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Please note: This paper contains a number of case studies and descriptions of client experiences that were provided by Victorian HACC service providers during the course of the project. Please note that to protect the privacy of consumers, all potentially identifiable information has been removed and personal details have been changed. Pseudonyms and stock images (purchased from istockphoto.com) have therefore been used throughout the paper. Service providers have provided consent for service information to be included and staff to be identified.
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## Glossary of terms

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<tbody>
<tr>
<td>ACHA</td>
<td>Assistance with Care and Housing for the Aged</td>
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<tr>
<td>ADL</td>
<td>Activity of Daily Living</td>
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<tr>
<td>AHA</td>
<td>Allied Health Assistant</td>
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<tr>
<td>ASM</td>
<td>Active Service Model</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander (ATSI)</td>
</tr>
<tr>
<td>CCW</td>
<td>Community Care Workers (also referred to as Direct Care Workers or Support Workers)</td>
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<tr>
<td>CHS</td>
<td>Community Health Service</td>
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<tr>
<td>CHSP</td>
<td>Commonwealth Home Support Programme</td>
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<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
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<tr>
<td>DHHS</td>
<td>Victorian, Department of Health and Human Services (formerly Department of Health [DH] and Department of Human Services [DHS])</td>
</tr>
<tr>
<td>DSS</td>
<td>Commonwealth Department of Social Services</td>
</tr>
<tr>
<td></td>
<td>Note: Responsibility for ageing and aged care now sits with the Commonwealth Department of Health (DoH).</td>
</tr>
<tr>
<td>DTC</td>
<td>Day Therapy Centres</td>
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<tr>
<td>GDCP</td>
<td>Goal Directed Care Plan / Planning</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HCS</td>
<td>Home Care Standards (also referred to as the Community Care Common Standards)</td>
</tr>
<tr>
<td>MAV</td>
<td>Municipal Association of Victoria</td>
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<tr>
<td>NRCP</td>
<td>National Respite for Carers Program</td>
</tr>
<tr>
<td>NSAF</td>
<td>National Screening and Assessment Form</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapy / Occupational Therapist</td>
</tr>
<tr>
<td>PAG</td>
<td>Planned Activity Group</td>
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</table>
### Definitions

<table>
<thead>
<tr>
<th>Term</th>
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<tr>
<td>Active Service Model (ASM)</td>
<td>&quot;The Victorian HACC Active Service Model is a quality improvement initiative that explicitly focuses on implementing person and family-centred care, wellness promotion, capacity building and restorative care in service delivery. &quot;This initiative aims to ensure that people attain the greatest level of independence they can and are actively involved in making decisions about their life. This includes understanding their goals, their decisions about the type of services they wish to receive and the desired outcomes&quot; (DH 2013 p. 93).</td>
</tr>
<tr>
<td>Bilateral Agreement</td>
<td>The Bilateral Agreement on Transitioning Responsibilities for Aged Care and Disability Services and its Schedules, including any Schedules added to the Agreement (COAG 2015).</td>
</tr>
<tr>
<td>Carer</td>
<td>&quot;Unpaid carers such as relatives, friends, neighbours or community members who look after the person. Some people may not have a carer while others may have many carers&quot; (DH 2013 p. 92).</td>
</tr>
<tr>
<td>Commonwealth Home Support Programme</td>
<td>The Commonwealth Home Support Programme (CHSP) provides entry-level maintenance, care, support and respite services for older people living in the community and their carers. Funded by the Commonwealth Government, the CHSP brings together four existing programs, Home and Community Care (HACC), National Respite for Carers Program (NRCP), Day Therapy Centres (DTC) Program and Assistance with Care and Housing for the Aged (ACHA) Program (DSS 2015a). Victorian HACC services commenced transition to the CHSP on 1st of July 2016.</td>
</tr>
<tr>
<td>Consumer</td>
<td>Consumers include people that receive HACC services (clients) and their carers. Within HACC services, the needs of clients and carers are considered in all elements of service delivery. Consumers are actively involved (where appropriate) in service access, assessment, care planning, service delivery and review (DH 2013 p. 92).</td>
</tr>
<tr>
<td>HACC Target Population</td>
<td>&quot;Older and frail people with moderate, severe or profound disabilities and younger people with moderate, severe or profound disabilities, and their unpaid carers&quot; (DH 2013 p. 92).</td>
</tr>
<tr>
<td>My Aged Care</td>
<td>My Aged Care has been established by the Australian Government as an identifiable entry point that older people, their families, and carers can access for information on ageing and aged care, have their needs assessed and be supported to locate and access services available to them.</td>
</tr>
<tr>
<td>Older People</td>
<td>People aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.</td>
</tr>
<tr>
<td>Reablement</td>
<td>&quot;Reablement involves time-limited interventions that are targeted towards a person’s specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities&quot; (DSS 2015c p 12).</td>
</tr>
<tr>
<td>Restorative Care</td>
<td>&quot;Restorative care involves evidence-based interventions led by allied health workers that allow a person to make a functional gain or improvement after a setback, or in order to avoid a preventable injury&quot; (DSS 2015c p 13).</td>
</tr>
<tr>
<td>Wellness</td>
<td>&quot;Wellness is an approach that involves assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourage actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home&quot; (DSS 2015c p 10).</td>
</tr>
<tr>
<td>Younger people</td>
<td>People aged under 65 years and Aboriginal and Torres Strait Islander people aged under 50 years</td>
</tr>
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</table>
Acknowledgements

We gratefully acknowledge the input of the following organisations and groups for their contribution to the project.

<table>
<thead>
<tr>
<th>Organisation</th>
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<tr>
<td>ASM Industry Consultant Statewide group</td>
<td>Glen Eira City Council</td>
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<tr>
<td>Bairnsdale Regional Health Service</td>
<td>Goulburn Valley Health</td>
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<tr>
<td>Ballarat Health Services</td>
<td>Hume Whittlesea Primary Care Partnership</td>
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<tr>
<td>Bass Coast Shire Council</td>
<td>Inner East Community Health Service</td>
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<td>Bayside City Council</td>
<td>Knox City Council</td>
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<td>Bendigo Health</td>
<td>Link Health and Community</td>
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<td>Bentleigh Bayside Community Health</td>
<td>Macedon Ranges Shire Council</td>
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<tr>
<td>Caulfield Community Health Service</td>
<td>Mallee Track Health &amp; Community Service</td>
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<tr>
<td>Central Bayside Community Health Service</td>
<td>Manningham Community Health Service</td>
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<tr>
<td>Central Goldfields Shire Council</td>
<td>Moorabool Shire Council</td>
</tr>
<tr>
<td>City of Ballarat</td>
<td>Mount Alexander Shire Council</td>
</tr>
<tr>
<td>Cobaw Community Health</td>
<td>Northern District Community Health Service</td>
</tr>
<tr>
<td>Cohealth</td>
<td>Outer Eastern Health &amp; Community Services Alliance</td>
</tr>
<tr>
<td>Department of Health and Human Services</td>
<td>Peninsula Community Health Service</td>
</tr>
<tr>
<td>Dianella Community Health</td>
<td>Shire of Campaspe</td>
</tr>
<tr>
<td>EACH Social and Community Health</td>
<td>Sunbury Community Health</td>
</tr>
<tr>
<td>Gateway Health</td>
<td>West Gippsland Healthcare Group</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction and Background

1.1 The purpose of this paper

Existing research highlights the immense value of Occupational Therapists (OT) in delivering person centred services that promote people’s ability to maximise their independence and remain safely at home and in the community. In particular, the research highlights OT’s unique skills and training in rehabilitation, recovery and enablement, their competency in holistic assessment and goal setting and their knowledge of the medical, physical, emotional and cognitive impacts of illness, disability and injury. These are some of the keys to OT’s success in being able to design and deliver services that are tailored to the needs of individuals to enhance their independence (Francis, Fisher et. al 2011, Rabiee and Glendinning 2011, SCIE 2011, COT 2013).

