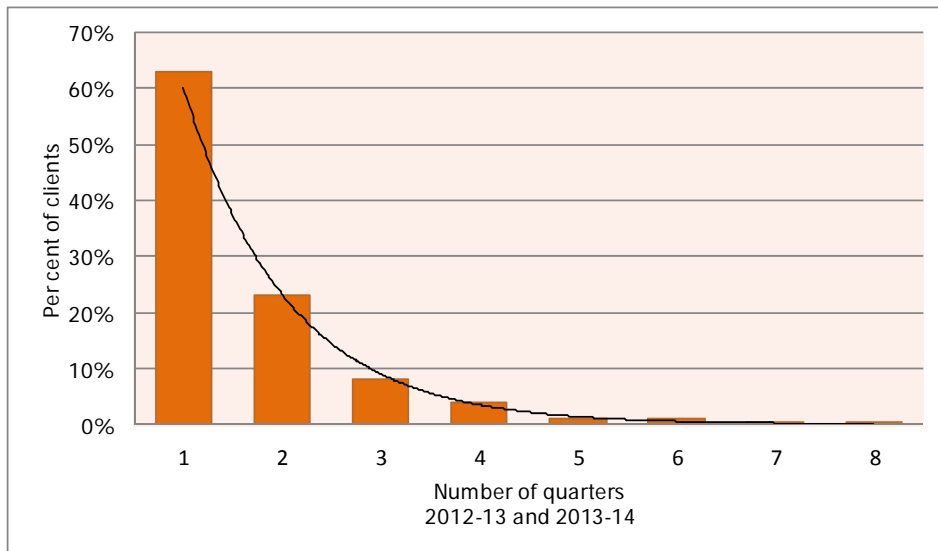
Sector feedback from A&S workers indicates that eight weeks is an inadequate length of time for many A&S service users due to the complexity of needs and waiting periods to access other services. It may be appropriate to extend the indicative time frame in the A&S practice guidelines from eight to 12 weeks.

The number of individual A&S service users reported in the MDS each quarter is an indication of A&S service duration.

Analysis of MDS data for the two year period 2012-2014 indicates that:

- 63 per cent of A&S service users appear in one quarter only (that is, within a 12 week period)
- 23 per cent of A&S service users appear in two quarters
- the remainder appear in three or more quarters.

Figure 8: Proportion of clients appearing over one or more quarters, 2012-2014



This shows that the majority of A&S clients receive a short term service (that is, less than 12 weeks) in accordance with the intention of the A&S to be a short term service.

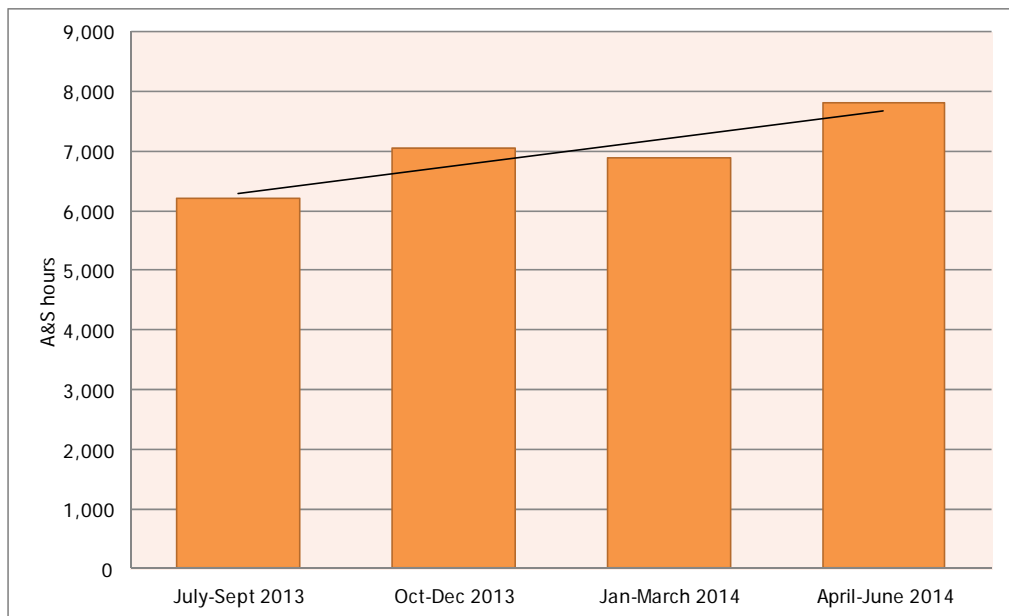
### A&S organisation type and hours

Based on HACC A&S MDS data for the 2013-2014 year, the types of organisations and number of A&S hours is summarised below.

As shown in Figure 9, a total of 27,927 hours were provided over the four quarters in the 2013-14 year.

The trend suggests an overall increasing number of service delivery hours per quarter.

Figure 9: Total number of A&S hours by quarter



As shown in Table 7, CALD organisations provided A&S services to the most individuals (this is because there are more CALD organisations providing A&S), however community health services provided the highest number of A&S hours per individual.

Table 7: Agency type and number of A&S hours 2013-14

Agency type	Number of agencies that reported A&S in 2013-2014 by agency type	Number of A&S clients	Number of A&S hours	A&S average hours per client
CALD	15	1,558	12,744	8
Health service	6	884	7,123	8
Other non government organisations	5	226	2,435	11
Council	5	197	1,614	8
ACCO	4	108	1,158	11
Community health	2	176	2,852	16
Total	37	3,149 <sup>13</sup>	27,926	9

There appears to be a relatively low number of hours per A&S client, for some agency types, given the clients are assessed by A&S agencies as having difficulty accessing services and have A&S support for around 12 weeks. Sector feedback is that this reflects the inability to count a significant proportion of the A&S hours in the MDS, due to the MDS counting rules, although this is contradictory as all client hours can in fact be counted.

A&S workers reported feeling under pressure to achieve client exit from the A&S service within the eight week timeframe. This may also contribute to the hours being lower per client than if the hours accumulating over more than eight weeks were counted. Further advice regarding the MDS counting rules, and adjustment from an eight to 12 week time frame, may generate a revised picture of this.

<sup>13</sup> Six clients received a service from more than one region.

### Use of other HACC services by A&S clients

Around 19 per cent of A&S clients had received services from the A&S agency in the year prior to them becoming an A&S client<sup>14</sup>. A marginally higher proportion at 24 per cent had received services from other agencies in the year prior to them becoming an A&S client.<sup>15</sup>

The majority of A&S clients (76 per cent) were not HACC service users of the HACC A&S agency or other agencies in the year before they became an A&S client.

In the 2013-2014 year, A&S clients received other HACC services from the A&S host agency, mainly planned activity group and allied health. Almost half, at 47 per cent of A&S clients (1,478 individuals), also received HACC services from other agencies – in particular assessment, domestic assistance, allied health nursing, personal care and planned activity group. (See Table 8).

Table 8: Use of other services by A&S clients, by HACC activity

Service type	A&S clients in 2013-14 who received other HACC services from the A&S host agency in 2013-14*		A&S clients in 2013-14 who received HACC services from other agencies in 2013-14**	
	Number	%	Number	%
Allied Health	<b>268</b>	9%	<b>305</b>	21%
Assessment	130	4%	<b>467</b>	32%
Case Management	107	3%	27	2%
Client Care Coordination	236	8%	179	12%
Domestic Assistance	86	3%	<b>372</b>	25%
Meals	45	1%	90	6%
Nursing	97	3%	<b>224</b>	15%
Planned activity group	<b>378</b>	12%	<b>196</b>	13%
Personal Care	23	1%	<b>200</b>	14%
Property Maintenance	49	2%	179	12%
Respite	28	1%	59	4%
Volunteer Social Support	94	3%	92	6%
Access and Support	3,143	100%	11	1%
Total	3,143	100%	1,478	100%

\* Of the total 3,143 clients in that year

\*\* Of the sub-set of the 1,478 clients who received services from other agencies in that year.

<sup>14</sup> n=600 of 3,143 A&S clients

<sup>15</sup> n=743 of 3,143 A&S clients.

A&S clients received services from a range of other agencies (other than the A&S host agency). The most common agency types were councils, community health centres and health services (see Table 9).

Table 9: A&S clients in 2013-14 who received HACC services from other agencies in 2013-14

Number of A&S clients* in 2013-14 who received HACC services from other agencies in 2013-14	Number of agencies by agency type
<b>689</b>	43 councils
<b>318</b>	42 CHS
<b>206</b>	13 health services
153	31 NGOs
51	15 CALD
35	8 ACCOs

\*Note that clients could have received services from more than one agency.

\*19 clients are not accounted for.

The analysis of A&S MDS data illustrates that the number of A&S clients: increased substantially almost doubling from the first to the last quarter in the 2013-2014 year; were mostly new to HACC; accessed other HACC service types and other HACC agencies' services, thus achieving improved access to a range of HACC services.

## 5.4 A&S implementation and activity reports

The information below is based on an analysis of the 38 A&S annual implementation reports submitted to the department by agencies in May 2014 and 40 A&S activity reports submitted to the department in the 2014 April-June quarter.

### Service promotion and information sharing

It is clear from the A&S activity reports (April-June 2014) that there is broad promotion of the A&S service to other services, community groups and potential clients. This is further reflected in the annual implementation reports.

In the three month period there were a total of 133 episodes of A&S promotion to potential clients from a diverse range of settings. These included cultural groups, men's sheds, public tenants associations, choir groups, community lunch groups, neighbourhood house groups, senior citizens centres and seniors groups, craft groups, morning tea groups, church groups, various support groups, elders groups. In rural areas the settings included general stores, hotels and cafes.

However over five times this number, at almost 700 episodes, information sharing occurred with a vast range of other organisations and networks. This extensive communication with other organisations reflects promotion of the A&S service to potential referrers and the exchange of information.

This high level of promotional activity and networking is congruent with the introduction of a new service type and the need to become familiar with the local service system and inform potential referring organisations of A&S. As implementation of A&S continues to progress, the initial level of networking activity may decrease, although changes in staffing mean that promotion and networking is required on an ongoing basis.

### Partnerships

Partnerships between the A&S agency and other service providers are essential in supporting the service coordination context within which the A&S service operates. The annual implementation reports describe the number and types of agencies partnered with, and the quarterly activity reports describe outcomes achieved, such as working together with other agencies.

