# Municipal Association of Victoria

**Response to Productivity Commission**
**Draft Report "*Caring for Older Australians*"**
**Date: 25 March, 2011**

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# 1 Executive Summary

The Municipal Association of Victoria (MAV) welcomes the opportunity to respond to the proposals and recommendations outlined in the Productivity Commission's Draft Report *"Caring for Older Australians".*

The MAV commends the Commission for its very comprehensive proposals for re designing a national aged care service system, and supports the principles upon which it is based and a number of the specific recommendations.

There are however, assumptions in the model that the Association challenges. There is also concern that the consequence of absorbing the HACC program into the aged care reforms, whilst improving service continuity, could see their decline over time as locally connected prevention and support services. This is not in any way suggested in the Draft Report, but it is a risk, particularly if the resources to meet all assessed needs are not provided and eligibility or access criteria are tightened in future to manage budget pressures.

The Commission has predicated its service system design on there being one level of government responsible for aged care in Australia. This is not the position currently supported by State and local government in Victoria, as reflected in the COAG decision of April, 2010. Although the Heads of Agreement signed at the COAG meeting on 13 February, 2011 proposed that the Commonwealth, Victorian and Western Australian Governments, with relevant local government stakeholders, work together to consider potential changes in responsibilities in Home and Community Care aged care and disability services before the next COAG meeting, it also notes the different models currently in operation and the importance of maintaining existing service delivery strengths in Victoria and Western Australia.

In presenting a national picture across aged care, the Draft Report does not adequately reflect the existing strengths of the current HACC system in Victoria, and some of the proposals for change could undermine these. Victoria has had a strong tradition of both state and local public sector involvement in service provision, funding and planning. This has delivered relatively integrated and equitable distribution of HACC service types, as well as ensuring that smaller communities have stable, capable providers with service models that benefit those communities.

The commitment to achieving integration, identifying and meeting gaps, and the accountability to local citizens provided by local government goes beyond what can be expected of other providers in a market based system. The exchange of skills and knowledge from the service provision role informs and improves councils' wider service delivery functions and community planning capacity in relation to older people. Victorian communities have supported their councils having a service provision role in a wide range of human services, including early years and aged care. Strong linkages have been developed between councils' HACC community care services and the local social, recreational, and health maintaining services used by older people. Some of these services have been provided and substantially funded by councils in response to the community need.

While councils could choose to continue in their service provision role, if the conditions and prices were right, the aged care system as proposed by the Productivity Commission would not necessarily engage with State and local government's knowledge and planning capacity. There is no structure or mechanism proposed for how such a centrally managed aged care system would relate to other levels of government and local communities, and without connecting to those local planning frameworks, how the knowledge of needs and service gaps from assessors and service providers would inform appropriate local service development.

The proposed model does address vertical integration, national uniformity and service continuity issues within aged care, and some of the horizontal connections such as palliative care. It is not as specific about how such a system would also maintain and improve the horizontal integration and pathways with primary health care, and the social and recreational services so important in supporting community living for older people.

The MAV is also concerned that the proposed market response approach to service development, based on meeting assessed individual needs with defined services at centrally fixed prices, will not be adequate to ensure timely and appropriate service options in all communities. Without some protections, incentives and planning processes, the market is unlikely to provide adequately in remote or low density areas, or for some of the more vulnerable target groups. In some rural areas of Victoria, there has not been a lot of interest to date in providing residential and community aged care from private for profit or the larger non profit organisations, leaving the State health services and councils as the major or only providers of such services in those communities.

Conversely, in local government's experience, a proliferation of competing providers in metropolitan areas can actually weaken the service system's capacity to work together co-operatively and efficiently, to improve clients' experience and share knowledge. A protective factor against "cherry picking" behaviour, is often the degree of allegiance, personal relationships and shared responsibility for making the system work for clients, that organisations feel when they are encouraged to be part of the local care system. In Victoria, the State Government has played a significant role in facilitating sector development, particularly in primary care and HACC, through resourcing and encouraging partnerships, shared training, regional planning processes and service co-ordination initiatives. It is not clear in the Draft Report whether the vision for a reformed aged care system acknowledges the need for such service development processes and how it would be managed.

The MAV would strongly concur with the Commission's position that pricing, subsidies and user co-contributions are inconsistent and inequitable within and between care settings. The MAV supports the need for pricing review and the principle that the supply of services should be uncapped and provided to meet assessed need. However, there is concern that the Draft Report does not capture the extent of under provision and under costing in the current HACC service system, as a base line for estimating future costs and the injection of funds needed to manage the transitions over the implementation period, and pay for an uncapped entitlement system. Just in relation to community care, there are considerable

anomalies in the funding and availability of particular service types across jurisdictions.

*For example*, community transport and care co-ordination service types in Victoria are well below the national average reported on in the HACC Annual Report 2008/09 (Commonwealth of Australia, 2010), which also shows that Victoria has the lowest unit price for domestic assistance. Local government significantly provides and funds community transport and domestic assistance in Victoria. Based on a survey of councils' 2009 costs, undertaken by the MAV, the estimated council contribution over and above the HACC output price for their core HACC services (domestic assistance, personal care, respite, property maintenance, delivered meals and Planned Activity Groups) was $66 million or 25%. In addition, a 2008/9 MAV survey estimated that councils spent over $21 million from their own revenue sources on providing community transport.