This paper provides a Victorian perspective on this issue and focuses on OT’s practice with older people. It documents the evolution of OT services in the Victorian HACC sector over recent years and the significant value that OTs add in delivering a broad range of HACC service types. It describes a number of ways that OTs have successfully worked with consumers and other staff to achieve positive outcomes, both for individual clients and by building the capacity of the broader workforce. It also provides a summary of the research that describes the value of OT in wellness, reablement and restorative care for older people, highlighting opportunities for local service providers as we transition to the Commonwealth Home Support Programme (CHSP).

This project commenced in 2015 and utilised a range of strategies to collect and collate the information within this paper. These include:

- a review of best practice guidelines, resources and project reports that have been developed to support good practice in the Victorian HACC sector
- a brief literature review of Australian and International literature about the role of OT in wellness and reablement programs
- group and individual consultations with OT service providers (including OTs, team leaders and program managers) and other key stakeholders (including ASM Industry Consultants, HACC assessment service staff and project workers)
- the development of case studies that celebrate examples of good practice and describe the enablers and barriers of these approaches.

We anticipate that this paper will be useful to strengthen the sector’s understanding of the broad range of ways that OTs can support clients and add value across a range of service types. It is designed to share key learnings from across the State and assist agencies to:

- orient new staff to the role of OTs in community care
- reflect on the strengths of their current practice and opportunities to build on good practice moving forward
- explore opportunities to engage OTs in new and different ways, including opportunities for interdisciplinary and interagency partnership and collaboration
- ensure that the expertise and skills of OTs are being utilised effectively to deliver the best possible services to the community.
1.2 The evolution of the role of OT in the Victorian HACC sector

Occupational therapists assist people to overcome various limitations in order to live more independent lives. Occupational therapists assist HACC-eligible people with activities of daily living, general functioning, mobility, aids and equipment, and home safety and thus support independent living.

Victorian HACC Program Manual 2013 (DH 2013)

Occupational Therapists (OT) play an important role in supporting clients to maintain their independence and improve their health and safety at home and in the community. This can include working with clients and carers to:

- build their confidence and skills to complete everyday tasks as independently as possible
- enhance the safety and usability of their home environment
- create, maintain or rebuild meaningful social connections
- learn new and different ways to complete activities
- access the community / get out and about.

The Victorian HACC program’s Active Service Model (ASM) approach places a strong emphasis on capacity building interventions that promote independence, functional skill development and the importance of social connections to maintain wellness (DH 2013). OT practice is underpinned by a social model of health and recognises the importance of physical, mental and emotional health in supporting people’s wellbeing (COT 2011). The alignment between the principles of ASM and OT practice, places OTs in a strong position to lead work in this space.

As the ASM initiative was introduced in Victoria, the HACC program recognised the value of OTs in delivering an ASM approach and invested significant resources in building the OT workforce. Over the last 5 years, Victoria’s HACC program has therefore invested in building and strengthening the OT workforce. In 2013-14 the budget for Victorian HACC OT services reached more than $35 million, which represents an increase of almost 50%1 since 2010 (DH 2014a). This has resulted in the creation of a number of new OT positions and the introduction of a range of new and innovative service delivery models. Subsequently there has been an increase of over 39% in the number of clients benefitting from OT intervention over the same period2 (DH 2014b).

Opportunities have also been sought to explore how OTs can utilise their skill and expertise to build the capacity of the broader HACC service sector to implement an ASM approach. These have focussed on building strong local partnerships and combining individual assessment and intervention with strategies to build the capacity of the broader HACC workforce to understand the role of OT, identify appropriate referrals, and work collaboratively to deliver appropriate and effective care. Examples include:

- increasing the use of functional assessments, advice and ‘hands on’ training to facilitate independence in Activities of Daily Living (ADLs)
- working collaboratively with clients and council staff (including assessment officers and Community Care Workers [CCW]) to refine goals and develop care plans for clients receiving personal care services including showering and dressing, escorted shopping, food preparation and home care
- working with Allied Health Assistants (AHAs), CCW and volunteers to deliver short term intensive functional skill development programs

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2 In 2010 there were 28,499 Victorian HACC clients receiving OT services compared with 39,627 clients in 2014.
• utilising OT knowledge and skills through secondary consultation, formal and informal case conferencing and education to assist staff to problem solve challenges, and develop innovative solutions to maximise client independence
• facilitating interdisciplinary groups programs to educate and up-skill clients with strategies to support independence in everyday activities.

The demand for OT service though, remains significant. Agencies are therefore encouraged to think creatively and consider innovative ways to make the most of OT resources. This is important to manage the demand for OT services and ensure they are delivering quality services to people who will get the most benefit.

1.3 Moving forward…
transitioning to the CHSP

On the 1st of July 2016, Victorian HACC services for people aged 65 and over transitioned into the Commonwealth Home Support Programme (CHSP). The CHSP provides entry-level maintenance, care, support and respite services for older people living in their own homes, and the community, and their carers (DSS 2015a). The CHSP brings together four programs:

• Commonwealth Home and Community Care (HACC) program
• Planned respite from the National Respite for Carers Program (NRCP)
• Day Therapy Centres (DTC) program
• Assistance with Care and Housing for the Aged (ACHA) program.

The CHSP seeks to “promote each client’s opportunity to maximise their capacity and quality of life” (DSS 2015a p. 14) by delivering services that:

• are client centred and tailored to the unique circumstances and cultural preferences of each client, their family and carers
• are flexible, responsive and build on the strengths, capacity and goals of individuals
• focus on retaining or regaining each client’s functional and psychosocial independence
• optimise consumers choice and encourage clients and carers to be actively involved in addressing their goals.

This approach is consistent with a broader global shift towards person centred approaches across health and aged care policy and practice (WHO 2015a).


The CHSP Programme Manual broadly describes service provision from a wellness, reablement or restorative care approach. In the Programme Manual, the Commonwealth states that while wellness is for everyone, some people will get a reablement service and some will get a restorative care approach (DSS 2015a).
The CHSP Good Practice Guide provides the following definitions:

“**Wellness** is an approach that involves assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourage actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home” (DSS 2015c p.6).

“**Reablement** involves time-limited interventions that are targeted towards a person’s specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities” (DSS 2015c p.8).

“**Restorative care** involves evidence-based interventions by allied health workers that allow a person to make a functional gain or improvement after a setback, or in order to avoid a preventable injury” (DSS 2015c p.9).