The number of other organisations that A&S providers have partnered with ranges from two to over 20. Based on the quarterly activity report for April-June 2014, almost every A&S service provider has linked with councils. Likewise, almost all service providers have partnered with one or more community health services. There are also relationships with other HACC service providers such nursing services, health services and non-government organisations.

### Training and professional development

Analysis of the 38 A&S implementation reports indicates that A&S workers undertook a range of training. Topics included dementia, the ASM, assessment and the HACC MDS. The most commonly identified training need was dementia (identified in 34 per cent of implementation plans) including early onset dementia.

### Referrals received by A&S workers

A&S workers reported in the activity reports that around 1,265 referrals were received in the sample three month period. The number of referrals ranged from none to over 100 per A&S funded agency, with an average of around 25 referrals (excluding outliers).

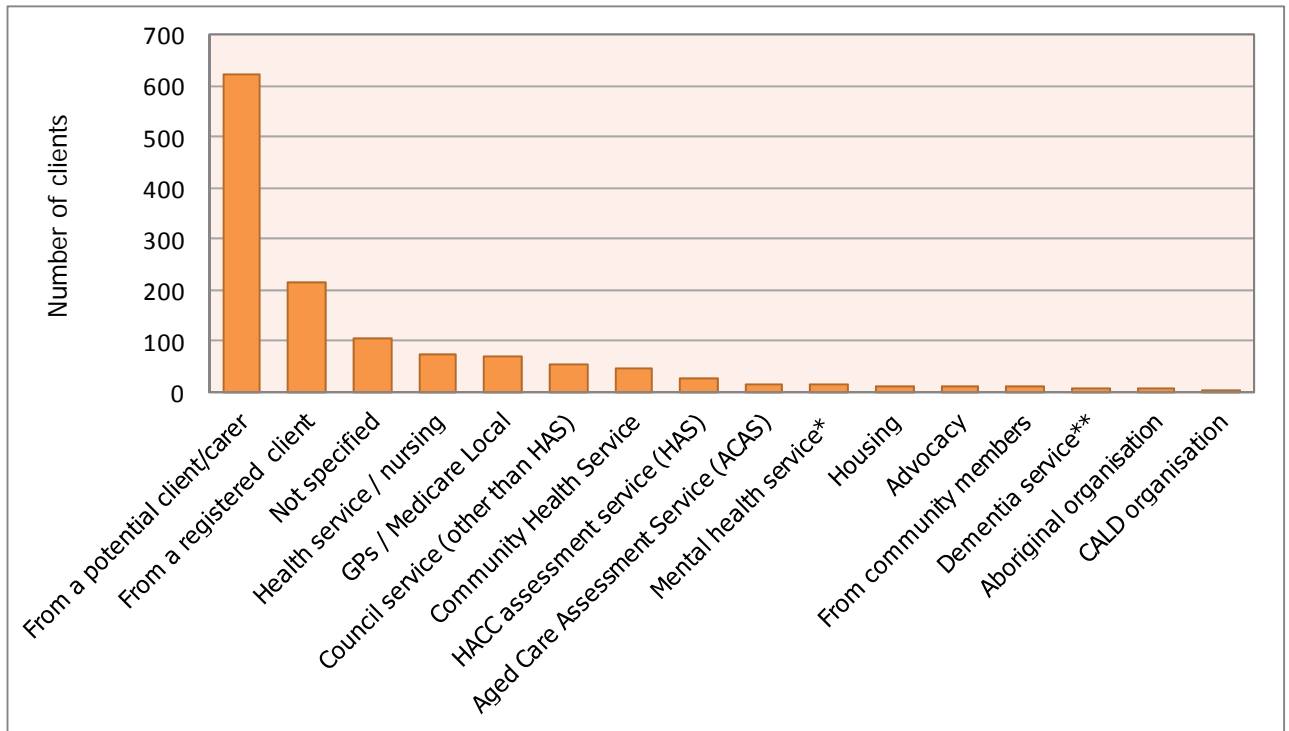
Around half of all referrals were directly from community members with the rest from existing HACC clients and a range of service providers:

- forty nine per cent were directly from a potential service user or carer
- seventeen per cent were already registered HACC service users

- six per cent were from health or nursing services
- five per cent were from general practitioners
- four per cent were from councils (services other than HAS)
- four per cent were from community health services
- two per cent were from HAS
- the remainder were from a range of other services including housing, advocacy, mental health, dementia or the referral source was not specified.

This suggests that the assertive outreach approach is effective in generating referrals, and that links with other organisations are equally as critical in generating referrals.

Figure 10: Source of referral to A&S services



\* Mental health service including Cognitive Dementia and Memory Service (CDAMS), Aged Psychiatry Assessment and Treatment Team (APATT)

\*\*Dementia service including Dementia Behaviour Management Advisory Service (DBMAS)

## A&S clients

The activity reports show a total of 1,020 A&S service users for the quarter. (The MDS data shows a total of 1,373 service users for the quarter therefore the activity report sample group represents around 75 per cent of all users).

Over one third of the service users received A&S past the eight week indicative time frame. Activity report comments suggest two key reasons for this - the time required to build trust and confidence with the person, and the waiting time for people to access other services.

A wide range of barriers to service users' accessing services were identified by A&S workers. These included (in descending frequency):

- the person's financial situation and capacity to pay for the service (the fee) and/or for transport
- the person's unwillingness to let unknown people into their homes, a lack of trust and their social isolation
- the person's lack of knowledge about the service system and services available
- language or literacy barriers
- mental health issues or memory loss
- attitudes or cultural beliefs
- complexity of the service system, including previous negative experiences
- lack of insight into their need for care
- waiting lists for services or the preference to wait for a specific service (e.g. ethnospecific) or worker (e.g. Aboriginal)
- other factors, such as the distance from a service or perceived lack of flexibility of service hours.



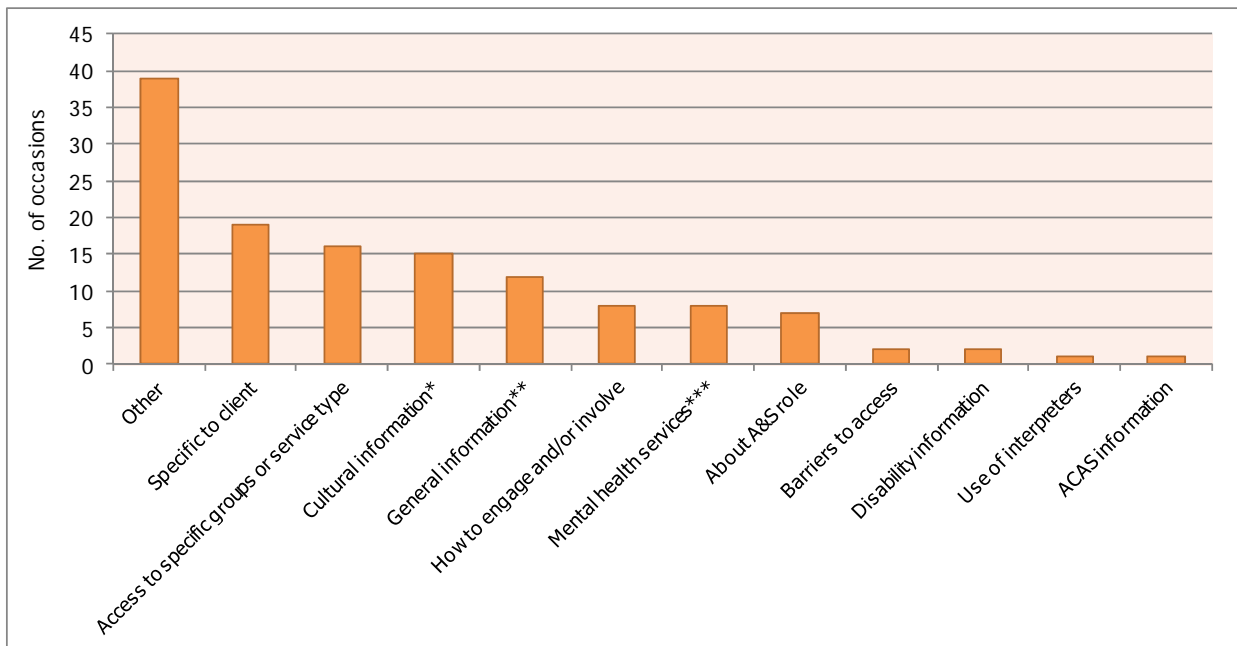
## Secondary consultation

In the April-June 2014 quarter there were around 200 occasions of secondary consultations. Secondary consultation is where a service provider contacts an A&S service to seek information and/or advice on working with a community group or person, with their consent. For example how to provide culturally appropriate services to CALD or Aboriginal communities or individuals. Secondary consultations ranged from none to up to 20 occasions per A&S worker.<sup>16</sup>

The type of organisations involved in the secondary consultation included (in descending order of frequency) community health services, councils, mental health services, ethno-specific organisations and statewide services (e.g. Alzheimer's Australia Victoria, Carers Victoria).

The focus of the secondary consultation encompassed information about specific diverse groups, eligibility and types of services, information specific to a particular service user, cultural or diversity information or resources, mental health services or dementia or other matters.

Figure 11: Focus of A&S secondary consultation



\* Cultural information including cultural sensitivity, practices

\*\* General information such as eligibility, services

\*\*\* Mental health information including about dementia support or services

<sup>16</sup> Excluding an outlier of 180 episodes by one A&S service.