This response from the MAV, on behalf of Victorian councils, thus focuses comments on how an improved nationally consistent community aged care system could be achieved for service users, whilst retaining some of the strengths of the current HACC system in Victoria. The elements which we consider necessary are:

1. That the roles of both State and local government in Victoria, in assisting the Commonwealth to implement a nationally consistent aged care system, be further negotiated and agreed through the COAG processes, to ensure that the management of the service delivery functions and pathways between the health and local community support services are maintained and further developed; to include: -

    - Consideration of the Victorian government taking responsibility for the Seniors Gateways and ensuring regionally effective linkages with other health, care and support systems, and sector development.

    - Acknowledgement of State and local government's statutory role in Victoria in health and wellbeing planning and for explicit linkages between the aged care system of services and the need for planning, funding and development of a wide range of preventive health and community support services (eg transport, meeting venues, health promotion and maintenance and social programs, other features of age friendly environments) necessary to support older people living at home and in the local community, over and above the aged care services alone.

2. That home based assessment be provided, even at early stages of needing support services – incorporating HACC Assessment Services' experience and local knowledge.

3. That the assessment services, and all approved providers of community care, be required to continue active service and restorative approaches within their services and that adequate funding is available for staff development, training and services types to support this.

4. That further work on the costs for a redesigned service system be provided in the final report, including the proposed new structures for administering it, increasing funding levels to meet current levels of unmet need and processes for protecting access for those with early and low care needs.

5. That the service types and range to be included in aged care funded entitlements, be more clearly outlined, as well as the processes for ensuring that services can develop to equitably match those entitlements.

## 2. Responses to Proposed Aged Care System

### 2 .1 Policy Objectives and Framework (Chapter 4)

Draft Recommendation 4.1

*"To guide future policy change, the aged care system should aim to:*

- *promote independence and wellness of older Australians and their continuing contribution to society*
- *ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change*
- *be consumer-directed, allowing older Australians to have choice and control over their lives*
- *treat older Australians receiving care and support with dignity and respect*
- *be easy to navigate — Australians need to know what care and support is available and how to access those services*
- *assist informal carers to perform their caring role*
- *be affordable for those requiring care and for society more generally*
- *provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations." (page XXV).*

The MAV supports these as suitable objectives in terms of outcomes for older people, but would also add objectives to build and sustain the service system capacity:

- attract and support a mix of sustainable providers of high quality services in all communities, including public sector and not for profit agencies.
- encourage co-operative efforts, efficient practices, shared learning of good practice, flexible responses and innovation amongst service providers
- use research, evidence and service utilisation and population data to inform planning processes and to improve linkages with other health and care systems at the local, regional and state levels.
- Invest in workforce attraction, retention and development.

The scope of what is to be included in the aged care system could be clearer in the Draft Report. Is it intended to include or integrate elements of the Veterans' community care services as part of the aged care system, or will it continue to operate as a parallel program?

It appears that it is intended to retain existing funded community care service types with the potential to expand to meet emerging needs and the program's objectives. However, the flexible range of services layered in building blocks as outlined in Figure 3 (page XX1X of Overview) does not, for example, include the existing HACC service types of allied health, counselling, podiatry and social support. Restorative services, health promotion and prevention activities are not included, despite the independence and wellbeing objectives.

There are other elements of life and support needs important to older people that are not funded in the current aged care system, which need consideration – for example, companion animal care and gardening services.

Although there is an emphasis through the draft report on wellness and maintaining health, there are not recommendations about how the aged care system will really embrace this, either through aged care funding or articulation with the widely used range of local community support and primary health care services. Local government has also been committed to using the HACC services, where necessary, as bridging or connecting services, to assist older people remain involved with or start using the general range of community provided social and recreation services, rather than their only option being HACC funded social support. Thus these linking functions also need to be recognised in the service types, further described in the case studies in Appendix 1.

## 2 .2 Care and Support (Chapter 8)

Draft Recommendation 8.1

*"The Australian Government should establish an Australian Seniors Gateway Agency to provide information, assessment, care coordination and carer referral services. The Gateway would deliver services via a regional structure.*

- *A platform within the Gateway would provide information on healthy ageing, social inclusion and participation, age-friendly accommodation, and also information on the availability, quality and costs of care services from approved providers, and how to access those services.*
- *Assessments of the needs of older people would be undertaken for their potential entitlement to approved care services, with the level of assessment resourcing varying according to anticipated need.*
- An aged care needs assessment instrument would be used to conduct assessments and an individual's entitlement to basic support, personal care and specialised care, and carer support. Assessments of financial capacity to make care co-contributions toward the cost of the services would also be arranged.
- Initial care coordination services would be provided, where appropriate, as part of the Gateway. If required, case management would be provided in the community or in residential aged care facilities by an individual's provider of choice.

*The Gateway would be established as a separate agency under the Financial Management and Accountability Act, 1997."*

**Seniors Gateways**

The Draft Report portrays a general view that services are difficult to understand or navigate. At the level of accessing the home and community care (HACC) services, the MAV doesn't believe this accurately reflects the majority experience in Victoria. The core HACC services are uniformly provided by councils, community health centres and district nursing or health services across all local communities, have been for a long time, and referring agencies and many people know who to contact locally. Since the "no wrong door' policy was introduced some years ago, much more effort has gone into ensuring people get advice about the range of service options they may need, not just the services provided by individual agencies. It is interesting to note that despite extensive advertising in local papers, the Commonwealth funded Carelinks information services have not been a significant source of direct referrals (0.1%) to the Victorian HACC services ("*Who Gets HACC"*, Department of Health, 2004/06).

However, the MAV would concede that aged care taken altogether has become more complicated. There is benefit in simplifying access to information and services for potential service users and family carers, and streamlining referrals from the health services, as well as having a nationally consistent approach to assessment, tools and data collection.