The Commonwealth have published a number of resources to support the implementation of the CHSP, including:

- *The CHSP Programme Manual* which outlines the requirements supporting the delivery and management of the CHSP (DSS 2015a).
- The *CHSP Programme Guidelines* which provide an overview of the CHSP and its activities, selection criteria, performance management and reporting. These guidelines form the basis of the business relationship between DSS and CHSP grant recipients (DSS 2015b).
- *Living Well at home: CHSP Good Practice Guide* which is designed to support the take-up of wellness approaches. It is NOT designed to be prescriptive or provide process guidelines (DSS 2015c).

As outlined in the following table, the wellness approach outlined in the CHSP aligns well with the ASM approach currently in place in Victoria and further supports a focus on capacity building, holistic service provision. The Commonwealth and State Governments have reinforced that Victorian HACC providers need to continue implementing their ASM approach. Through the ongoing implementation of ASM, Victorian HACC providers are well placed to transition to the CHSP and adopt the new principles and concepts of wellness, reablement and restorative care.
## Aligning ASM to Wellness and Reablement

**Excerpt from DHHS (2016) Information bulletin aligning ASM to Wellness and Reablement.**

<table>
<thead>
<tr>
<th>CHSP Wellness (CHSP Manual)</th>
<th>HACC ASM (Victorian HACC program manual)</th>
<th>HACC ASM key components (Victorian HACC program manual)</th>
</tr>
</thead>
</table>
| Promote each client's opportunity to maximise their capacity and quality of life through:  
  • being client-centred and providing opportunities for each client to be actively involved in addressing their goals  
  • focusing on retaining or regaining each client's functional and psychosocial independence  
  • building on the strengths, capacity and goals of individuals | People want to remain autonomous.  
People have potential to improve their capacity.  
People's needs should be viewed in a holistic way. | Actively involving clients in setting goals and making decisions about their care |

Provide services tailored to the unique circumstances and cultural preference of each client, their family and carers | HACC services should be organised around the person and family or carer. The person should not be slotted into existing services. | Promoting a wellness or active ageing approach that emphasises optimal physical and mental health of older people (Diversity – inclusive services & practice) |

Ensure choice and flexibility is optimised for each client, their carers and families | People want to remain autonomous.  
People's needs should be viewed in a holistic way. | Providing timely and flexible service provision to support people to reach their goals. |

Emphasise responsive service provision for an agreed time period and with agreed review points | Goal Directed Care planning: progress towards goals is systematically monitored with regular reviews |  |

Support community and civic participation that provide valued roles, a sense of purpose and personal confidence | People's needs should be viewed in a holistic way. | Social activities are based on each person's interests. Care planning should consider functional, social and emotional needs as well as opportunities for meaningful social participation, social connectedness and life enjoyment |

Develop and promote strong partnerships and collaborative working relationships between the person, their carers and family, support workers and grant recipients. | A person's needs are best met where there are strong partnerships and collaborative working relationships between the person, their carers and family, support workers and service providers. | HACC assessment practice and Goal Directed Care Planning. The service should be organised around the person and carer |
Chapter 2: Delivering an ASM approach…
What makes it work?

This chapter provides a summary of participant feedback from the individual and group consultations about the enablers of an ASM approach and links these back to the broader evidence around good practice in wellness and restorative care services. A number of case studies and quotes are also presented to illustrate key points and provide examples of the practices discussed.

During the consultation forums, participants from local government and community health services were asked to reflect on their experience implementing the ASM. They reported that the introduction of ASM (and their participation in a range of projects) had supported them to broaden their scope of practice and utilise their skill set to work in new and different ways. They identified a range of resulting benefits for clients, including that they were better able to address client goals, enhance their independence and work to reduce clients’ ongoing reliance on services. Participants also described benefits in relation to enhancing their own role satisfaction and increasing other staff’s understanding of the broad role of OTs.

Participants were asked to reflect on their current practice and identify the key practices, approaches or strategies that had been most effective in enabling an ASM approach. Three key themes were identified:

- Goal Directed Care Planning (GDCP)
- Working in partnership (with a focus on partnerships and collaboration between Council and Community Health staff)3
- Utilising OTs expertise to build the capacity of the broader workforce to deliver an ASM approach.

“OTs have led the way in delivering ASM. Its bread and butter for OTs and I think a lot of that comes from them being out in the community with people, doing assessments and really getting to know clients. They pick up challenges through conversation and observation and help people figure out solutions that are right for them. We’ve got to stay flexible and let them work this way to make the most of their skills.”

Consultation survey response, Local Government representative

3 Partnerships with a wide range of service types are important to support effective, holistic, person centred care. The consultations held in relation to developing this paper included representatives from Councils and Community Health Services. The value of partnerships between these agencies is therefore highlighted.
2.1 Goal Directed Care Planning (GDCP)

The most commonly identified enabler of an ASM approach was Goal Directed Care Planning (GDCP). GDCP is defined as

“The ongoing process through which staff and clients work together, to collaboratively set goals, establish priorities and develop strategies to achieve positive and meaningful outcomes for clients.”

Pascale 2015

Participants reported that identifying client goals and working collaboratively to develop a care plan had enabled them to deliver individualised care that focusses on each client’s individual priorities.

They highlighted that collaborating with clients about their goals had assisted them to effectively engage clients, harness their motivation and support them to make meaningful changes in their lives. The consultations also identified that GDCP has delivered a range of benefits for staff. Having clear information about client goals has allowed clinicians, assessment officers and CCW to make effective use of their time, communicate effectively with other team members and ultimately, enhance their role satisfaction.

Participants felt that the full benefits of this approach can only be achieved after a comprehensive assessment and that it is important to ensure that service providers continue to work collaboratively with each person to set goals and develop a GDCP. The group also identified the importance of clarifying the roles and responsibilities of staff in developing, refining and maintaining GDCP.

There is strong evidence that supports the importance of holistic, strengths based assessments to facilitate effective GDCP and this approach is reinforced in the CHSP Good Practice Guide and the My Aged Care National Screening and Assessment Form (NSAF) User Guide (Hammond 2010, Hirst, Lane et. al. 2011, Resiliency Initiatives 2013, DSS 2015c, DSS 2015d).
A new care planning approach

cosheath

cosheath have implemented a whole of organisation strategy to embed person centred, goal directed care planning across all cosheath services. This has included a comprehensive review of their organisational systems, policies and processes, community consultations (codesign), ongoing training for all service delivery staff and the development of a range of tools and resources to support implementation.

Within the Occupational Therapy team, clinicians felt confident in their ability to set goals and develop plans for their clients, but raised concerns about how to integrate GDCP into existing appointment times, particularly when they also needed to complete a comprehensive initial assessment. The OTs were therefore encouraged to utilise the GDCP to guide their initial assessments, rather than completing their traditional assessment form for every client.

Providing the OTs permission to work in this way, has empowered them to use their clinical reasoning and created space to focus on what is most important to each consumer.

The OTs are experienced clinicians and are supported to use their professional judgement to conduct meaningful assessments. Of course, when the OTs identify areas of concern, they continue to provide clinical recommendations and document outcomes within their progress notes. They also provide clients with education about the role of OT and potential triggers for future referrals.

This approach has delivered great results. The OT team has received positive feedback from their clients and the new GDCP has been one of the strategies that have assisted to reduce the waiting list from around 100 to 20 clients. The OTs feel confident that they are utilising their skills and expertise and delivering more individualised, person centred intervention. They have also been able to embed the new GDCP approach without placing additional burden on staff.
GDCP is identified within policy and best practice literature as a fundamental component of person centred service delivery. It empowers clients to be actively engaged in making decisions about their care, facilitates collaboration and ensures that services are tailored to meet the individual needs and priorities of clients (Sanderson 2000, Glendinning, Jones et. al. 2010, Robertson, Emerson et. al. 2010, DH 2011).