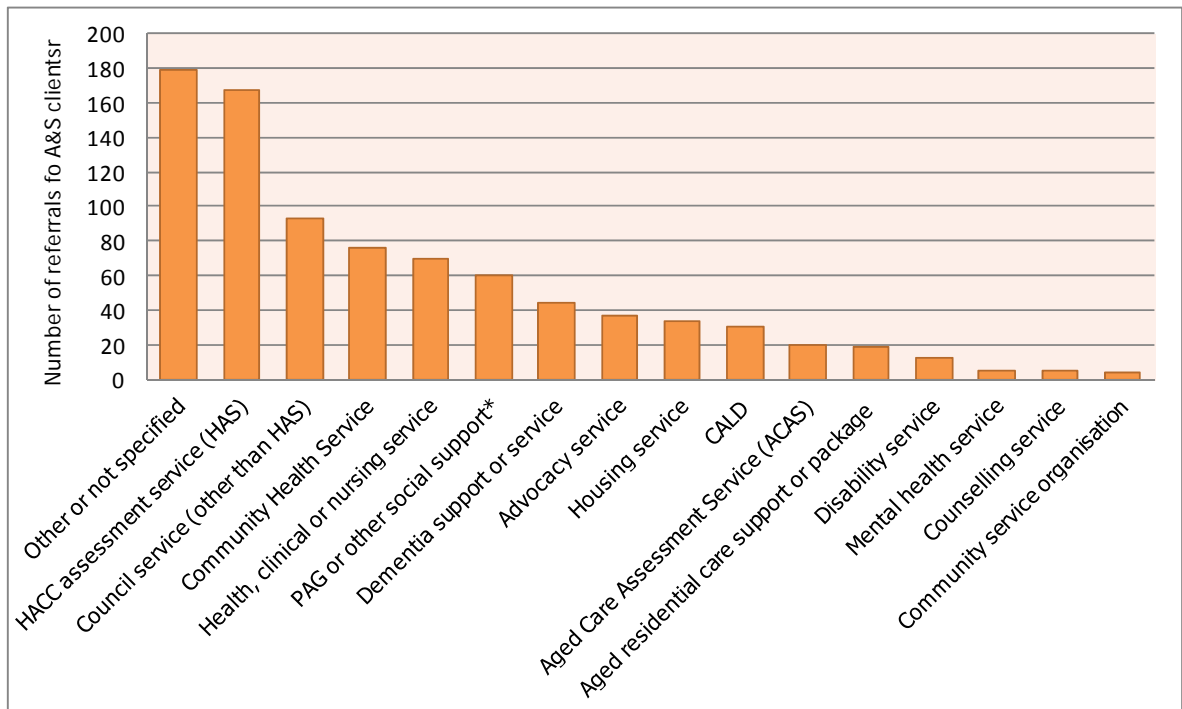
### Referrals sent by A&S workers

A&S workers sent a significant number of referrals, indicating the focus of the role in linking clients to relevant services.

Around 862 were sent on behalf of registered A&S service users in the sample quarter. Although the recipient organisation was not identified in the activity reports for about one quarter of these, referrals were made (in descending frequency) to:

- HACC assessment services
- council services (other than HACC assessment services)
- community health services
- health services including nursing or other clinical services
- social support, planned activity groups, respite and carer support
- dementia services
- advocacy services
- housing services
- CALD services
- Other – Aged Care Assessment Services, disability services, counselling and mental health services.

Figure 12: Referrals made by A&S workers for A&S registered clients



\* Includes club, group, respite, carer support

In addition, around 415 referrals were made for HACC eligible people who were not registered A&S clients, to organisations such as health services, councils, community health services, housing services, HACC assessment services, advocacy services, social support services, statewide organisations, disability services, dementia services, mental health and ACAS.

Overall, the data outlined above from the A&S annual and quarterly implementation reporting processes complements that available through the HACC MDS. It illustrates that the A&S service is actively linking clients with diverse characteristics to services.

## 5.5 Reducing barriers to access

Sector feedback (provided through the consultation and survey processes) was sought on A&S services effectiveness in reducing barriers to access for people with diverse characteristics.

The feedback indicates that A&S services were effective because (in descending frequency):

- A&S workers have the **time to build rapport** with the client and work with them in a flexible manner, provide information and assist them to navigate and access the service system
  - *By providing trained personnel with time to establish a relationship and build trust with the client/carer and have the knowledge of the range of services and programs that are appropriate to client needs.*
  - *Gentle, one on one introduction to services. Having time to explain and introduce service slowly.*
- A&S workers establish relationships and **facilitate links** with services, to empower the client and support engagement and access to services
  - *The A&S services give people information which enables and empowers them to access services.*
  - *A&S role is critical in providing links between [the service and the client] and ensuring clients remain connected.*
- A&S workers **support other providers to consider new responses**
  - *People from diverse special groups may experience significant barriers, A&S [services] work with the client to overcome these barriers.*
  - *Staff better trained to work with diverse people.*

Numerous examples of this effectiveness were provided for diverse groups. These examples indicate how the A&S service has been effective in reducing barriers to access. It reflects the fundamental design and intention of the A&S service.

Figure 13: Examples of reduced barriers for diverse groups (from sector feedback)

Group	Quotes
Aboriginal	<ul style="list-style-type: none"> <li>– <i>Aboriginal clients now have A&amp;S to help inform them about services and are able to feel confident to access services.</i></li> <li>– <i>A&amp;S worker set up partnerships with generic organisations to work out the fees and what the organisation and the ACCO can provide.</i></li> <li>– <i>A&amp;S workers in the Aboriginal spaces require particular support and a clear understanding and commitment from their organisation. The organisation needs to be aware of the cultural sensitivity issues and be able to accommodate the A&amp;S workers needs. Flexibility is key.</i></li> </ul>
CALD	<ul style="list-style-type: none"> <li>– <i>A&amp;S has acted as a bridge in journeying with an individual or community, especially within the CALD community, where language and knowledge over the system or pathway is unknown. It builds familiarity with an individual and opens the door towards establishing trust.</i></li> <li>– <i>Community members over 65 from a CALD background become familiar with A&amp;S worker. Over time they come forward with smaller issues such as getting cleaning or tree removal. Some later come forward with more complex issues.</i></li> <li>– <i>CALD client with language barriers, serious health concerns, socially isolated and financial issues presents with a layer of issues to address, and need for linking and short term intervention.</i></li> </ul>
Insecure housing /financial disadvantage	<ul style="list-style-type: none"> <li>– <i>Homeless clients often don't recognise or understand their options - A&amp;S provide that linkage and unpacking of the system.</i></li> <li>– <i>Financially disadvantaged and at risk of homelessness and CALD. A client from South America who needed HACC services to assist with activities of daily living – the client lived with family who refused HACC worker to come to the house. The client was asked to leave the home - client had no assets, language barrier, didn't understand Australian systems, financially disadvantaged. A&amp;S assisted with priority housing application, referral to council HACC for support with ADLS. Client now lives independently with support of council service.</i></li> </ul>
People with dementia	<ul style="list-style-type: none"> <li>– <i>Dementia A&amp;S worker. Supporting client and carers to access services, joint assessments work well to avoid duplication.</i></li> </ul>
Rural and remote	<ul style="list-style-type: none"> <li>– <i>Rural, CALD and dementia. Support for a man with dementia, linked into social support, but unable to manage personal and household hygiene. A&amp;S support to access resources for continence aids and cleaning services to bring property up to a standard that then had care staff assist him to maintain a basic level of standards.</i></li> </ul>

## 5.6 Positive aspects of A&S

Sector feedback (provided through the consultation and survey process) was sought about the positive and challenging aspects of the A&S role.

### Linking with the service system

The most positive aspect was strengthened links, collaboration and referral processes that in turn reduced barriers and improved access for clients.

- *It's been great to be able to work jointly with an A&S worker who has the ability and time to establish relationships with other HACC/Aged Care services which are important to enhance effectiveness.*
- *The interface with A&S has been successful in our organisation because of the effort put into relationship building by all involved.*

### Building rapport, using a person centred approach

The second positive aspect was being able to spend time with clients to develop rapport, provide information and increase awareness, and problem solve through creative solutions, thus using a person-centred approach.

- *The most positive aspect is being able to spend time with the client, learning about what is important to them and developing rapport so that they are willing to consider a range of service options that were perhaps foreign to them previously.*
- *Accessing our service becomes about the client's needs. Not the client accessing a service that we provide.*
- *Having the assistance of the A&S support person has allowed us to be more inventive at introducing people to our service, for example, we have organised small group outings, quiet coffee mornings, walks.*
- *Clients having one point of contact who they can trust and give honest feedback on services. A&S has been positive and effective with CALD, dementia, homeless and disability clients.*
- *The most positive has been assisting people with dementia. It has been beneficial to be able to give the extra time and support to these people to enable them to be confident in using services and not drop out of services.*
- *LGBTI groups - breaking down issues regarding shame, past/current sexual abuse, culturally diverse, Aboriginal clients who are LGBTI - providing a safe and supportive environment to start dealing with issues that have shamed and ostracised them from family.*

- *Increase in accessing services, greater awareness by community of services, much greater engagement of community, emphasis on shared responsibility by all staff. Greater understanding by organisation at higher level of needs/issues.*
- *For CALD and dementia: supporting people to gain thorough and holistic assessment, providing support through direct contact that allows a person to communicate their concerns and needs (in a non-clinical environment) where they can sometimes feel rushed and inhibited, not having time to review and understand information so they can ask more appropriate questions.*

## 5.7 Network support

HACC Aboriginal sector staff are supported by their regional Aboriginal network which provides peer support, and sharing of information and best practice. The four networks are each resourced by an Aboriginal Development Officer. The networks link to the statewide Victorian Committee for Aboriginal Aged Care and Disability (VCAACD).

The Ethnic Communities Council of Victoria (ECCV) hosts a bi-monthly A&S peer support network and a quarterly meeting for A&S managers, which is resourced by a HACC sectoral development role. This role supports the capacity building of A&S workers through dissemination of information, sharing of best practice, peer support and promotion of professional development opportunities.

Stakeholders acknowledged the value of the HACC sectoral development roles in providing a point of contact for specialist advice, capacity building and facilitation of training opportunities.