The Draft Report does not outline the accountability and governance structure for the proposed Gateway Agency as constituted under the Financial Management and Accountability Act, but the MAV would have concerns if there were no mechanisms for involving local knowledge in the operation of regional centres. An option for regional centres to be operated on a contract basis by other government or non government agencies is canvassed in the Draft Report, and in Victoria, the MAV would see this could be an appropriate role for the State Government to manage and that an inter- government agreement could define arrangements, such as currently occurs for the Aged Care Assessment Services.

The scale and location for the gateway centres should be informed primarily by their function. The Draft Report proposes a wide range of functions to operate from regional gateway centres, however in Victoria, the MAV recommends that the gateway centres be used primarily for the phone based information and needs identification services, and that the existing network of assessment services be utilised to provide the home based information, assessment, care planning and co-ordination functions, i.e. the face to face, home based client contact.

The phone and web based provision of information and initial needs assessment could cover larger catchments, but the volume of calls, and working environment for the number of staff required to respond to them, would need to be considered alongside regional identity and system interface issues. There are existing services (in Victoria and elsewhere) with experience in implementing high volume information and referral call centres, such as the Royal District Nursing Service, and Seniors Information Victoria, and building on their experience should be considered in developing implementation plans. Some further resolution will be required between existing information services about the detail of the scope and depth of the information service to be provided via the gateways.

Home based assessment is essential and should utilise the assessment services with local knowledge and local placement. Centres covering large regions would be very inefficient as locations for home visiting assessors. In Victoria it is recommended that the home based assessment functions of the gateways be undertaken by the HACC Assessment Services (HAS) which are located in every municipality and the Aged Care Assessment Services (ACAS) which cover sub – regions of three to four municipalities. These could remain co-located in the current health and HACC organisations, at least initially, but be managed and operate with separateness from service provision, and in close consort with, or under contract to, the gateways, and use the national guidelines, tools and information management system. Scale considerations include both volume of referrals and meeting efficiencies in travel time for home visits, and being able to know about and relate to the associated services.

Seniors Gateways' catchments or coverage should be inclusive of full local government areas and within State regions, with practical considerations for variations in the cross border communities, such as Albury/Wodonga. Logical catchments should be resolved as part of implementation, through consultation and local knowledge of the communities of interest, people flows and transport options between regional centres and larger towns and rural surrounds, and utilisation patterns of health and related services. Victoria has an established foundation of primary care and HACC services, and some aged care services, working together in sub regional Primary Care Partnerships (usually two to four LGAs), particularly around service co-ordination and health promotion. The ACAS sub regions are consistent with major hospital catchments and patient flows. It would be important that any new regional services consider their relationship to existing structures, as well as emerging ones, such as Medicare Locals.

**Base assessment**

The MAV supports the notion of a building block approach to basic and higher levels of support, and agrees with the quote (Davis, Dorevitch and Garratt) in the Draft Report that "*assessment is the cornerstone of contemporary care for older people".* (page 231).

The Victorian HACC experience would suggest that although there are some circumstances in which an online or phone based assessment would be sufficient to establish needs for some community support services, most assessment and care planning capable of addressing *"advice on healthy ageing, falls prevention and care coordination"(page 236), as* well as assessing ADL and IADLs, other environmental risks, social support needs and carers' needs, discussion of provider choice, client responsibilities for fees and OHS, requires a face to face, home based assessment process. In addition, there are many potential service users who are not comfortable discussing their circumstances with unknown people on the phone, nor able to absorb information and advice in that way.

Thus the assumption that need for basic or lower levels of community services can be met by phone assessment alone by a regional agency or that the mode of assessment should be left only to consumer choice, has to be challenged. Home based assessment with local knowledge best meets the need for connections with other local services and restorative care alternatives. Discussing goals and priorities with an individual is more focused and realistic in the context of how they

live in their own home. Assessment skills also rely on observation of people and their environment and an interactive approach where the value of the information provided is enhanced by how it is delivered and tailored to that individual. See, for example, the case study in Appendix 1, which illustrates that even people presenting with lower level needs can require quite a mix of local services and referrals to achieve a good outcome.

*For example*: How would individuals be encouraged to consider the benefits of continuing to undertake some housework tasks, by changing equipment and more capacity building options, or be referred to the most appropriate restorative program, if they choose a phone assessment rather than a home visit and are given an entitlement to a housework service? This already occurs with DVA clients. Victorian experience suggests that assistance with housework is highly valued, and it is not easy to discuss the wider benefits of the physical activity involved in doing daily tasks and encourage more independence in this area once an individual is told they have an entitlement to a housework service. Phone conversation is not the best method of identifying why an individual is having difficulty with housework tasks or what else could be done about this, or even how much housework time is needed in that environment.

The model outlined in Appendix B does acknowledge the importance of face to face assessment, and provides a detailed blueprint for the functioning of regional gateways. Much of it describes good practice but some of the detail would require more discussion as part of planning implementation, certainly around governance, roles of a lead agency, and the monitoring and advocacy roles. Effective assessment also requires regular review of care plans and re – assessment and although the proposed model does include this phase, it is not currently as well developed in the HACC assessment funding and hours as would be needed to deliver the new model. In Victoria, the cost of reviewing care plans with new clients is built in, but the implementation process would have to consider the additional costing involved in reviewing the large base of existing clients as rigorously.