Within the CHSP, GDCP is named ‘support planning’ and is described in the CHSP Good Practice Guide as a core component of care. Specific practice standards related to GDCP are also embedded within the Home Care Standards (HCS)4 (DOHA 2010).

Participants identified the importance of training staff and receiving support from management to adopt and embed effective GDCP practice. This is supported by existing evidence that demonstrates that embedding effective GDCP requires a multifactorial approach including:

- staff with the skills and confidence to actively engage consumers in the GDCP process and create care plans that are meaningful and useful
- engagement of staff across the organisation to implement a consistent, team approach
- appropriate tools and templates that enable staff to document the information required efficiently and effectively
- supportive organisational systems, policies and procedures
- opportunities for ongoing learning and support

(Sanderson and Smull 2010, Cook and Miller 2012, Pascale 2015, NDS 2014).

A number of forum participants also identified the value of shared care planning across local networks to reduce duplication, improve communication and support collaboration between agencies. Electronic care planning tools (e.g. e-care planning tools embedded in online applications) were identified as particularly useful, but needed to be supported by shared training, clear processes and a formal agreement between agencies about their application.

### 2.2 Working in partnership

Throughout the consultations, participants described the importance of working collaboratively and building strong relationships within and between local service providers to deliver effective, coordinated care. The group discussed a number of strategies that have supported effective collaboration. These included:

- case conferencing
- joint assessments
- secondary consultation
- colocation of staff
- clear referral pathways and processes
- interagency working groups / projects
- formal and informal networking opportunities
- shared training / professional development.

These strategies have created a range of benefits for clients, staff and organisations. Staff reported that their partnerships had provided them with a much better understanding of each other’s roles, facilitated better communication and information sharing. By developing or strengthening their working relationships, staff became more confident to reach out to each other and share their knowledge. For some participants, this has also resulted in increases in both the quality and quantity of interagency referrals. For clients and carers, participants identified that working in partnership has resulted in reduced barriers to access, minimised duplication and staff working together to identify and implement a range of creative service solutions to achieve their client’s goals.

“Since ASM was introduced, we’ve learned to work together and that’s been central to our success. Breaking down the silos has been important. We need to work with our clients as one big team – that’s the only way to get great outcomes for our clients, and it makes all of our jobs so much easier.”

Case study participant, OT Service Provider

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4 Standards related to GDCP are HCS Expected Outcomes 2.2, 2.3 & 2.4 (DOHA 2010)
Following the introduction of the ASM, a range of projects were established that focussed on supporting partnerships between local HACC providers. While the benefits of working together were reinforced, a number of projects also emphasised the need to dedicate time and resources to building partnerships, the importance of management support and clear structures and processes that supported staff to work collaboratively (HealthWest 2013, Cairns 2014, Gretgrix 2014).

These findings were reinforced in the consultations. In particular, staff discussed the importance of a whole team approach and remaining flexible, so that partnership arrangements could evolve and change over time to meet the needs of clients and staff. For example, a number of participants had been involved in colocation projects, where OTs spent time each week based in a Council. While this had been beneficial for staff to establish relationships, understand each other’s roles and communicate more effectively, a number of staff reported that once these relationships had been established, the need to be located in the same space lessened. Instead, they were able to collaborate effectively via informal consultation, regular meetings and streamlined referral pathways.

The work that has taken place through a range of ASM projects has also highlighted the important role that assessment services play in linking clients into OT services at the right time and making the most of the services that are available. This includes:

- ensuring that assessment staff understand the broad scope of the role of HACC OTs so they can make appropriate referrals
- OTs working collaboratively with clients, assessment officers, CCW and other Council staff to design and deliver personalised service options across a range of service types (including personal care, home care and respite).

Given that the consultations included staff from OT service providers and Local Government, it is not surprising that the importance of partnerships between Councils and Community Health Services were highlighted. A number of participants did highlight the benefits of collaborating with a range of service providers (e.g. other HACC service providers, acute and subacute health services, GPs, Planned Activity Groups [PAG]).

“Co-locating with assessment staff and doing joint assessments were really useful initially to help us get to know each other. We also provided education to outlying assessment officers who missed out on informal office discussions. It’s been essential to be flexible though, so that we could make changes and respond to barriers or suggestions as they came to light.

As the assessment officers have developed a better understanding of the role of an OT, we’ve found that the information provided in referrals is more relevant. We’ve also been able to support our referrals with better verbal communication between agencies. This has been helpful to brainstorm potential referrals and to reduce the duplication of assessment when we see new clients.

Support from managers in both organisations has been key. It takes time to develop relationships and processes to support us working together. You can’t just jump into client work without spending time building the actual partnership. If I was starting a new partnership, the first thing I would do is have management from both agencies meet and develop a working relationship and a broad agreement about how it will work.”

Case study participant, OT Service Provider
Working in Partnership

Goulburn Valley Health

The Goulburn Valley Health Rural Allied Health Team (RAHT) developed partnerships with the four HACC Assessment Services (HAS) in our catchment area (Greater Shepparton City Council, Moira Healthcare Alliance, Strathbogie Shire and Rumbalara Aged and Disability Service).

One of the first priorities was to invest time in building the relationships with each service. Each partnership involved all Allied Health disciplines, however the approach taken with each HAS was different, depending on the service needs and proximity/geographical location. In addition to offering networking and joint client collaboration opportunities for staff, ensuring there was support and commitment from management was important. It was acknowledged that establishing the partnerships would take time. Integral to the initial success was identifying “champions” in each team who supported the partnership and ASM philosophy. The champions helped to support and engage fellow team members and work through any challenges. As staff members developed working relationships, trust and knowledge of each other’s roles, agencies worked together to develop and implement the systems and processes required to support a partnership approach. The DHHS, Hume Region worked closely with the service involved. They considered the time clinicians spent in establishing the partnerships when reviewing the data reporting results, acknowledging the wider benefits in addressing the care needs of our consumers.

While co-location was an important part of the initial approach, as the partnerships developed, the physical location of staff became less important. Spending time with key people in other services remains an important part of induction processes and this has been valuable to maintain a collaborative approach. Co-location has largely been replaced with regular and planned case discussions between services and opportunities for secondary consultation. In addition management meetings are undertaken to ensure a cohesive approach is maintained within the varying priorities, processes and requirements of each organisation.

Since developing the partnerships, staff have developed a much greater understanding of each other’s roles and are more confident to talk to clients (and other staff) about the services that can be provided to support our consumers to meet their goals.

The RAHT also developed a referral guideline which outlined the potential reasons for referral and information required to assist in accurately triaging referrals. Team members have found that HAS are calling more frequently to seek secondary consultation regarding referrals, early intervention strategies and to generally problem solve and seek advice to enhance client care. The quality of referrals has improved and there has been a reduction in duplication of assessment for both clients and staff. Furthermore the number of referrals from HAS to the RAHT noticeably increased from 2% of RAHT referrals in 2006/7 up to 17% in 2014/15 and has been as high as 35% in 2010/11.