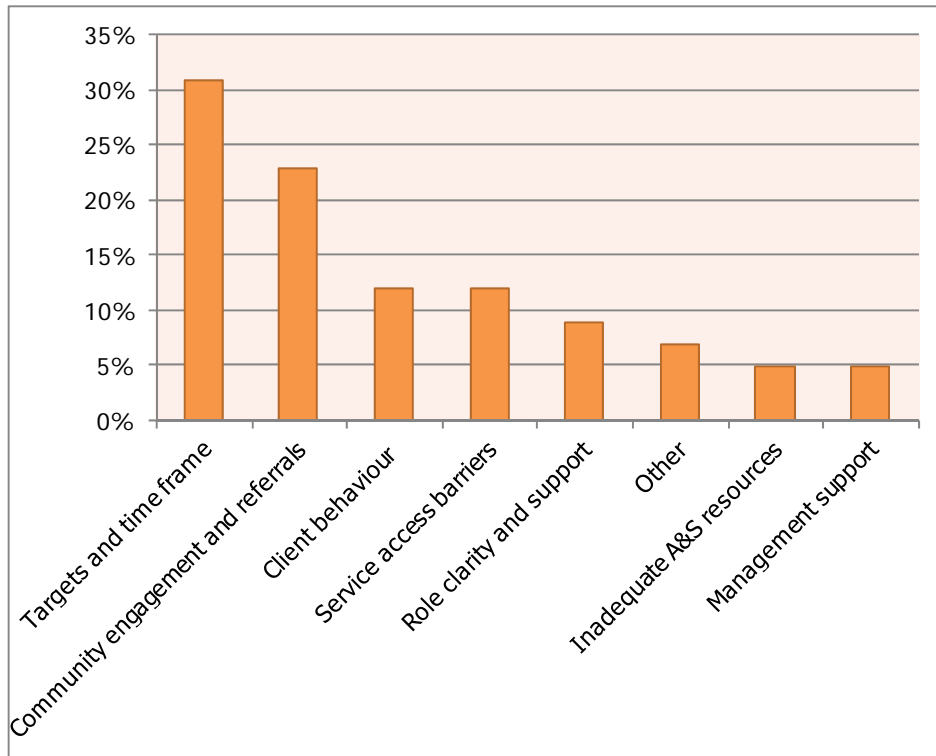
- *The HACC sectoral development roles and HDAs (as well as A&S workers) have been crucial in terms of the implementation of diversity plans and without these roles very little ongoing development of diversity planning and practice would get any priority.*

The Diversity Working Group was also noted as a forum to provide a statewide, strategic perspective in sharing information and best practice within and across diverse groups.

## 5.8 Challenging aspects of A&S

Challenging aspects of the A&S role were identified as meeting targets, community engagement, client resistance, role clarity and management support.

Figure 14: A&S challenges



### Targets and time frame

Challenges in relation to the targets, timeframe, inadequate travel time, and lack of A&S service in some locations accounted for 32 per cent of feedback on challenging aspects of the role.

- *Target hours – the split of 70% direct care and 30% engagement may not be realistic.*
- *The A&S target hours, timeframe and reporting: meeting targets is stressful (pressure) – the criteria and guidelines are too strict.*
- *The service delivery hours expected in rural areas are virtually impossible to achieve. This causes distress to the A&S workers themselves as they feel they are not achieving what they are expected to - despite support from their managers.*
- *Eight weeks with the socially diverse and disadvantaged can take all of eight weeks then facilitating a transfer to other services.*
- *Reporting is cumbersome and time consuming.*
- *Not enough A&S workers.*

## Community engagement and referrals

Challenges in relation to the assertive outreach model, community engagement and generating referrals accounted for 25 per cent of total feedback.

- *A lot more than 20% of networking is done and required in order to obtain referrals and build relationships and trust with Indigenous communities.*
- *Most challenging for A&S is generating new referrals/finding appropriate clients within the wider community. Balancing promotion/networking with client hours.*
- *I guess a challenge has been balancing the role and my time, such as finding referrals, networking, client work.*
- *Direct assertive outreach part is part of community engagement activity and such is not captured in A&S MDS hours.*

## Client engagement and service access barriers

Issues such as client resistance, building rapport and developing client confidence within a short timeframe, and delays in service access or fees, each accounted for 13 per cent of responses.

- *Working with clients with dementia is the most challenging - cognitive impairment and lack of insight into their own condition it can be difficult to convince these clients to try new services. It requires even more intensive one to one support to build a relationship. When you mix this with a person who has lost their English or is non-English speaking the situation is even more complex.*
- *Homeless clients and clients with mental health issues prove to be a cohort that have extreme difficulties in engaging. These experiences with such clients is defined frequently by unreliability, volatility, slower progress and poorer outcomes.*



### A&S role clarity and support

A small proportion of comments (ten per cent) related to challenges with the A&S role, boundaries and lack of management support and supervision.

- *The A&S worker continues to receive complex referrals which often are not about linking client/s to other services, in particular HACC services. ... The A&S program is evolving into a 'casework' service. The A&S worker has to deal with many [client] issues and work with those issues prior to any referral being made. Often this translates into having to work with the client/s for a much longer period of time as the worker sorts through issues, family issues such as elder abuse, mental health, drug and alcohol to give a few examples.*
- *A&S workers need clearer boundaries when it comes to what type of services we (A&S workers) can assist the clients with.*
- *Lack of management or CEO capacity for support in smaller ACCOs.*

### Other

An estimated 10 to 15 per cent of sector participants in the consultation process were unaware of the A&S service. There was one negative comment, and some comments that reflected a lack of knowledge about the A&S service.

- *Our staff see minimal reward for the client or agency for the amount of effort required to work with A&S. Often the A&S create unrealistic expectations of our service/timeframes for clients, leaving our staff to apologise, re-educate the client/family and then address the issue ourselves (service assessment or referral).*
- *Unaware until today of the A&S service. Don't know who, how or when to contact.*

Analysis of the annual implementation reports and quarterly narrative reports indicated similar themes about the positive outcomes and challenges in relation to the A&S service.

## 5.9 Summary of positive and challenging aspects

A summary of the positive outcomes and challenges, based on sector feedback (consultation workshops and survey), analysis of the A&S report annual implementation report (May 2014) and quarterly report (April-June 2014) is shown below.

Figure 15: A&S positive outcomes and challenges

	Positive outcomes – A&S	Challenges – A&S
Service system	<ul style="list-style-type: none"> <li>Strengthened partnerships, networks and linkages between services.</li> <li>Improved awareness and understanding of individuals with diverse characteristics and community needs.</li> <li>Timely and appropriate referrals supporting increased access.</li> </ul>	<ul style="list-style-type: none"> <li>Promoting the A&amp;S role to the sector (some partnering arrangements were not as effective as hoped).</li> <li>Eight week timeline insufficient due to complexity of A&amp;S service users.</li> <li>Waiting lists for assessment and/or services.</li> </ul>
Organisational level	<ul style="list-style-type: none"> <li>Increased capacity and opportunity to reach out to diverse groups in a manner appropriate and respectful of their diversity.</li> <li>Increased assistance for people with complex needs and multiple diversity characteristics.</li> <li>Capacity building and increased understanding of diversity by staff.</li> <li>Skill development of workers to support individuals with diverse characteristics.</li> </ul>	<ul style="list-style-type: none"> <li>Some agencies thought the A&amp;S role was too narrowly defined whereas others thought it was unclear.</li> <li>Proportion of client versus other hours (70:30), time for networking and stakeholder engagement.</li> <li>Reporting and data collection considered as being onerous and disproportionate to funding (particularly for small agencies).</li> <li>Knowledge of services, communication and referral pathways, adjusting to how different services work.</li> <li>Target hours too high. Inadequate travel time in target hours.<sup>17</sup></li> <li>Travel time in rural areas.</li> <li>Information technology support and systems.</li> </ul>
Individual level	<ul style="list-style-type: none"> <li>Development of rapport and trust, person centred approach, access to services and coordination of supports.</li> <li>Improved confidence in the use of services, contributing to increased independence.</li> <li>Increased knowledge about the service system.</li> <li>Increased involvement of the community through word-of-mouth.</li> <li>Provision of support for the person during the assessment process.</li> <li>Positive feedback from service users, carers, community members and other organisations.</li> </ul>	<ul style="list-style-type: none"> <li>Promoting the A&amp;S role to the community.</li> <li>Identifying A&amp;S service users.</li> <li>The time required to establish trust and build rapport.</li> <li>Client resistance to support.</li> <li>Cost of services.</li> </ul>

<sup>17</sup> Travel time is included in the HACC unit price as for all other HACC service types.

## 5.10 Improvements to A&S

Data from the sector consultation process about how the A&S service and role could further improve client outcomes reflects four key themes as shown in order of priority.

### Targets and reporting

Firstly, feedback highlighted concern about meeting A&S targets and the need to increase the length of time available to work with the person (that is, beyond eight weeks). This was supported through commentary in the A&S quarterly and annual reports that highlighted the need to extend the indicative eight week time frame, increase the proportion of time allowed for networking, and better recognise travel time particularly in rural and remote areas. Other suggestions were to add a brokerage component to the A&S service.

A&S services noted in the annual or quarterly activity reporting that the reporting needed to be simplified.

### Promotion of the A&S service

Secondly, marketing and promotion of the A&S service to the community and the sector, and further information about the A&S role, purpose and benefits was identified for further improvement.

- *Departmental advertising and promotion of role. Widen the scope of A&S workers. Provide [generic] brochures.*
- *Using existing partnerships to promote role.*
- *More promotion and higher profile.*
- *Having a resource that lists service providers by region such as dementia services, mental health services, community transport, disability, services, housing services.*
- *For some organisations the A&S role has been an emerging/developmental function. The full potential of the role has yet to be realised.*

Specific suggestions about how the A&S service could be further promoted, and to whom, were to:

- increase advertising and promotion, including through mainstream media, and at community events
- promote the service to all HACC funded agencies and relevant staff
- promote the service to hospitals, medical centres, GPs and other medical and health services, and non-HACC services
- provide information to network meetings and staff meetings (e.g. *'A&S worker to attend alliance meetings to discuss/promote role*

*and assist agencies to consider what they could do to improve access for clients')*

- promote to all ethno-specific services and use ethno-specific media channels
- include information on websites (My Aged Care), in service directories, e-newsletters and so forth
- ongoing community engagement – especially with Aboriginal and CALD communities.

### Distribution of A&S

Thirdly, there was feedback about the need to increase the allocation of A&S funding so A&S services are available in more locations.

- *Unfamiliar with these roles throughout Victoria- fantastic initiative... We want one too!!*
- *I think it is a very necessary role and would be great if there were more.*
- *Extend to include all [region]!!*

### Other

The last theme reflected the ongoing need for management support, ongoing access to professional development and peer support for the A&S worker. Some stakeholders also noted the need for better links between A&S services and local HACC assessment services.

## 5.11 Summary – A&S

A&S is a relatively new service of the HACC program in Victoria.

Introduction of the service has required time for A&S roles to develop links with other organisations, and to engage with diverse communities.

Some A&S services have not yet matured to full operational capacity.

Whilst this project is a review of implementation progress and not an evaluation of A&S performance, feedback and MDS reporting suggests that in some locations A&S services have been unable to provide the expected direct client support hours.

A&S services report in two formats - activity reports and the MDS. The activity reports include details about promotion to the community, assertive outreach and linking to the service system. These activities are integral to the A&S role. Time spent in these activities warrant consideration of inclusion into the MDS.