Although there is an emphasis through the Draft Report on wellness and maintaining health, there are not recommendations about how the aged care system will really embrace this, nor how it will articulate with the widely used range of local community support and primary health care services, outside the aged care range. Victoria has invested in additional HACC allied health in the community health centres to improve the multi – disciplinary input into assessment, capacity building and restorative opportunities in the HACC services. Access to allied health (whether through HACC, Enhanced Primary Care or Community Rehabilitation Centres) is likely to be variable across regions and States and is an example of where the regional primary care and aged care planning and pathway processes will need to align to get the best service outcomes for individuals, and where local knowledge is critical.

Implementing an active service approach in HACC services in Victoria has also emphasised the need for a wide range of flexible services even within one HACC service type.

*For example* - a suitable domestic assistance response to meet an individual's needs may include one or more of the following:

spring cleaning, sorting and rubbish removal, cleaning equipment loan, information and advice on equipment purchase and use, teaching new techniques, pet care, household bill paying and shopping, a range of specific cleaning tasks with or for the person.

It will be a challenge initially to do a national benchmark for the price for some of these more individualised services, and it may well be that a market approach to accessing this range of services with choice of providers, will not work efficiently for some service types and in some areas, given the scale and level of demand. Pricing should not restrict flexible responses for individuals. There is also concern over the degree to which providers will be prepared to share information about sourcing good options in a region (e.g. for rubbish removal) and more efficient ways of operating (such as sharing access to an equipment pool for loan) when they are competitors for the work, or whether there would be any incentive for undertaking the community development work to build a more efficient and capacity building neighbourhood volunteer support program to help meet pet care needs.

**Care co-ordination and case management**

The MAV is pleased to see the Commission's Draft Report has recognised the need for both care co-ordination and case management as separate services, and that they should be available to individuals and families as needed. Care coordination could be provided both by assessment services and lead agencies providing the core or main community care services to an individual. In the MAV's initial submission it was recommended that, like information and assessment, there would be no client fee for these connecting services, but it is not clear if the Draft Report has accepted this.

As current funding levels for care co-ordination and case management don't reflect the existing level of need/demand, there is likely to be an additional cost to implement these functions in the aged care system, as well as managing the expectations and service growth needed in the implementation stages. There is also an emerging debate about the skill sets and competencies needed to undertake all aspects of care co-ordination roles, and it is an area which provides opportunities for career progression and releasing scarce allied health, nursing and social work time.

The Commission's Draft Report (*page 369)* acknowledges these shifts in scope of practice in the Chapter on Workforce.

*"Developing and implementing widened scopes of practice for health workers is one of the tasks of the recently formed Health Workforce Australia, which was created following the Commission's report into Australia's Health Workforce (PC 2005a)."*

*"The Commission considers that widened scopes of practice will become increasingly important as broader health workforce shortages become more acute. It is also a very valuable vehicle for improving the human capital of Australia's health workforce.*

**Enhancing consumer choice**

Draft Recommendation 8.2

*The Australian Government should replace the current system of discrete care packages with a single integrated, and flexible, system of care provision. This would deliver care services currently provided under Home and Community Care, Commonwealth funded care packages and the care component of residential aged care services.*

*The Australian Government should approve a range of care services to individuals on an entitlement basis, based on assessed need. Individuals should be given an option to choose an approved provider or providers*.

*The Australian Government would set the scheduled price of each service. To support these revised arrangements, Australian governments should fund an expanded system of aged care consumer advocacy services.*

The MAV supports the need for an expanded system of aged care consumer advocacy services, and the need to provide support for more vulnerable people in accessing services and exercising choices. It is important that in a national system, funding is outcome based and that successful local models are not lost in favour of some more nationally uniform approach. For example, in Victoria, council HACC services have been able to take an outreach role in assessment, linked to internal relationships and referrals from councils' health inspectors and local laws, about vulnerable people for whom there is community concern or complaint and who don't seek or readily accept help. The HACC program also funds a Community Connections outreach service to undertake one on one engagement work with hard to reach individuals and the Supported Access Pilot Project, which supports individuals in CALD communities who are having difficulty accessing and using HACC services.

The MAV supports the principle that the system should generally be able to give consumers some choice of providers, and that providers should be free to offer a wider range of services. There would be concern, however, if organisations felt pressure to provide a broad range of services in order to attract and retain clients and funding without the scale, experience or skill base to really deliver them well. The MAV contends that encouraging provider partnerships and facilitated pathways, not competition, is often a better way of ensuring easy access to a good, integrated and efficient service mix for clients. Presumably there will be smaller more specialised agencies who want to deliver a narrow range of localised services, perhaps around social support, and more centralised registration and approved provider and quality requirements should not be discouraging for them.

There are reservations about the Commonwealth's remote processes for approving providers, particularly without a policy commitment to preserving public sector and not for profit organisations in the mix of choices for service users; any processes for considering the characteristics and views of the population areas to be served and the impact on the area; plus much more rigour about assessing organisations' sustainability and capacity to provide in rural areas, from a regional base, than

appears to have been the case to date. There needs to be wider industry agreement and evidence for organisational capacity and suitable service delivery models across different population scales and densities.

*For example*, the outcome of multiple providers winning tenders through DVA and CACPs funding rounds in some small rural communities has been that there has been no increase in multi agency presence in local areas, and community care workers have had to become employees of three organisations to do the same amount of work, for the same number of clients, but with three different wage rates. Only the council provides a local presence and supports staff with face to face supervision, yet the council's economies of scale and viability in providing home care services have been reduced.