Now that working relationships have been established at both staff and management levels, agency protocols have been developed with a number of the HAS services in our catchment area. This has been effective to describe and further embed the partnership approach by detailing the relevant systems and practices and reiterating the commitment and responsibilities of each service.

Working together is now embedded in our philosophy across all services. Therefore rather than having dedicated partnership positions, everyone is involved.
Independent Living Group

Knox Social and Community Health (KSCH)

The Occupational Therapists (OTs) at KSCH continue to run the Independent Living Group for clients who are completing their daily activities and would like to develop skills/techniques to complete these tasks safely and independently. The group runs over 6 weekly sessions and includes 15-18 clients. Each session includes an educational talk, practical ‘hands on’ circuit, tea and coffee, time for a chat and questions. Each week, we focus on a different topic, including joint protection, energy conservation, back care, vision, falls prevention, home safety and considerations for the future.

The program is run by 4 staff, including OTs from KSCH and Knox City Council, Allied Health Assistants and volunteers. A physiotherapist is also involved in developing and reviewing the exercise component of the program.

The aim of the program is to allow clients the opportunity to trial assistive aids and learn tips about how they can manage everyday activities more independently (and potentially use less services).

For many clients, participating in the group gives them a chance to recognise they’re not alone. They support each other, share ideas and help each other problem solve. This builds their confidence and provides them with new skills.

This group has been a great supplement to our existing OT services. We’ve been able to offer people, who would not have been a priority for our standard OT service, a place in the group and channel a number of referrals to the group, rather than completing one-on-one assessments. This has allowed us to address unmet needs and deliver broader services to our clients.

We now run the group 4 times a year and it is regularly booked out each term. We continue to adapt the group to tailor the program to what people need and want. We have had excellent feedback from clients who have completed this program.
The CHSP Programme manual and Good Practice Guide emphasise a partnership approach as a key element of practice for all service providers. Working in partnership is therefore identified as one of the key service delivery principles:

“Develop and promote strong partnerships and collaborative working relationships between the person, their carers and family, support workers and grant recipients.”


The CHSP Programme Guidelines state that grant recipients are responsible for ensuring they “work collaboratively to deliver services” (DSS 2015a p.86). Working in partnership with clients, staff and other service providers is also identified as a key enabler of good practice in a range of examples outlined in the Good Practice Guide (DSS 2015c). Moving forward, it will be important that agencies continue working in partnership and that systems are in place that recognise and support them to work together effectively and efficiently.

2.3 Utilising OTs expertise to build the capacity of the broader workforce

Utilising a collaborative, holistic and strengths based approach to enable people’s independence is fundamental to OT practice (WFOT 2010, Layton, Clarke et. al. 2014). A number of studies have been completed that highlight the importance of OTs in delivering ASM, wellness and reablement approaches. They reinforce that OTs holistic understanding of the broad determinants of health and wellbeing and their innovative approach to facilitating independence, places them in a strong position to support clients directly and indirectly achieve positive outcomes (Steultjens, Dekker et. al. 2004, COT 2011, SCIE 2011). The role of OTs as a resource to support and up-skill the broader workforce (e.g. CCW, assessment officers and other health professionals) has been identified as a key enabler of success in reablement programs (BAOT 2008, Ryburn, Wells et. al. 2009, Rabiee and Glendinning 2011). The consultations highlighted that maximising the value of OTs expertise was not only dependent on OTs themselves, but on the entire HACC workforce understanding the broad role of OTs so that they could make appropriate referrals.

“We were really enthusiastic about having an OT join our team, but we didn’t realise the extent of their knowledge and skills so the role has really grown over the last couple of years and the OT has brought so much more to the team than we anticipated.

Initially we thought OTs just focussed on providing equipment, rails and ramps and we had no idea that they look at things like cooking, shopping and socialisation.

I’ve learned that OT’s actually have enormous expertise and knowledge of health conditions and think about all of the aspects that impact on a person’s function and independence. They look at a person’s whole lifestyle – the OT thinks about how someone is living and how they can improve that.

Our OT talks to people about a wide range of issues, like how eating well affects their health, teaches people about different ways to get their clothes on and off and access the community. She also helps us find different ways to work with people so that we can keep our clients and the Community Care Workers safe. This has meant that we’ve been able to continue providing services to some clients that previously we would have considered to have care needs that were too high to be managed within HACC services.

She is always coming up with new ideas and constantly surprising us with her range of skills. Having an OT join our team has been incredibly valuable for our clients and for our staff.”

Case study participant, OT Service Provider (OT in Council)
Across the Victorian HACC sector, there is significant demand for OT resources and in many services, this is associated with long waiting lists for OT assessment. In order to make efficient use of limited OT resources, opportunities to engage OT skills beyond individual assessments and intervention have been explored. Examples include:

- OTs delivering education and capacity building programs for staff (including assessment officers, CCW, PAG staff and other allied health professionals)
- secondary consultations
- joint assessments (e.g. with assessment officers and other Allied Health professionals)
- OTs developing functional skill development programs that could be carried out by other staff (such as CCW or Allied Health Assistants).

By accessing OT support via secondary consultation, informal discussion and problem solving, staff had been able to deliver a range of services in flexible and innovative ways to assist clients and carers maintain their independence and safety at home and in the community. They noted that the introduction of the ASM had been the driver for many agencies to explore new ways of working, in an environment where capacity building activities and partnerships were actively supported within the HACC program.

Throughout the consultations, the participants identified these capacity building initiatives as important enablers of an ASM approach across a range of activities. Some of the key benefits included:

- staff (including assessment officers and CCWs) having a better understanding of the role of OTs and broadening the scope of referrals to OTs (moving away from referrals that relate only to home safety assessments and equipment provision)
- CCWs initiating referrals (usually by providing feedback to assessment officers) to support client independence in a range of personal, domestic and community activities
- OTs working collaboratively with Council and Community Health staff
- CCWs having a better understanding of an ASM approach and opportunities to facilitate client independence (e.g. by adopting a ‘doing with not for’ approach and identifying opportunities to utilise simple aids and equipment)
- creating opportunities for formal and informal communication between OTs, assessment officers and CCWs to discuss challenges, brainstorm ideas and discuss potential referrals.
Supporting older people living well at home…Understanding the role of OT

Eastern Region OT in Council Projects

Knox, Maroondah, Monash and Whitehorse City Councils

In Melbourne’s Eastern Metropolitan Region (EMR), OTs were employed in 4 local Councils to work with local residents who receive, or require, other Council services (such as showering or domestic assistance). These pilot projects were established to improve access to OT services for local HACC eligible people and facilitate timely intervention and support thus enhancing reablement opportunities.

The OTs work with clients and carers to assist them stay at home safely, remain active and do as much for themselves as possible. The OTs also work with council staff including assessment officers, Community Care Workers (CCW) and social support staff to build their capacity to adopt an ASM / wellness approach. They have approached this in a whole range of ways, including:

- Working collaboratively with clients and staff to design and implement care plans that are designed to maximise people’s independence and participation in daily activities (e.g. CCW working alongside clients to prepare meals, rather than utilising delivered meals services).
- Developing functional skill development or retraining programs that focus on building the client’s skill, confidence or capacity (delivering a reablement approach).
- Providing advice and/or training to carers, CCW and other staff about manual handling and strategies to assist in safe client care.
- Rolling out the Enabling the use of Easy Living Equipment in everyday activities project to Council staff and clients.
- Working together to develop resources for clients and staff (e.g. OT in Council service brochures and energy conservation resources).
- Working with staff and clients within local Planned Activity Groups (PAG) and social support services to ensure that programs are set up to meet the needs of individual clients and that staff have the skills and knowledge to deliver care confidently and competently. The OTs have also been able to reduce manual handling risks for PAG staff and increase their understanding of Allied Health services, so that appropriate referrals can be made.