Overall, implementation of the A&S activity is progressing well with evidence (MDS data, activity reports and analysis of consultation feedback) of the A&S services targeting communities and individuals with diverse characteristics.

HACC MDS data indicates that the number of A&S clients is increasing over time, that most A&S clients are new to HACC, and that the A&S service successfully links them to HACC and other services.

A&S services are able to work effectively with their clients because they can spend the time to engage and build rapport with the client in a person centred manner.

The case studies (see Appendices) illustrate the complexity of the A&S clients and the sophisticated skills required by A&S workers to successfully engage with these clients and link them to services. The case studies and feedback indicate that: *'A&S opens the door to the service system'*.

The nature of the A&S role highlights the importance of A&S workers access to adequate peer support, supervision, mentoring and debriefing within their auspice agency.

In addition to a supportive agency, auspice agencies need systems, structures and protocols to link to other key parts of the HACC sector, including their local HACC assessment service. Positive working relationships between HACC assessment services and A&S services are essential to ensuring smooth assessment pathways and enabling A&S workers to access information about the local service system and potential services for their A&S clients. This is an area which requires development.

Likewise, the sectoral development roles, networks and peer support groups for A&S workers to link into are important for support, information and for effective service outcomes.

Ongoing marketing and promotion of the A&S service, expansion to enable statewide coverage, increasing the eight week indicative time frame, and ongoing peer support and management support, will support the continued success of the implementation of this new service type.

## 5.12 Priorities and top three items

In addition to specific feedback about diversity planning and practice, including A&S, the sector were invited to comment on the top three things (excluding additional funding) that would be effective in generally improving access to HACC services for people with diverse characteristics.

Analysis of feedback reveals four key themes (from highest to lowest number of responses) as shown in Table 10 and categorised as pertaining to the service sector, community, workforce, reporting and evaluation.

Table 10: General feedback

Theme	Comments
<p><b>Service sector</b></p> <p>Promotion to the service sector, partnerships, networking, referrals, assessment, inclusive practice, service flexibility.</p>	<ul style="list-style-type: none"> <li>– <i>Improve knowledge of GPs re HACC services to support referral pathways.</i></li> <li>– <i>A real 'no wrong door' policy...links with acute health and GP clinics.</i></li> <li>– <i>Encourage greater diversity and flexibility of service options.</i></li> <li>– <i>Waive client fees as it creates shame and may increase risk.</i></li> <li>– <i>Support MOUs with culturally respectful organisations.</i></li> <li>– <i>Develop assertive outreach programs targeting diverse communities.</i></li> <li>– <i>Networks, partnerships and advice from peak bodies, specialists.</i></li> <li>– <i>Perhaps visits from A&amp;S workers to discuss their roles to organisations.</i></li> </ul>
<p><b>Community</b></p> <p>Promotion to community, community consultation, education, empowerment, co-design, information resources.</p>	<ul style="list-style-type: none"> <li>– <i>Promote HACC services in partnership with community organisations.</i></li> <li>– <i>A public education campaign ...short messages in a variety of languages.</i></li> <li>– <i>Production of a DVD, in a selection of languages that can be played in waiting areas or via a YouTube link to community organisations.</i></li> <li>– <i>Positive articles in newspapers- including other language newspapers- about HACC services and how to learn more about them.</i></li> <li>– <i>Engaging Community members from within CALD groups to inform their communities about current services (community guides) or volunteers.</i></li> <li>– <i>Social marketing.</i></li> <li>– <i>Co-design, involve consumers in design of services ...</i></li> </ul>
<p><b>Workforce</b></p> <p>Workforce matters including professional development.</p>	<ul style="list-style-type: none"> <li>– <i>Training delivered at service, specific to staff needs.</i></li> <li>– <i>Aboriginal specific workforce in areas not presently covered.</i></li> <li>– <i>Training for management to improve understanding of diversity generally and to support the A&amp;S role.</i></li> <li>– <i>Mentoring for new A&amp;S workers.</i></li> <li>– <i>Rainbow tick accreditation.</i></li> </ul>
<p><b>Reporting and evaluation</b></p>	<ul style="list-style-type: none"> <li>– <i>Easier and improved reporting templates.</i></li> <li>– <i>Performance measure and evidence of deliverables.</i></li> </ul>

## 6. Discussion and conclusion

### 6.1 Review findings

#### Scope

The information presented in this review report is based on analysis of the 10 sector consultations, survey responses, stakeholder meetings, diversity plan reviews, and A&S MDS data and reports. The data provides a comprehensive picture about how diversity planning and practice, including diversity planning by HACC funded agencies, the HDA roles and A&S services, has been implemented to date.

#### Diversity planning and HDA role

Diversity planning is well accepted by the majority of the HACC sector in Victoria. The analysis conducted for this review indicates that the majority of HACC funded agencies engaged in diversity planning and implemented strategies to respond to the diversity within their communities, indicating there has been comprehensive and active implementation by the majority of HACC funded agencies in Victoria.

A wide range of strategies are evident including partnership development, staff training and professional development, updating of service user information, policies and procedures, new service responses and inclusive practices.

Diversity planning has occurred within a single HACC triennium, and within an environment of competing workload priorities and time pressures (particularly for small agencies with limited infrastructure).

The HDA role has been noted by many respondents and the department as a critical success factor. The role has led and championed diversity planning and practice in each region, influencing agencies' commitment to and implementation of the initiative.

The sectoral development roles and Diversity Working Group members support change within their respective organisations and sectors. They provide leadership in relation to information sharing, best practice and synergistic outcomes across the breadth of diversity.

## A&S

In the 2013-2014 year, 52 A&S services provided A&S support to a total of 3,143 A&S clients with diverse characteristics to access the service system. The majority of the clients (76 per cent) had not received services from the A&S agency or other HACC funded organisation in the previous year, suggesting they were new entrants to the HACC service system.

As a relatively new HACC service type, A&S is still becoming known to organisations and communities, and has not yet reached maturity. There is extensive service promotion and networking, increasing client numbers and evidence of improved access to services.

## Outcomes

The evidence documented in this report indicates that implementation of diversity planning and practice has been extremely positive.

It is a quality initiative which has now been embraced by the sector and is leading to improved access by marginalised and diverse groups and individuals experiencing barriers to access as a result of their diverse characteristics.

A range of network structures have provided effective support and communication channels to support implementation. These include the statewide HACC Diversity Working Group, HDA network, regional alliances and networks, and A&S peer support networks. Without these structures there would be less profile, leadership or prioritising of diversity planning and practice.

Sector feedback about priorities or suggestions for diversity planning and practice into the future focussed on:

- vertical integration of diversity planning and practice within organisations
- horizontal integration of diversity planning and practice across the organisation
- ongoing collaboration with other organisations
- further embedding A&S services into the service system, and
- ongoing sectoral development support.



## 6.2 Recommendations and priorities

### Recommendation 1:

Continue to lead and support statewide implementation of diversity planning and practice.

Rationale	Priorities
<p>The department has successfully led, resourced and championed diversity planning and practice to the sector as a quality initiative. This has enabled consistency and accountability across the state.</p>	<ul style="list-style-type: none"> <li>a) Maintain a structure to support the capacity for ongoing diversity planning and practice.</li> <li>b) Continue to promote and support effective network structures including the statewide HACC Diversity Working Group, HDA network, regional alliances/networks and A&amp;S networks.</li> <li>c) Continue to utilise the networks and HDA roles to facilitate regional forums and promote statewide and regional diversity planning and practice priorities.</li> </ul>
<p>HACC diversity planning is only one planning function within organisations. There is the need to continue to promote diversity planning and practice, particularly at the senior management level, through the integration of diversity planning with other organisation wide planning processes.</p>	<ul style="list-style-type: none"> <li>d) Develop a statewide presentation emphasising the benefits of integrated diversity planning and practice, for presentation to agency boards and senior management.</li> </ul>
<p>The sector is seeking assistance on how to measure the impact and outcomes of diversity planning and practice. Evaluation should have clear links to relevant standards and the capacity for variation between agencies.</p>	<ul style="list-style-type: none"> <li>e) Oversee the development of an evaluation framework and tools with links to standards, to assist agencies in assessing the impact of agency diversity planning and practice.</li> </ul>
<p>Diversity planning and practice and the ASM are inherently interrelated as they both encompass person-centred practice with a focus on autonomy, wellness and independence.</p>	<ul style="list-style-type: none"> <li>f) Align diversity planning and ASM planning.</li> <li>g) Develop an integrated, team approach between the HDAs and ASM ICs at the regional level for consistent practices, to facilitate messaging and sharing of information.</li> </ul>

Recommendation 2:

Continue to imbed the HDA roles.

Rationale	Priorities
<p>The HDA role is an important link between the region and the sector. There is some minor variation in how the HDA role supports agencies in each region due to the differing size of regions and service system structure.</p>	<ul style="list-style-type: none"> <li>a) Develop a statewide HDA workplan that outlines strategic priorities at the statewide level and aligns with the ASM IC workplan.</li> <li>b) Where capacity permits the HDA role should offer support to individual agencies in a coordinated approach with the ASM IC.</li> </ul>
<p>Resourcing the HDA role in each region has been critical to the successful implementation of diversity planning and practice. The HDA role can promote the integration of diversity planning with organisation wide planning processes, and to facilitate cross-agency collaboration for client outcomes.</p>	<ul style="list-style-type: none"> <li>c) Increase the number of HDAs in metropolitan regions.</li> <li>d) Develop strategies for improved collaborative working relationships between HDAs and the sectoral development roles in peak organisations.</li> <li>e) HDAs to promote diversity planning and practice at a senior management level within funded agencies. For example promote the establishment of diversity champions within agencies.</li> <li>f) HDAs to facilitate agency collaboration, in particular for improved service coordination practices between mainstream organisations and ethno-specific organisations and ACCOs.</li> <li>g) HDAs to take a greater role in A&amp;S regional networks and supporting links between A&amp;S services and the broader HACC service system.</li> </ul>
<p>Up to date demographic and client data is a critical factor in supporting agencies to develop priority areas in their diversity plans.</p>	<ul style="list-style-type: none"> <li>h) HDAs to access professional development on sourcing population data, and assist agencies in its interpretation.</li> </ul>
<p>Professional development has been a key strategy in the implementation of diversity planning and practice to date and has been effective in promoting a broader workforce understanding and acceptance of diversity, particularly in relation to LGBTI and dementia. Professional development opportunities will assist to encourage broader workforce awareness and acceptance of diversity.</p>	<ul style="list-style-type: none"> <li>i) HDAs to continue to identify and promote opportunities for professional development for funded agency staff in relation to diversity, including the HACC training calendar.</li> </ul>