Some councils have been willing to be CACP and DVA home care providers, to provide better scale and continuity for clients, but have not been selected through the competitive processes. There is not a lot of evidence to date that these remote, paper based selection processes, actually produce a stronger service system or choice for local communities.

It seems more important that service users be able to choose between a smaller range of reliable, experienced and well managed services rather than have choice drive the growth of an even more fragmented community care industry of variable quality and standards. See for example, the growth in small private Family Day Care Schemes in Victoria and the complex issues of support and guidance involved in trying to ensure they can operate at acceptable standards. Community care, like family day care, is at the very boundary of informal and formal care and there are inherent risks in home based care for both workers and those cared for, that need to be understood, balanced and well managed. Service users don't always understand differences in risk management standards when choosing and using services, until a problem is encountered.

There are also concerns about the risks in managing the workforce attraction and sustainability issues when service providers have no security about levels of funding and that the lower paid care workers will bear the brunt of this insecurity. It could lead to higher degrees of casualisation in the workforce and run counter to competing for a scarce workforce and attracting and retaining the skill levels and staff continuity required to provide quality care.

## 2.3 Paying for aged care and options for broadening the funding base (Chapters 6 and 7)

Draft Recommendations 1.1 and 1.2

*1.1 The Australian Government should adopt separate policy settings (including for subsidies and co-contributions) for the major cost components of aged care, namely care (personal and health), everyday living expenses and accommodation.*

*1.2 The Australian Government should adopt the following principles to guide the funding of aged care:*

- *Accommodation and everyday living expenses should be the responsibility of individual ,with a safety net for those of limited means*

- *Health services should attract a universal subsidy, consistent with Australia's public health care funding policies*
- *Individuals should contribute to the cost of their personal care according to their capacity to pay, but should not be exposed to catastrophic costs of care*

**Accommodation**

The above principles and proposals in the Draft Report to support choice of method for paying for accommodation and the provision of government supported schemes to address accessing equity in the home, and the sale of a home not affecting pension payments, appear to provide clarity and fairness.

The retention of a proportion of places for those with limited means per facility or region should provide sufficient protection of access for low income residents and areas. However whether the need is for the 40% or more or less, is likely to vary between areas and over time, and it is unclear how this is to be identified and monitored transparently at a regional level. The MAV would not support providers just trading places between themselves with no mechanisms for accountability of outcome to the local community, nor reference to local preferences, as it could reduce geographic access, particularly in rural areas, and choice for those on lower incomes.

The basic accommodation standard should be set at an individual, not shared, room. The choice of a single room reflects industry and community expectations and protects lower income residents from having to accept different standards for privacy than others. In consideration of costs, it may be realistic for some sharing of en suites or bathrooms and the minimum standard shouldn't deter flexible design to allow for sharing when individual choice or care needs require it.

**Everyday Living Expenses**

Although not many Victorian councils are still involved in the provision of residential aged care, the MAV supports the removal of restrictions and distinctions in licences for extra services in residential care facilities, and agrees that care recipients should not contribute more to their costs than the cost of having the care provided. In principle, care subsidies and co-contributions should be consistent across community and residential care (page 185). However, is this possible, given that the price for care services has to reflect the costs of providing those services in the different settings and the costs of providing personal care or meals can be different between residential and home based settings?

Whilst having an external agency such as Centrelink, with a role in providing comprehensive means testing to determine care recipients' contributions to care in both community and residential care settings seems appropriate for higher level care needs, the MAV agrees that a simpler test for those using smaller amounts of services is appropriate. The $100 pw value proposed may be too low to accommodate the higher intensity, but short term interventions needed in restorative care, and will need more consideration and review once national benchmarking has established the price ranges and the uniform assessment data shows the utilisation patterns.

There is concern about if and where discretion about fees in the system will lie, although it is assumed it would be with the assessment service. There can be a disincentive for some people to use needed services because of the means test process or fee level and assessors and/or lead agencies will need the discretion to waive or discount fees in these more exceptional circumstances, and providers will need to be protected from such fee losses. Currently HACC requires providers not to exclude people from needed services because of inability to pay, but in a more mixed economy of providers, some would not take on people who don't pay their fees unless compensated by additional funding.

Meals services have commented that it is not uncommon for some clients to cease or reduce services when fees increase, and often it is those most at nutritional risk. Although making a choice, it is not always the best choice with a good outcome. Individuals can have expenses that make even low fees excessive, such as payments to support families here and overseas, pharmaceuticals and aids, alcohol consumption, and be unwilling to declare to others how their income is spent. Even talking about fees can be a disincentive to use services for some clients from very vulnerable groups e.g. Aboriginal and newer immigrant clients, those with cognitive or mental health conditions, homeless or eccentric lifestyles. Often better outcomes for individuals and the community are assured by encouraging a trial of the needed service before introducing a discussion about the fees, and sometimes the only way to achieve a good outcome is to reduce or waiver fees.

There would appear to be value in having an external agency - the proposed Australian Aged Care Regulation Commission - make recommendations to the government re co-contributions, scheduled set of prices for care services, and indexation, lifetime stop loss limit and price for basic residential care accommodation. It has long been a source of frustration to local government HACC services that the indexation formula used by Treasury bears little relationship to the wage indexation in the sector. Such recommendations, and the methodologies and reports they are based on, should be transparent and publicly available.

The MAV supports the implementation plan proposal for a benchmarking study of aged care costs in both community and residential settings, as long as these take into account state and regional differences in awards and travel and include all reasonable costs to meet legal requirements and maintain quality standards such as OHS, administration, information management and staff supervision and training, as well as appropriate funding for the more atypical or one off service responses.