Since having an OT within their team, Council assessment officers and Community Care Workers now have a better understanding of the role of OT and are referring a broad range of clients, who previously weren’t accessing OT services.

The Council OTs are therefore working with a different group of HACC eligible clients and addressing a previously unmet need. The capacity building work that the OTs have done with Council staff has also provided a range of other benefits, ensuring that the entire team is better placed to deliver an enabling approach and support the independence and safety of clients accessing Council services.

“The OT has been instrumental in helping Council staff to understand the ASM and adopt a person centred with all of our clients. The OT has opened staff’s eyes to all new opportunities and is a great source of information and ideas for the whole team.”
More than just OH&S

Maryborough District Health Service

Brenda had a stroke 20 years ago, resulting in total weakness on the left side of her body and reduced vision of her left side. She lives independently in her own unit and receives support from Community Care Workers (CCW) for personal care, shopping assistance and to complete a home exercise program prescribed by her physiotherapist. Brenda is surrounded by supportive family and friends, who also assist her.

Brenda's workers raised concerns about how to safely assist her while transferring on and off furniture and her wheelchair. The OT was called in to address this Occupational Health and Safety (OH&S) issue. The OT provided education to the workers and developed tip sheets to be kept in Brenda's home.

The OT also identified that Brenda had been using a manual wheelchair to go to the shops. The uneven terrain raised some concerns about the workers safety while pushing the wheelchair. Brenda agreed to trial an electric wheelchair. Over 3 months, the OT trained Brenda to use the electric wheelchair and Brenda found it provided some real benefits in relation to her being able to go to the bank and post office, go out for a coffee and select groceries herself, rather than having to rely on others to do her shopping for her. Her vision loss remained a problem however, for her to be able to safely operate the electric wheelchair alone in the community.

The OT and Brenda agreed that the best option would be to teach the workers to be able to supervise Brenda so that she would be safe and retain her independence in the community.

The OT set up a training session with 9 CCW. Brenda put on an afternoon tea for everyone before she and the OT taught each worker how to use the wheelchair and provide supervision.

While the original OT referral had been to address a specific OH&S issue for workers, the OT was able to use their broad skill set to consider opportunities to promote Brenda's independence and address the safety of the client and staff in the community.

This has been a great success and has allowed Brenda to take control of her community activities, despite declining health over recent months. The OT worked with Brenda's strengths, Brenda was actively involved in making decisions about what was right for her and took pride in hosting the training session. Brenda and her workers have subsequently called in the OT to assist with a range of other issues and they continue to work together to find ways to maximise her independence at home.
Maximising independence with Easy Living Equipment

Knox City Council
Josie is a 79 year old lady that lives alone. She has severe lower back pain and receives home help and personal care assistance to attend to her feet and back when showering.

Her support worker noted that Josie had difficulty reaching her feet, which made it difficult for her to independently wash herself in the shower, dry herself and put on her socks and shoes. This prompted the support worker to refer Josie to our Easy Living Equipment program, which includes having a specially trained support worker visit the client at home to provide education and training around the use of readily available, non-complex aides and equipment.

The support worker recommended trying a pick up stick, long handled toe washer/dryer, sock donner, and long handled shoe horn. The support worker also recommended and provided education to Josie about the use of a long handled sponge to promote independence when showering. Josie decided to purchase the aids, which are invoiced via the monthly invoice system.

The OT checked in with Josie 4 weeks after she’d received the equipment.

With her long handled aids, Josie is now able to wash and dry her feet and put on her shoes and socks independently. Josie reported that she no longer required a support worker to assist with her personal care needs.
Fit 4 you – Volunteer Sewing Program

Maroondah City Council

There are so many simple and inexpensive modifications that can make fashionable clothes more comfortable and functional and household tasks easier. Unfortunately, many people just aren’t aware of how easy some of the solutions can be. Maroondah City Council have therefore established the Fit 4 You program, which customises clothes and linen and sews customised aids that can improve people’s independence and make everyday tasks easier. This can include:

- replacing buttons with Velcro, modifying bras, adding grab loops to the waistband of pants or a fabric loop to a zipper to make it easier to get clothes on and off
- modifying clothes so they’re more comfortable, sit neatly and allow easier movement in a wheelchair (e.g. by creating a split in the sides of tops or attaching shirts to pants so they don’t ride up)
- elasticising pants at the ankle or incorporating an inner pocket to keep catheter bags or tubes tucked in and out of sight
- sewing inexpensive long handled aids to make washing and drying feet easier
- adding loops or hooks to tea towels so they don’t fall to the floor
- modifying bedsheets to make changing and making the bed easier and stop bedding becoming tangled or sliding off during the night (e.g. fitted or clip on top sheets).

Every client receives a customised solution that’s right for them.

Fit 4 you is available to HACC eligible people living in the City of Maroondah. OT’s from the Council and the local Community Health Service work with each client to identify an appropriate solution that is then sewn by the volunteer. Clients are charged for the cost of materials (which is usually around $3 per item) and are invited to contribute a gold coin donation. The OT works with the client, their family and carers to teach them how to use the modified aid.

These simple adaptations can make a real difference to people’s day to day lives, allowing them to overcome challenges and maximise their independence. For many people, looking good is an important part of feeling good. Modifying clothing can provide people with more clothing options, reduce their dependence on services (e.g. if they receive personal care because they’re unable to do up their buttons or bras or reach down to wash and dry their feet safely) and genuinely improve people’s self-esteem. From a service perspective, the program is very cost effective and has the potential to reduce some clients’ need for ongoing services or enable clients to use their services in new and different ways.
Carer Support Group

Mallee Track Health & Community Service

Our carer support group is open to anyone in the local community who cares for a loved one. Many of the carers who attend are caring for a parent or spouse.

Each month, we focus on a different topic. The carers are involved in planning each session, so the topics reflect what’s most important to the participants. Recent topics have included Alzheimer’s disease, continence and falls prevention. We invite guest speakers to come in, but also encourage the carers to share their ideas and experiences.

The group is scheduled at the same time as our Planned Activity Group (PAG) so that clients can access respite via the PAG group while their carer attends the group. We also have a strong working relationship with our local Carer Support Service, so clients can also access in-home respite if necessary.

One of the key benefits of the group has been bringing carers together to support each other through their caring journey. Many carers share similar experiences of grief and loss and face common challenges around navigating the service system and negotiating their carer roles. The group provides them with an important opportunity to come together with people that understand their experience and share their stories. We also link carers in to other services and supports as required and encourage them to be actively involved in making decisions about what’s right for them.

Over time, it has become evident that it is important to have a facilitator that is skilled in group interactions and therapeutic interventions leading the group. The group also acts as therapeutic group undertaking stress management techniques and self care discussions. It is about working with carers to build their resilience. Many of the carers are caring for someone with reducing functional ability, so the group provides an opportunity to monitor other physical and support needs and be proactive with referrals to services. We see much less crisis respite needed when people feel supported and linked into services.