Recommendation 3:

Continue to promote and implement A&S

Rationale	Priorities
<p>There is strong support for the ongoing advertising and promotion of the A&amp;S service, to the community and to the broader service system (e.g. GPs, health services etc).</p>	<ul style="list-style-type: none"> <li>a) Continue to include information about the A&amp;S service in relevant service directories, and to further promote and distribute the statewide A&amp;S brochure.</li> <li>b) Support a shared understanding of the A&amp;S role and scope through regional and statewide alliances and forums.</li> </ul>
<p>Currently there is not statewide A&amp;S service coverage. Feedback from the sector indicates demand for A&amp;S services in other locations.</p>	<ul style="list-style-type: none"> <li>c) Consider closer linking of the allocation of A&amp;S resources to agencies diversity plan priorities and target geographical areas based on population data planning.</li> </ul>
<p>The A&amp;S roles require ongoing access to professional development, management support, access to supervision, debriefing and peer support networks.</p>	<ul style="list-style-type: none"> <li>d) Provide professional development for A&amp;S workers, for example, through an A&amp;S training needs analysis and the HACC training calendar.</li> <li>e) Encourage ongoing management support for A&amp;S workers to further develop the availability of peer support, debriefing and mentoring systems and processes and regional and statewide support networks.</li> <li>f) Update the designation criteria for A&amp;S services and distribute to funded agencies to ensure all managers (which may have changed over time) are aware of these criteria and the associated responsibilities.</li> </ul>
<p>Due to the nature of the client group and service system delays, eight weeks is too short a time frame for the A&amp;S client support episode.</p>	<ul style="list-style-type: none"> <li>g) Extend the A&amp;S indicative timeframe from eight to 12 weeks.</li> </ul>
<p>The HACC MDS is the mechanism by which A&amp;S service use and delivery is measured. Sector feedback reflects that limitations within the MDS preclude more accurate reporting of some client demographic data (e.g. dementia) and A&amp;S activities.</p>	<ul style="list-style-type: none"> <li>h) Develop improved MDS reporting requirements that more fully capture the A&amp;S role and continue to clarify A&amp;S counting rules with the sector.</li> <li>i) Promote the reporting of diversity characteristics, such as memory loss and confusion and housing status, in the MDS.</li> </ul>

Rationale	Priorities
<p>A&amp;S roles are well placed to understand issues about barriers to accessing HACC services and can contribute to diversity planning.</p>	<ul style="list-style-type: none"> <li data-bbox="730 322 1444 573">j) Further facilitate the development of effective relationships between A&amp;S services and the broader HACC service system, in particular with HACC assessment services. This will provide A&amp;S workers with a contact point for detailed information about the local service system and ensure smooth assessment pathways for A&amp;S clients.</li> <li data-bbox="730 595 1444 846">k) Ensure participation of HDAs, ASM ICs and Aboriginal Development Officers at A&amp;S networks. Include the participation of peak organisation diversity roles where necessary. This will enhance a shared understanding of access barriers to services and contribute to a catchment wide understanding of diversity planning priorities.</li> </ul>

There is compelling evidence from this review that diversity planning and practice is generating outcomes for clients that are cognisant with the spirit and objectives of the HACC program for Victoria's diverse community.

An action plan outlining specific tasks to address these priorities, with ongoing leadership and input by the department, the Diversity Working Group and networks, will support the continued successful implementation of diversity planning and practice in Victoria.

## Appendices

### Appendix 1: Case studies – diversity planning

This section provides case studies that describe how selected agencies developed processes to implement diversity planning within their organisations.

This case study outlines the process used by a nursing service to introduce diversity planning and practice across 14 sites.

Figure 16: Case study – Introduction of diversity planning and practice in a nursing service

Element	Introduction of diversity planning and practice
Situation / requirement	Need for the Diversity Coordinator to introduce diversity planning and practice across a large metropolitan organisation with multiple sites and services and link with the 14 site-based diversity actions plans. Need for an organisational wide approach and consistency across regions. Understand how the organisation (not funded for A&S) could work with the A&S service providers and think of them as a joint partner in the client pathway.
What we did first	Discussed at Senior Management level and agreed that it was a policy reform and required a systematic approach throughout the organisation. Used the 'Working with A&S Services' guide to develop a PowerPoint presentation. Presented this to the Executive, General Managers and 13 Client Services managers. The presentation included information about the new HACC A&S service, implications for the organisation's policies and procedures, and recommendations for quality improvements to enable the interface with the A&S service. Discussed practical considerations such as the care pathway, assertive outreach and secondary consultation. Placed the presentation and list of A&S organisations/contact details on the intranet for easy access by Client Service Managers in different regions.
What we progressed with	Made incremental changes to policies and procedures, such as: the admissions policy – to find out if an A&S worker is/should be involved; guidelines for working with Aboriginal people – includes prompt to engage with A&S worker; the client care record and checklist; the Clinical Holistic Assessment Tool and consent policy and forms. Embedded information into the organisations training.
Outcomes	Effective introduction and implementation across sites with diversity planning and practice embedded into policies and procedures.

Source: Summarised from information provided during the consultation process.

The case study below outlines the systematic approach and process used by a health service to introduce diversity planning and practice; and is followed by a case study about the process used by a council to introduce LGBTI training as a key diversity planning strategy.

Figure 17: Case study – Introduction of diversity planning and practice in a health service

Element	Introduction of diversity planning and practice
Situation / requirement	Need to introduce diversity planning and practice across a large health organisation with multiple sites.
What we did first	Had a workshop and undertook a gap analysis and used data to set priorities. Developed a quality committee. Started in HACC then spread out through other areas of the organisation.
What was most important	A coordinated approach from different parts of the organisation to manage time inputs and resources effectively; to get impact and 'quick wins; to articulate benefits of participations (if you have a representative on the committee you will get updated policies and procedures to reduce duplication e.g. sexuality policy); to harness interest and energy.
What we learned	It was ambitious and there are always competing priorities. It took longer than we thought however is progressing well.

Source: Summarised from information provided during the consultation process.

Figure 18: Case study – LGBTI training

Element	LGBTI training in response to diversity planning
Situation / requirement	The regional HACC Diversity Plan highlighted the need for LGBTI training. The initial reaction from council staff was "Why do we have to do this, we already treat everyone the same" and "We do not have any LGBTI clients."
What we did	Organised training in LGBTI diversity in aged care. We produced a draft Diversity Statement including LGBTI, and asked for staff input around the wording. HACC managers have commenced adding inclusive service clauses to all of their HACC documentation, including Position Descriptions, Agency Service Agreements, Staff Interview Questions, and Support Worker and Team Leader Manuals.
What worked	Talking about the subject and content of the training helped towards familiarising our HACC staff to increase their understanding of LGBTI. We explained some of the concerns that our LGBTI clients may have accessing services. During group meetings we used some of the examples from the training about actual HACC recipients and their experiences with HACC providers. This has really helped our direct support workers understand why this is such an important issue.
Outcomes	The council has recently established a LGBTI Advisory Committee to provide advice and information on issues facing the LGBTI community and on the development and implementation of the Council's Inclusion, Access and Equity Plan.

Source: Summarised from documentation provided to the review consultant.

## Appendix 2: Case studies – A&S

This case study provides a summary of how the A&S service assisted a person living in unsafe and insecure accommodation to overcome barriers to accessing services. It highlights the skills of the A&S workers in engaging with the person and the use of creative problem solving.

Figure 19: Case study – Person in insecure and unsafe housing

Element	A&S service
Presenting situation	Elderly man living in a structurally unsafe shed, without adequate power, sanitation or kitchen facilities. Concerns re hoarding and squalor. Man surviving on one meal each day from the local hotel. Referred to A&S by other council officers as eviction was pending.
What we did first	Considered a safe approach – met the man and sat out the front in the yard to talk. Built rapport and found out about what was important to him.
What was most important to the person	Staying on [his] land and not being evicted. (Also important to the A&S worker was managing safety concerns and working towards improved access, health and wellbeing).
Options and approaches we considered	How the man's living environment could be safe and how he could avoid being evicted, through working with other parts of council and developing practical solutions. Considering whether the man would be better off living somewhere else.
What we progressed with	Sleeping at his sister's house which was nearby and returning to his shed during the day. Provision of HACC delivered meals. Slowly joining group outings. (Rejected: Moving the man off his land due to safety and risk issues)
What worked	Sleeping at his sisters with access to bathroom facilities. Joining bus outings – other people on the bus encouraged him to improve his personal hygiene. Continuing to spend time at his shed, on his land, with his possessions.
What we learned	Practical and safe solutions require lateral thinking. Change is incremental and one improvement can be followed by another.
Outcomes	The man stayed on his land plus had a safer living and sleeping environment, improved access to food and good nutrition and increased social participation.

Source: As described by an A&S worker at a consultation session.

The following case study provides a summary of how the A&S service assisted an Aboriginal person to overcome barriers to access to services. It highlights how the A&S worker was able to take the time to build rapport with the person, gain their trust, and increase their confidence in accessing and ultimately using services.

Figure 20: Case study – Aboriginal person

Element	A&S service
Presenting situation	Referral to A&S workers by Aboriginal Hospital Liaison Officer (AHLO) of an 80 year old Aboriginal woman with complex and poorly managed chronic health conditions. Poor knowledge regarding her health and medication and no regular GP. Presented at emergency after falling at home. Isolated – socially and culturally. Forcibly removed from her family as a child and consequently did not trust service providers or government. No family or other supports and not connected to the local or wider Aboriginal community. Not accessing Aboriginal or mainstream services.
What we did	A&S and the AHLO conducted a joint home visit in which the time was spent making introductions and building rapport and trust. Additional phone contact to maintain rapport, build trust, check welfare and encourage service access.
What we progressed with	Joint assessment conducted by A&S and AHLO. Elder reluctantly agreed to try Aboriginal planned activity group (PAG). A&S worker meets the client at the PAG and introduces her to other members of the group. Has a positive experience and develops a relationship with PAG staff over time.  Referrals also completed for ACAS, occupational therapy, Aboriginal care coordination and a local general practitioner (GP) registered for the Close the Gap initiative.
Outcomes	12 months later...Elder attends Aboriginal PAG and Older Persons Social Group. Is in receipt of a Community Aged Care Package. Attends local Aboriginal community group. Attends regular appointments with GP. Health conditions are well managed. Currently working with "Link Up", an Aboriginal service which helps people locate and connect with their families.