There is also agreement about the need for some services to be block funded – in particular to underpin the viability or alternate service models in smaller rural and remote areas. This might also be true for some agencies with service models for meeting special needs groups such as Aboriginal services or those for homeless people, or supporting hoarders. Funding models for social support, community transport and delivered meals require more consideration – not all are based on using volunteers, and not all are currently HACC funded. Councils are often the major funders of these service types in Victoria.

There is considerable concern about the sustainability of delivered meals, as a service type, under current subsidy arrangements, for both service users and councils. Meals Victoria undertook a provider survey in 2008, and 49% believed the

delivered meals service was unsustainable, 51% citing costs as the major factor, and 39% citing difficulty in recruiting volunteers (Meals Victoria, 2008:viii). Provider organisations (majority are councils) estimated they were contributing $13.4 million (35%) to the costs of providing delivered meals, with the HACC subsidy contributing 14.7%.

If councils are to be considered only as service providers and not program partners in the reformed aged care system, they would not be willing to continue to subsidise the service price. In any transition process, there would also be a reluctance to extend HACC service rates and council subsidy to CACP clients where packages are currently providing near or full cost recovery rates.

*For example*: Community Transport

The Draft Report acknowledges the importance of assisted and community transport in an age care system.

*Page 363: "Community transport schemes provide valuable assistance to older people and, indirectly, to their carers. These schemes often draw on volunteers (who may be reimbursed for their 'petrol costs') and contribute to the social capital of local communities. The Commission is proposing that such schemes should continue to be block funded in recognition of the important roles that they play (draft recommendation 8.4). In areas that are not well served, local councils can often be a focus for organising a community based scheme."*

*Page 376: " For older people living independently in the community, especially those without informal carers, the lack of appropriate transport options limits their capacity to access medical and health services, and can constrain opportunities for social inclusion and participation. Community transport options need to be accessible and affordable to enable older people living in their own homes to access health care services"*

The Home and Community Care Program Annual Report, 2008 – 2009 (Commonwealth of Australia, 2010), shows the differences between jurisdictions in the current provision of HACC funded transport, and although 18% of all HACC clients received transport services, it is acknowledged that this doesn't include Victoria, where the MDS does not report transport data.

Councils' involvement in community transport directly reflects the lack of appropriate funding over time to meet local need from HACC or other programs. Not all councils have the financial capacity to address transport needs themselves, however in 2008, 90% of councils in Victoria spent at least $21 million of their own revenue in providing or contributing to community transport schemes, in vehicles, staff, organising and re –imbursing volunteers, or in grants to other organisations. These services are mainly used by HACC clients and other aged and disabled residents. The State Government also subsidises taxi use and funds the Transport Connections program in rural and urban fringe areas, to support those communities work together to improve local transport and access, both generally and for particular needs groups such as older people. There have been funded pilot programs to improve older people's mobility and use of public transport and transitions from driving. There is evidence that ceasing driving is often a key marker for risk of functional loss and reduction in social activities in older people,

and that capacity building approaches can be effective and should be funded in a community care system.  Access to suitable transport is always a key issue raised by older people in consultations.

The MAV agrees that mobility training, assisted and community transport are all essential elements of a community aged care system, but there would be substantial additional costs if an adequate level of transport assistance is provided to meet assessed needs. Service responses to individual assessed needs won't automatically result in the most cost effective service development without locally connected planning.  Assisted transport for shopping and medical appointments (one on one) is currently funded as part of HACC in Victoria, but not separated out as a service type.  It is not provided in all locations because of the unfunded costs and risks.  Travel costs reimbursed to drivers are not fully included in the unit price, particularly where greater distances are involved,  and there are  a range of duty of care and Occupational Health and Safety risks to manage when using volunteers or staff to transport clients in their own vehicles, plus additional training and administrative costs to maintain appropriate quality systems. Assisted transport should be identified as a service type and appropriately funded in community care.

Across Australia there are a range of responsibilities and service models in place providing group community transport, including the important linkages to other forms of local public and assisted transport.  Some are HACC funded, some are not.  To  determine what transport assistance is part of and funded in the proposed aged care system and what is not, may require a review process by all jurisdictions, as has been recommended  for  addressing the variations in home maintenance and modifications.

## 2.4 Catering for diversity (Chapter 9)

Draft Recommendations 9.1, 9.2 and 9.3

*9.1 The proposed Australian Seniors Gateway Agency (draft recommendation 8.1) should cater for diversity by:*

- *ensuring all older people have access to information and assessment services*
- *providing interpreter services to convey information to older people and their carers, to enable them to make informed choices*
- *ensuring that diagnostic tools are culturally appropriate for the assessment of care needs.*

*9.2 The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), in transparently recommending the scheduled set of prices for care services, should take into account costs associated with catering for diversity, including:*

- *providing ongoing and comprehensive interpreter services (either within facilities or through telephone translators) for clients from non-English speaking backgrounds*
- ensuring staff can undertake professional development activities which increase their cultural awareness.