We can talk to carers to see how they are going and how they are looking after themselves, supporting them to continue to do their caring role. Every situation is different which is where the problem solving expertise of OT comes in. This is core OT practice – taking a very person centred approach and focusing on building the capacity of carers is really important. Having an OT lead the group has been really effective and we receive great feedback from our participants.

Supporting carers is an important part of our role in the community and OTs have an enormous amount of expertise to really make a difference to this important group.
Chapter 3: Maximising the value of OT services in the CHSP

After considering the current role of OTs in the Victorian HACC sector, the consultations sought to explore participants’ perceptions of the role of OTs in the CHSP. Forum participants reported that the concept of wellness, as a philosophy that underpins all service delivery, was consistent with their current practice and aligned well with an ASM approach. Wellness as a philosophy describes the way that staff adopt a person centred approach in their work with all clients and carers. That is, staff complete a holistic, strengths based assessment and work collaboratively with clients and carers to design and deliver services that are responsive to their individual circumstances, needs, priorities and goals. All clients and carers are supported to set their own goals and empowered to be actively involved in making decisions about their care (regardless of their current level of function, diagnosis or prognosis). This is consistent with the way that a wellness approach is described within the CHSP programme manual (DSS 2015a p.18).

Participants were also asked to reflect on how the value of the OT role could be maintained and supported through transition to the CHSP. Participants highlighted that maintaining a holistic approach to assessment and service delivery was integral to achieving this. That included that OTs:

- are supported to deliver interventions across the continuum of care (prevention and wellness through to restorative care)
- continue to work in partnership with others (to support service delivery for individual clients and to promote good practice more broadly)
- receive referrals from My Aged Care for an OT assessment, rather than a particular intervention (i.e. rather than the OT being sent a referral for a rail at the front entrance, the OT needs to be able to complete a holistic assessment to explore a range of issues that may impact on the client and carers health, wellbeing and quality of life).

“One of the benefits of us working with OTs has been that they have been able to work with clients on a whole range of issues … far beyond what the original referral was for. Often we identify an immediate safety issue, but the OT can work with the person to come up with completely different ways to approach an activity. Rather than delivering meals for the rest of someone’s life, sometimes they can set up the kitchen differently or shop with someone and then the person can stay independent. That helps them stay in charge of their own life, but it also means that we’re not putting in unnecessary services forever.”

Consultation survey response, Local Government representative

“OT is all about working with people as individuals…very few of our referrals actually cover the scope of work that the OTs end up doing with clients. Being able to make the most of our OT’s skills is about building rapport and helping clients and carers think differently about a whole range of Activities of Daily Living (ADLs). We might get a referral for a rail in the toilet and end up discussing social engagement, community access and gardening. Sometimes it all happens at once and sometimes it happens over time – you can only plant the seeds and then let the client take the lead about what they’re ready to address.”

Consultation survey response, OT service provider
OT involvement can be a key enabler of an ASM / wellness approach across a range of service types. The table below includes examples of how an OT can provide support to clients and carers across a range of service types. This list is not exhaustive, but along with the case studies included throughout this paper, should provide an indication of the breadth of the role of OTs in the community.

<table>
<thead>
<tr>
<th>CHSP Service Type</th>
<th>Potential OT interventions</th>
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<tbody>
<tr>
<td>Personal Care</td>
<td>Provide education to client, carer and/or CCW to maximise safety and independence during personal care activities such as showering, dressing, toileting, eating and medication management.</td>
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<td></td>
<td>Assess safety of home environment and recommend aids, equipment and/or modifications.</td>
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<td></td>
<td>Educate CCW about simple aids and equipment that could be trialed with individual clients as appropriate (as per the <em>Enabling the use of Easy Living Equipment in everyday activities</em> project).</td>
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<td></td>
<td>Implement falls prevention strategies and advice to enhance mobility and safety moving in and around the home.</td>
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<tr>
<td>Domestic Assistance</td>
<td>Provide advice, information and ideas about how to improve safety and independence in a range of home care tasks such as cleaning, making beds and laundry. This may include providing education to the client, carer or CCW about:</td>
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<td></td>
<td>• energy conservation strategies</td>
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<td></td>
<td>• strategies to assist with declining memory, planning and other cognitive issues</td>
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<td></td>
<td>• falls prevention and safe mobility during tasks.</td>
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<tr>
<td>Other Food Services</td>
<td>Provide advice and education to enhance the client’s knowledge, skill, confidence and safety to prepare meals. This may include:</td>
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<td></td>
<td>• reviewing kitchen set up</td>
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<td></td>
<td>• discussing meal planning and preparation strategies</td>
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<td></td>
<td>• recommending modified utensils and/or aids to promote independence and safety.</td>
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<tr>
<td>Social Support (Individual and Group)</td>
<td>Work with carers and CCW to identify ways to engage the client in appropriate and meaningful activities.</td>
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<td></td>
<td>Recommend opportunities to modify activities and/or environment to maximise client participation (e.g. by setting up activities in different ways, reviewing where and how the client is positioned etc.).</td>
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<td></td>
<td>Provide education to clients, staff and volunteers about safe vehicle transfers and community access strategies.</td>
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<td></td>
<td>Enable clients to participate effectively in shopping (e.g. by providing advice about how to effectively plan their shopping list, mobilise safely in the community and ways that carers can maximise client independence and safety).</td>
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<tr>
<td>CHSP Service Type</td>
<td>Potential OT interventions</td>
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<tr>
<td>Home Maintenance and Modifications</td>
<td>Complete a home assessment and make recommendations regarding home maintenance and/or modifications to increase or maintain the client’s independence, safety, accessibility and wellbeing. This may include recommendations about:</td>
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<td>• installing rails, ramps and other aids</td>
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<td>• modifying steps, pathways and access points</td>
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<td></td>
<td>• minimising trip and fall hazards.</td>
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<td>• re-hanging or removing doors, repairing pathways etc. to improve access</td>
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<td></td>
<td>• re-organising bathroom, kitchen or work areas</td>
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<td></td>
<td>• re-designing low maintenance gardens (e.g. raised garden beds).</td>
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<tr>
<td>Nursing, Allied Health &amp; Therapy Services</td>
<td>Work collaboratively with nurses and other Allied Health clinicians to identify and implement strategies to increase or maintain the client’s safety, independence and participation in meaningful activities.</td>
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<td></td>
<td>This may include, working together to enable clients in relation to:</td>
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<td>• medication management</td>
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<td>• personal care</td>
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<td>• pain management</td>
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<td></td>
<td>• behaviour management</td>
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<td></td>
<td>• nutrition, eating and meal preparation.</td>
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Chapter 4: Conclusion

As described throughout this paper, the sector consultations, and published literature reiterate the importance of the role of OTs in delivering an ASM / wellness, reablement and restorative approach and the value that OTs can add through both direct assessment and intervention and through their work with the broader workforce.

Key benefits of OT involvement were identified as their ability to complete a holistic assessment, identify opportunities to facilitate independence across a broad range of activities and deliver care that can address specific challenges, reduce existing risks and/or proactively address potential challenges. This provides immediate benefits to the client but also ensures efficient use of resources across a range of service types.