Source: Summarised from information provided by a HDA.



The following case study provides a brief summary of how the A&S service assisted a person from a CALD background, with limited literacy, to overcome barriers to access to services. It highlights the importance of understanding the client's level of health literacy and how communication can influence the outcome.

Figure 21: Case study – Person from a CALD background

Element	A&S service
Presenting situation	A&S worker visited an isolated, elderly Croatian client with limited literacy and complex needs, including concerns about incontinence. The client was not receiving any services and was hesitant about accepting or paying for supports. The A&S worker built rapport with the woman and made a referral to the ACAS for assessment.
The importance of understanding	Joint assessment with ACAS – in attendance was the A&S worker, interpreter and ACAS assessor. The ACAS assessor asked the client 'Do you have any incontinence issues?' The interpreter translated as 'Are you incontinent?' The client, not fully understanding and being embarrassed replied 'I don't have any of that.' The A&S worker explained in simple language what incontinence meant, so that the client understood. Following further discussion and clarification, strategies were developed and agreed, including access to subsidised continence aids.
What was most important to the person	A&S worker who spoke the same language as the client and was able to provide simple explanations.
What worked	Building rapport with the client, speaking the same language, being present at the assessment. A practical result in terms of access to continence aids.
What we learned	The importance of communication and health literacy, how the A&S workers who had spent time getting to know and understand the client can assist in supporting the assessment process.

Source: Summarised from information provided by a HDA.

The following case study provides a brief summary of how the A&S service assisted a person with dementia to overcome barriers to accessing services. It illustrates a person centred approach and the importance of understanding what is important to the client and carer.

Figure 22: Case study – Person with dementia

Element	A&S service
Presenting situation	Mr A walked into office seeking assistance. He had picked up a brochure at the health clinic. Mrs A diagnosed with Alzheimer's disease in 2013. No services in place – previous offers of support had been rejected.
What we did first	Organised a home visit to gather information. Had an interesting and lengthy discussion with Mr and Mrs A about services available.
What was most important to the person	Mr A wanted his wife to stay at home but was not aware of in-home supports. Mrs A wished to continue bird watching, because she found it quite calming.
Options and approaches we considered	How to reduce the carer stress and support the care relationship. Referral for HACC in-home respite with the aim of supporting Mrs A in her bird watching hobby (for example by looking at bird books) to enable Mr A to have a break from his care role. Options for carer support in short and longer term.
What we progressed with (and what we rejected)	Referral for HACC in-home respite (as above). Also referrals to carer support, Alzheimer's Vic. and ACAS. (Rejected: PAG referral as client becomes agitated away from home)
What worked	In-home respite for Mrs A and ACAS assessment for residential respite as required. Carer support and Alzheimer's Vic. counselling for Mr A, who is now enjoying social contact.
What we learned	The importance of meeting both client and carer needs.
Outcomes	Fantastic outcomes for all referrals made. Both client and carer are currently happy and further services will be introduced at a later date as needs arise.

Source: Summarised from information provided by a HDA.

The following more detailed case study provides a brief summary of how the A&S service assisted a rural, isolated person to overcome barriers to access to services. It demonstrates the value of the A&S role in facilitating risk reduction for vulnerable persons with a history of service refusal, and the practice skills used the A&S worker.

Figure 23: Case study – Rural area

Element	A&S service
Presenting situation	<p>Informal referral from an ACAS worker requesting that the A&amp;S worker talk with the HACC assessment officer regarding an elderly couple in a country town, who had been approved for home care packages but declined services. The ACAS worker was concerned because the wife had dementia, the husband had a physical disability from a childhood illness, and a child with significant vision impairment lived with them.</p> <p>The A&amp;S spoke with the HACC assessment officer, who confirmed that the family was known to them and had declined services in the past. The elderly couple had expressed some concern regarding the maintenance of their large garden. HACC property maintenance was unable to provide the kind of service that they sought and the couple were advised of private options for garden maintenance.</p>
What we did first	<p>The A&amp;S worker phoned the couple and made an appointment to visit. The couple were warm and receptive. The A&amp;S worker explained that the visit was in response to the concerns of local service providers and to see if they were OK. The couple recounted that they had been visited by several people but nothing had eventuated. They were able to find papers with names and roles of the providers, which they showed to the A&amp;S worker.</p> <p>The A&amp;S worker's goal for the first appointment was to engage with the couple and access further meetings. No attempt was made to problem solve, but instead identify opportunities to validate the couple's autonomy, positive life story, and agree on current issues.</p>
What was most important	<p>Several vulnerabilities were evident to the A&amp;S worker. However, the only client-identified issue was the maintenance of their extensive garden. The A&amp;S worker concluded the interview with a request that they would consider options to help with the garden, permission to talk to others for their ideas, and to return in a week with some suggestions for discussion. The couple agreed to this, and made it clear that they did not require assistance inside the home.</p>
Options and approaches we considered	<p>At the next visit the A&amp;S worker noted further client vulnerabilities – the couple had returned from a visit to a local clinic for tests however could not recall what the tests were or why they were needed. The A&amp;S worker also observed the wife prepare morning tea, while the husband brought in firewood in a bucket balanced on his walker.</p> <p>During the visit A&amp;S worker continued to develop rapport, and suggested that a Home Care Package with case management might provide the best option for garden maintenance. The A&amp;S worker left some printed information and it was agreed that the A&amp;S worker would phone in a few days to hear what their thoughts on the matter were.</p> <p>When the worker phoned back the husband stated that they had read the information but was unable to recall what they had read. The A&amp;S worker requested</p>

Element	A&S service
	<p>permission to discuss it with their son, to which they agreed. The son was enthusiastic about service involvement as he had made numerous attempts to arrange help for them in the past. The son was invited to meet the case manager and discuss strategies. The A&amp;S worker expressed the concern that the couple would decline the home care package because of the fees. The son agreed to pay the fees and as Enduring Power of Attorney could sign any documentation.</p>
<p>What we progressed with</p>	<p>The A&amp;S worker and case manager conducted a joint visit and advised of the arrangement with the son. They discussed a plan for garden maintenance and what other service options could be available through the package. The couple consented to the arrangements and were informed that they could phone the case manager at any time to discuss any support they required.</p>
<p>What worked</p>	<p>Communication based on respect for client identified strengths and desires, rather than a focus on deficit or risk reduction.</p> <p>Identification of needs through a conversation and genuine interest in the client's life stories, with subtle guiding of the conversation to gain more clarity where needed.</p> <p>Collaborative problem solving (such as the A&amp;S seeking information and relaying findings) rather than providing solutions from the position of knowledge and authority.</p> <p>Involving the son to overcome the potential financial barrier, after sufficient trust with the couple had been established so that they would not feel that their autonomy was being overridden.</p>
<p>What we learned</p>	<p>This self-reliant couple felt safer refusing services rather than agreeing to something that they did not fully understand. They had concerns about the cost of living, which indicated that they may be reluctant to pay for services. Given the history of service refusal and the evidence of need associated with the couple's declining self-efficacy it was important to engage them at the point at which they might be willing to accept services.</p> <p>The A&amp;S worker used collaborative, non directive problem solving, for the needs identified by the clients. (Other needs and risks identified by the worker were noted for possible later action after positive service use was established).</p> <p>The A&amp;S worker introduced the case manager to facilitate trust enable transition.</p> <p>Without the A&amp;S intervention this couple would have continued to live with progressive physical, mental, and social decline, possible to the point of crisis. The A&amp;S intervention was provided in a manner that respected autonomy and self determination.</p>
<p>Outcomes</p>	<p>The case manager arranged for a local qualified Grey Army horticulturalist to provide garden maintenance. The case manager has formed a trusted relationship with the clients and family so that interventions that are agreeable to the clients can be implemented in future. For example home help, shopping assistance, transport assistance, medication checks, falls prevention, monitoring of cognitive decline, introduction of carer supports and dementia specific services, social inclusion events, and allied health HACC services. This will enable this couple to remain in their own home into the foreseeable future.</p>

Source: Summarised from information provided by an A&S worker.

The following case study outlines the process used by the A&S service to ensure a collaborative working relationship with council and effective referral processes.

Figure 24: Case study – Introduction of A&S service and co-location with a council