*9.3 The Australian Government should ensure that remote and Indigenous aged care services be actively supported before remedial intervention is required. This support would include but not be limited to:*

- *the construction, replacement and maintenance of appropriate building stock*
- *meeting quality standards for service delivery*
- *clinical and managerial staff development, including locally delivered programs and enhanced use of technology assisted training*
- *funding models that are aimed at ensuring service sustainability and that recognise the need for the building of local capacity to staff and manage such services over time.*

*"In principle, the delivery of aged care for special needs groups should:*

- *ensure access to services — reducing discrimination for those groups that age earlier than others, such as Indigenous Australians and the homeless, or those who may be challenging for service providers, such as those with a behavioural condition*
- *support specialised models of care — ensuring providers have the flexibility to meet the preferences of some groups that require different aged care services because of cultural, religious or other values*
- *encourage service providers to tailor services to meet particular sets of needs and to create culturally responsive services such as through training packages to provide workers with specialised skills and understanding, and to ensure that policies and practices reflect such needs*
- *acknowledge the higher costs of service delivery or difficulties accessing capital for some services catering for large proportions of clients with special needs.*

The MAV would support the recommendations and above principles (outlined on page 273), but would think it reasonable that all providers receiving government funding should be required, not just encouraged, to appropriately address the diverse needs in their communities through culturally appropriate practices and staff training. Although the current Aged Care and HACC legislation has been framed around special needs, future legislation should build on a human rights framework and a much broader approach to diversity.

There should be explicit policy directed strategies, reportable transparent outcomes, trend analyses of access at the local, state and national levels, and research based on both the service user experiences and evaluation of specialised service delivery models, as well as facilitated sharing of good practice.

## 2.5 Age friendly housing and retirement villages (Chapter 10)

Draft Recommendation 10.1

*The Australian, state and territory governments should develop a coordinated and integrated national policy approach to the provision of home maintenance and modification services, with a nominated lead agency in each jurisdiction.*

*To support this national approach, all governments should develop benchmarks for the levels of services to be provided, terms of eligibility and co-contributions, and the development of professional and technical expertise.*

The MAV supports the need for some review and development of a more uniform approach to home modifications and home maintenance services. However there is value in preserving the locally based and responsive home maintenance services for small repair and maintenance and minor modifications tasks to improve access and safety, such as installation of handrails, as well as assisting older people make their homes more environmentally suitable and adaptive and safe in extreme climate conditions. This has been an area where the council HACC services in Victoria have been able to be outreaching and proactive in offering additional support and advice to older people. Importantly, the need for some home maintenance assistance or advice is often an early entry point to using community services, and where they are provided as one off services from an initial needs assessment, it is essential that home maintenance workers are trained to identify indicators that the person may require more assessment and support.

The Draft Report acknowledges the importance of assistive technologies but doesn't really propose how to improve equitable access to them or what would be part of the aged care system and what requires improved linkages with other systems.

*Page 263: "Assistive technologies can increase the independence of frail older people and reduce the physical and emotional burden on carers."*

Any review of home modifications would also need to consider the appropriate links and relationship between home modification and State run Aids and Equipment schemes and the Independent Living Centres, and other allied health and rehabilitation services.

Draft Recommendation 10.2

*For older people with functional limitations who want to adapt their housing, the Australian Government should develop building design standards for residential housing that meet their access needs. Those standards should be informed by an evidence base of the dimensions and capabilities of people aged 65 and older and of the dimensions and capabilities of contemporary disability aids.*

The MAV would support this approach.

**Housing Design**

The Commission's Draft Report accepts the value of universal design standards, but suggests that, from the perspective of older Australians, mandatory application for all new housing is not warranted given the community wide costs.

The MAV considers this is too narrow a view of the wider community benefits – and the importance of housing access for a range of people and circumstances. However, developers/investors do need education and incentives to understand the importance of their role in ageing-in-place, age-friendly cities and neighbourhoods.

In a recent submission to the Commonwealth's *"Our Cities and Population Strategy"* the MAV states:

*"There is now widespread and mainstream acknowledgment that good planning and design can significantly reduce construction and operational costs for occupants. This, coupled with social and environmental imperatives to shift Australia to a more compact/sustainable urban form where land and transport uses are fully integrated, suggests the timing for National adoption of universal design principles is in equal parts entirely appropriate, timely and achievable (in the context of the Federal governments current interest in developing a National Urban policy).*

*Accessible housing is an example of the link between liveability and good planning and design, with well demonstrated economic and social benefits. Accessible housing principles encompass universal design and affordability – not just in the initial cost of purchasing a home, but throughout its life cycle. Similarly good planning and design can significantly reduce construction and operational costs and associated emissions for occupants, through such elements as passive solar orientation and natural ventilation.*

*National adoption of these principles and associated standards could result in significant cost savings to governments and the community as a whole."*

**Improving the age friendliness of communities**

The Draft Report acknowledges that *"While some coordination of efforts to advance age-friendly communities has emerged (under the ALGA umbrella for example) there appears to be no national focus or formal bringing together of best practice across Australian, state, territory and local governments*. (page 322).

*"Although the WHO guide and checklist provide a common model for informing government approaches to developing age friendly communities, there may be merit in assigning responsibility for overseeing progress and developments in this area to the Local Government and Planning Ministers Council*." (page 322)

The MAV would welcome a national inter government co-ordinated approach. It is, however, important to acknowledge that age friendly communities not only rely on urban design and the built environment. It is also about confronting ageism, promoting images and opportunities for positive ageing experiences and full engagement in community life. It requires resources for both planning and implementing changes.

Draft Recommendation 10.3

*10.3 The Council of Australian Governments should develop a strategic policy framework for ensuring that sufficient housing is available that would cost effectively meet the demands of an ageing population.*

The MAV would support the proposals for a co-ordinated approach across jurisdictions. There would also be benefits in adopting common definitions for supported housing types, with mechanisms for aggregating state and national data from local areas, to assist in monitoring changes and regional variations.