The forum participants advocated very strongly that OTs play an important role across the continuum of wellness, reablement and restorative care. The participants felt that optimising these benefits was reliant on OTs being able to complete a holistic assessment and care planning process with each client and remaining responsive to their changing needs over time. Throughout the consultation forums and case studies, participants emphasised that a person centred (ASM or wellness) approach requires staff to remain responsive to changing needs, flexible and focus on client goals. This is also identified as one of the key enablers of effective reablement services that has a significant impact on client’s satisfaction and outcomes (Glendinning, Jones et. al. 2010, Mishra and Rostgaard 2015).

The consultations also highlighted that successful outcomes are dependent on the broader workforce understanding the role of OT, local agencies working together and a commitment to ongoing learning and system development on everyone’s part. The strengths of existing local partnerships need to be maintained and supported. It will also be important for agencies to consider building new relationships and maintaining effective communication with My Aged Care, Regional Assessment Services and service providers.

Agencies are now thinking about the impact of transition on the way they deliver services. The State and Commonwealth have provided a strong message to the Victorian HACC sector about the alignment between ASM and a wellness, reablement and restorative approach and reiterated the importance of continuing their work in this space. The consultations have also highlighted the need for agencies to recognise their skills and ensure that good practice drives the system, rather than the system driving practice. The aged care sector is working towards creating systems that support clients to be empowered, health literate and able to make informed choices about their care. During the transition process (2016-19), agencies have an opportunity to reflect on the strengths of their current practice, generate evidence of the importance of these approaches and the difference this makes (for consumers, staff, agencies, partnerships) to achieve these objectives.

To support this, agencies are encouraged to focus on ensuring that staff understand that wellness, reablement and restorative care is not a new approach, but rather provides new language to support holistic, person centred care as described in the ASM.
Useful resources

**Occupational Therapy explained**


World Federation of Occupational Therapists: http://www.wfot.org/

The College of Occupational Therapists have developed a range of leaflets that explain how OT can assist people get the most from life: https://www.cot.co.uk/leaflets/leaflets. Of particular interest may be:

- **Occupational Therapy, Helping you live life your way**: https://www.cot.co.uk/sites/default/files/marketing_materials/public/what-is-ot-leaflet.pdf
- **Occupational Therapy and Dementia**: https://www.cot.co.uk/sites/default/files/marketing_materials/public/Helping-people-to-live-with-dementia.pdf

**Commonwealth Home Support Programme**

The Commonwealth have published a number of resources to support the implementation of the CHSP. These are available from the Australian Government’s Ageing and Aged Care website at: https://agedcare.health.gov.au/programs/commonwealth-home-support-programme/resources

Key resources include:

- Department of Social Services (2015) The CHSP Programme Guidelines
- Department of Social Services (2015) Living Well at home: CHSP Good Practice Guide


**Reablement**

The following agencies have published a range of resources that describe the reablement approach and strategies to support its implementation:

- Social Care Institute of Excellence (SCIE) http://www.scie.org.uk/atoz/?f_az_subject_thesaurus_terms_s=reablement&st=atoz


**Occupational Therapy in wellness and reablement services**


**Person Centred Care**

The following websites include a range of resources about person centred approaches:

- The Picker Institute: http://cgp.pickerinstitute.org/?page_id=1319
- Helen Sanderson and Associates: http://helensandersonassociates.co.uk/
- The Learning Community for Person Centered Practices: http://www.learningcommunity.us/


Helen Sanderson and Associates *Person centred thinking and planning.* Available at: http://www.learningcommunity.us/documents/pctandplanning.pdf


**Person centred assessment and Goal Directed Care Planning**


Manningham Community Health Service (2014) *Orientation to Healthy Ageing Principles for Allied Health Staff.* Available at: http://www.emralliance.org/orientation-to-healthy-ageing-principles-for-allied-health.html

**Working in partnership**

The following websites include a range of toolkits, case studies, research articles and guides to support effective partnership work.

- The Partnering initiative: http://thepartneringinitiative.org/publications/
- Big Lottery Fund (UK): https://www.biglotteryfund.org.uk/research/making-the-most-of-funding/partnership-working
References


NDS (2014). Progress for Providers - Checking your progress in using person-centred approaches (Managers) National Disability Services (NDS) and Helen Sanderson Associates (Australia) on behalf of NSW Industry Development Fund. Sydney, NSW Department of Family and Community Services, Ageing Disability and Home Care.


### Appendix 1: Sector consultation forums – Combined attendance lists

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
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</thead>
<tbody>
<tr>
<td>Adrienne Doherty</td>
<td>OT</td>
<td>Ballarat Health Services</td>
</tr>
<tr>
<td>Anna Dimmer</td>
<td>Team Leader, Community Care</td>
<td>Inner East CHS</td>
</tr>
<tr>
<td>Annalee Gardam</td>
<td>Acting Allied Health Manager / OT</td>
<td>Gateway Health</td>
</tr>
<tr>
<td>Bec Porter</td>
<td>Senior Clinician / OT</td>
<td>Bentleigh Bayside Community Health</td>
</tr>
<tr>
<td>Beth Dawson</td>
<td>ASM Industry Consultant (Hume Region)</td>
<td>DHHS</td>
</tr>
<tr>
<td>Carolyn Bolton</td>
<td>ASM Industry Consultant (North West Metro Region)</td>
<td>Hume Whittlesea PCP</td>
</tr>
<tr>
<td>Debra Starr</td>
<td>Integrated Services and Planning Manager</td>
<td>Central Bayside CHS</td>
</tr>
<tr>
<td>Emily West</td>
<td>Team Leader, Adult Health</td>
<td>Caulfield CHS</td>
</tr>
<tr>
<td>Fay Wallis</td>
<td>Senior OT, Rural Health Team</td>
<td>Bendigo Health</td>
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<td>Faye Ennor-Severs</td>
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<tr>
<td>Glenn Becher</td>
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<td>Bairnsdale Regional Health Service</td>
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<td>Guy Walter</td>
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<td>Hannah Austin</td>
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<tr>
<td>Heather Russell</td>
<td>Manager HACC Service Development</td>
<td>DHHS</td>
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<tr>
<td>Jenelle Gannon</td>
<td>Manager – Rural Allied Health Team</td>
<td>Goulburn Valley Health</td>
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<tr>
<td>Jennifer Ebdon</td>
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<td>Jerri Nelson</td>
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<tr>
<td>Kate Palmer</td>
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<td>West Gippsland Healthcare Group</td>
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<td>Lisa Dean</td>
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<td>EACH Social and Community Health</td>
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<tr>
<td>Lisa Manser</td>
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<td>Lyndal Munro</td>
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<tr>
<td>Mina Stevenson</td>
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<td>Naomi Lowen</td>
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<tr>
<td>Oliver Romanes</td>
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<td>Peta Woolard</td>
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<tr>
<td>Rachael Vaccaro</td>
<td>OT (Strengthening Life Skills Program)</td>
<td>Ballarat Health Services</td>
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<td>Renee Arnott</td>
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<td>Richard Adams</td>
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<td>Robert Haughton</td>
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<td>Robyn Salt</td>
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<td>Sarah Green</td>
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<tr>
<td>Sarah Vesey</td>
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<tr>
<td>Sharon Taylor</td>
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<td>Sue Seddon</td>
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<td>Susan Kennedy</td>
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<td>Wendy Altmann</td>
<td>ASM Industry Consultant (Grampians Region)</td>
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