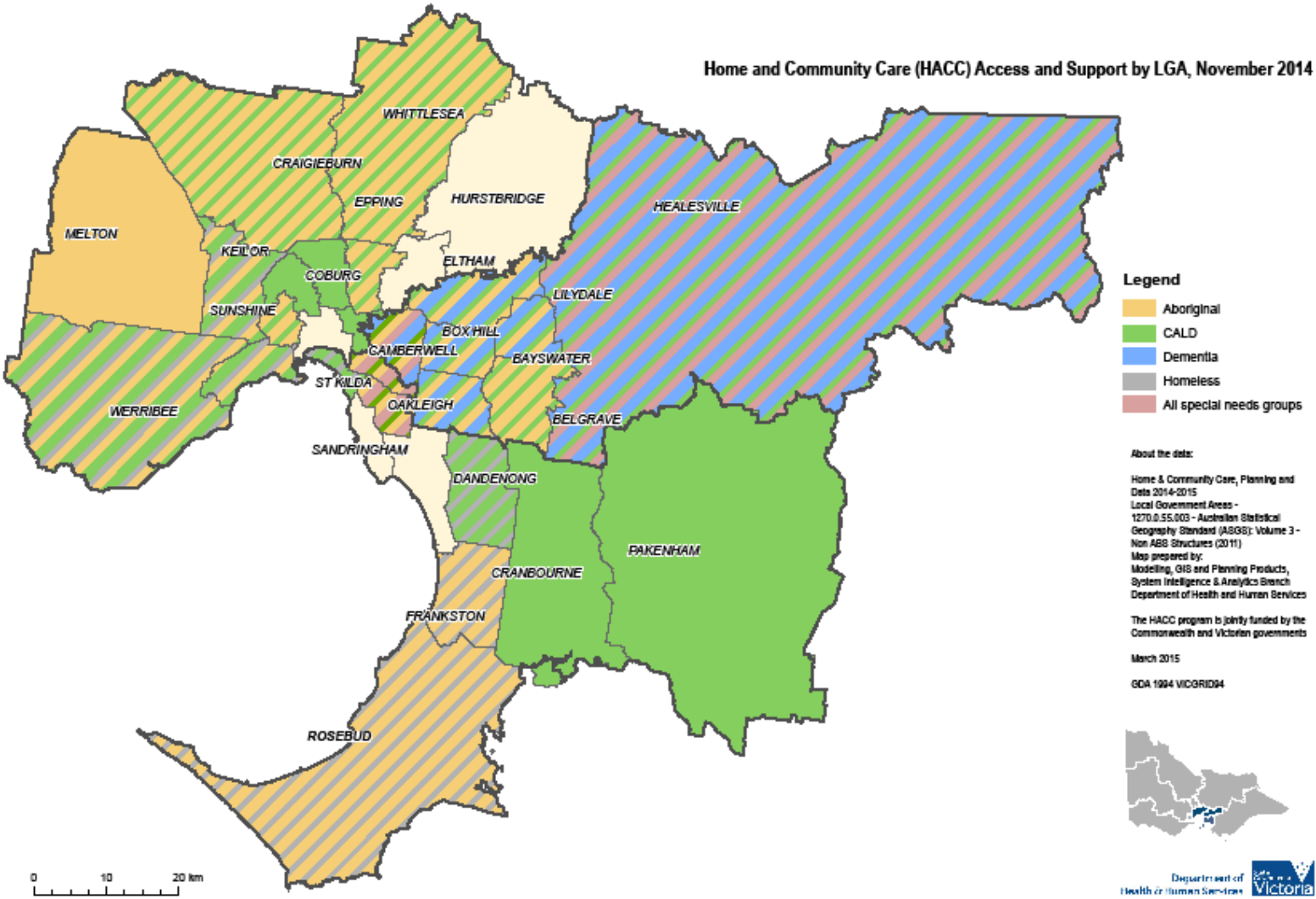
Element	Introduction the A&S service
Situation / requirement	<p>A multicultural service wished to introduce its A&amp;S service to the local council to enhance access and outcomes for CALD clients.</p> <p>The team leader and two A&amp;S staff made contact with the council community care team, with the aim of introducing the A&amp;S service and supporting the good working relationship between the two organisations. Following discussion it was decided that the way forward was to co-locate the A&amp;S staff with the council community care team one day per fortnight.</p>
What we did first	<p>The multicultural service was invited to address the council community care team's leadership meeting. The presentation focussed on the A&amp;S role, its scope of practice and the aged care services available through the multicultural service.</p> <p>Team leaders from both organisations and the A&amp;S staff then met to prepare for the co-location. There were two key tasks: council prepared a Statement of Work; and the multicultural service developed a simple self-assessment tool to evaluate the development of each staff member's knowledge and skills during the co-location.</p>
What we progressed with	<p>During the next six months the A&amp;S staff received orientation to the council community care team and service delivery, observing all stages of the client journey and care pathway. This included the 'one point' entry process, intake, living at home assessments, care plan documentation and staff rostering. The A&amp;S staff had access to the community care team's HACC policies and procedures, such as the Priority of Access tool, and were provided with a work station and included in email communications. Over this period, 12 assessments were conducted by council assessment staff with the A&amp;S staff present. Council staff and A&amp;S staff discussed how to work collaboratively during a living at home assessment, with the understanding that council had the formal assessment role. Throughout the process there was frequent communication between team leaders of both organisations and with the staff involved. Staff completed the self-assessment evaluations, meetings were held within each organisation and together, to discuss the progress and outcomes of the initiative.</p>
Outcomes	<p>Overall, staff from both organisations reported that they had improved their knowledge about each others' services, and respected the skills and knowledge of each organisation that contributed to quality service delivery. The strengthened working relationship resulted in easier communication between staff from both organisations, particularly about service coordination practice. Key findings were that A&amp;S staff felt more informed and confident about providing information to prospective clients about council's HACC services and processes; council staff reported an increased awareness of CALD clients and their needs, leading to increased responsiveness in assessment and care planning practice, and a good understanding of A&amp;S role; and there was positive feedback from the CALD community.</p>

Source: Summarised from information provided by an A&S agency.

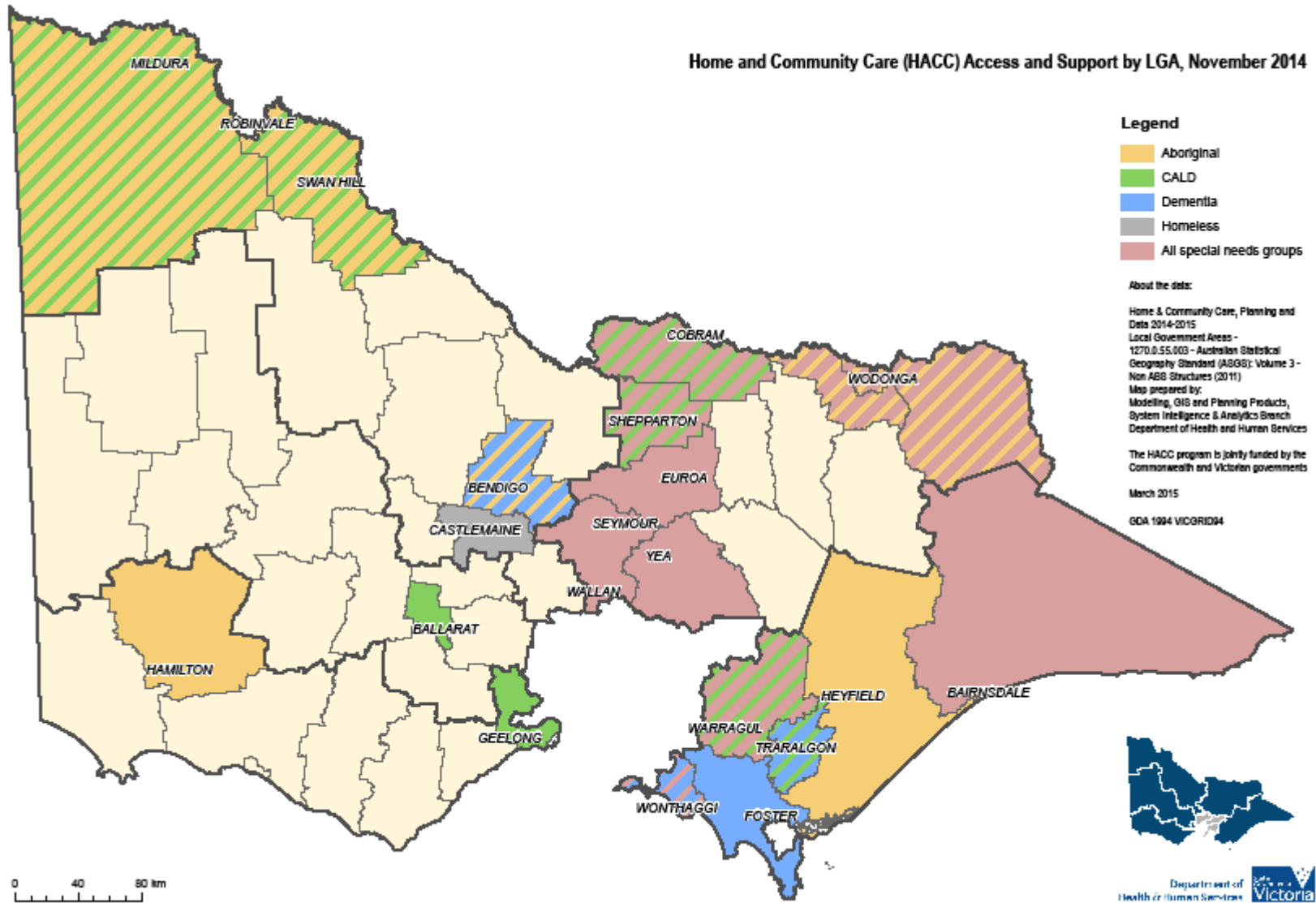
## Appendix 3: Consultation questions

Element	Questions
Diversity planning	<p>1 What has been the most useful outcome of diversity planning for your organisation?</p> <p>2 What aspects of diversity planning have worked best?</p> <p>3 What aspects of diversity planning have been most challenging?</p> <p>4 How can diversity planning be improved? (You may wish to consider the process, the template, guidelines, timelines, the stakeholders, or other points).</p> <p>5 Developing links and partnerships is a common strategy in diversity plans. What outcomes have resulted from this for your organisation?</p> <p>6 What types of strategies might you consider next?</p> <p>7 In future, how could your organisation measure the impact and outcomes of diversity planning?</p>
HACC Diversity Adviser	<p>8 Has your organisation received information, assistance or advice from the HDA in your region?</p> <p>9 If so, how did it influence your diversity planning or practice?</p> <p>10 Do you have any suggestions about how the HDA role can further support diversity planning and practice?</p>
Access and support	<p>11 How has the A&amp;S service been effective in reducing barriers to access for people with diverse characteristics?</p> <p>12 For which group (Aboriginal, CALD, dementia, rural, homeless etc)? Can you provide an example?</p> <p>13 What do you think has been the most positive and effective aspect of the A&amp;S role and for which group? How could this be improved?</p> <p>14 What do you think has been the most challenging aspect of the A&amp;S role and for which group? How could these challenges be overcome?</p> <p>15 The A&amp;S service is a relatively new HACC activity. How else could it be promoted so that more referrals are received, and from which group?</p> <p>16 Do you have any suggestions about the A&amp;S role and how to improve outcomes?</p>
General	<p>17 Based on your knowledge and experience, what do you think are the top three things (excluding additional funding) that would be effective in improving access to HACC services for people with diverse characteristics?</p> <p>18 Have some or all of the information resources been of use? If so, which ones (e.g. the Diversity planning practice guide 2011, the A&amp;S practice guide 2013, the guide for working with A&amp;S services) and why? What other information would be useful?</p> <p>19 What priorities or suggestions do you have for improving HACC diversity planning and practice into the future?</p> <p>20 Do you have any other feedback or suggestions about HACC diversity planning and practice?</p>

# Appendix 4: A&S locations



## Home and Community Care (HACC) Access and Support by LGA, November 2014



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