One of the difficulties in attracting supported and residential care housing options in both inner urban areas, where land is expensive and competing with higher return development options, and rural areas with lower volume demand, is the industry reliance on large scale development models. Supported housing options in Disability have been able to manage smaller, more residential scale, but aged care proposals have grown larger over time. Hopefully with the separation of funding for care and accommodation, smaller scale and more variety in housing options can be developed to better meet the diversity in the ageing population and the locations where they are needed.

Draft Recommendation 10.4,10.5

*10. 4 The regulation of retirement villages and other retirement specific living option should remain the responsibility of state and territory governments, and should not be aligned with the regulation of aged care.*

*10.5 State and territory governments should pursue nationally consistent retirement village legislation under the aegis of the Council of Australian Governments. Changes to state and territory government legislation under this process should:*

- *be informed by research jointly commissioned by the industry and government*
- *have regard to the industry's accreditation process.*

MAV agrees with these two recommendations.

## 2.6 Workforce issues (Chapter 11)

*"Improving the attractiveness of aged care and developing a sustainable workforce to meet future demand will require an integrated approach in a number of areas, particularly remunerating staff competitively, fostering a rewarding working environment (including better management), providing further opportunities for skill development (including increasing scopes of practice) and exploring the scope to source care workers internationally".* (page 362)

While the MAV would agree with the above assessment in the Draft Report, and the actions outlined in the Draft Recommendations, there is not a lot of detail about where the system responsibility for co-ordinating and monitoring an integrated proactive approach regarding the age care workforce planning actually lies? Is it intended to be Health Workforce Australia? Will Department of Health and Ageing take a lead role on workforce issues? It is such a critical issue in making the aged care system work, it has to be front and centre of any responsibility for aged care.

The Commission strongly supports improving the means by which older Australians are able to more effectively access services by allied health practitioners (page 376), referring to the GP Practice Incentives Program in residential aged care. As referred to earlier, HACC in Victoria has also invested in improving access to allied health to support capacity building approaches, through the statewide system of locally based community health services. The Medicare funded Enhanced Primary Care initiative, and Community Rehabilitation Services as part of Victoria's sub acute ambulatory care services, also improve access for older people and the State Government has been very active in workforce programs to recruit and retain allied health workers in rural areas.

Access to allied health will remain a critical issue in both health services and community and residential aged care, but it is not clear how the Commission sees these program and funding interfaces being addressed into the future, or is it assumed that the regional health planning role of the Medicare Locals will identify such service and inter- face gaps to inform Department of Health and Ageing funding and workforce planning responses?

The Draft Report states that aged care workers will need to be adaptable and have a broad range of skills. Based on the HACC experience in Victoria, there is an ongoing pressure for skill development, and the amount and level of training and costs are underestimated in the service pricing, particularly for the direct care workforce. There is already quite a difference in the amount of training provided by council HACC services and some of the private home care services and also between councils of different resource levels and scale. To ensure that training continues to be a priority, training should be funded separately to service provision, as part of the workforce development and quality objectives, and that specified funded annual training is required of all providers.

As raised earlier, there are risks when service providers have no security about levels of funding as this could lead to a more casual workforce and run counter to competing for a scarce workforce and attracting and retaining the skill levels and staff continuity required to provide quality care.

## 3. Reform implementation (Chapter 14)

Given the under provision against demand in the community care system now, there is a risk in the implementation stage that service users' expectations based on assessed need and service entitlement won't be able to be met by the existing levels of funded services (during stage 2), or that with the removal of quantity restrictions at the beginning of stage 3, that the service capacity will have developed in all areas. There needs to be a significant injection of funds into the underdeveloped HACC services and community aged care packages during the first three years of the implementation period, to ensure that HACC services aren't absorbed by the higher level needs.

The proposal for an Implementation Task Force comprises only Commonwealth Government department officials. Consideration should be given to state based structures as well, with a wider representation of State and local government, providers and consumer groups, to also be feeding into the implementation process, as well as other consultation processes.

# 4. APPENDICES

**APPENDIX 1.**

**Good Practice in Victorian Local Government**
**HACC Social Connections Program**
**MAV, September 2010.**

**CASE STUDIES - SOCIAL CONNECTIONS PROGRAMS**

**Background**

This section of the report presents material on the elements of good practice in council HACC social connections programs. In late 2009, the Municipal Association of Victoria reviewed a number of council 'good practice' examples of HACC social connections programs with the aim of highlighting the key elements of their success and identifying common themes and approaches across these programs. In undertaking this project, information was collected on the development, operation and structure of programs for HACC eligible clients that supported their participation in social activities to reduce their risk of social isolation.

The review found that the success of a social connections program will depend not only on the quality and capacity of a program to meet an older person's needs but also the client's readiness, capacity and support to participate. Social participation programs for HACC clients often develop with activities undertaken **at home, to** build capacity and confidence in readiness for participation in activities **away from home**. This report focuses predominantly on identifying the elements of social connections programs delivered in settings **away from home**.

**Overview of 'Good Practice' Programs**

The project collected information from successful programs currently being run in councils across Victoria. A range of program initiatives were included with the intention of displaying a diversity of approaches being implemented across the state. The programs and councils reviewed were:

- Boroondara – Social Connections program
- Greater Dandenong – Community Care Social Connections
- Port Phillip – Social Support & Recreation Access (SSARA)
- Yarra – Willowview Social Support Program

Informal discussions with other councils and information generated from a workshop held in December 2009, has helped refine the information within this report.

**Case Study Overview**

| Council | Program Name | Target Group | Staffing | Funding Source | Program Focus |
|---|---|---|---|---|---|
| Port Phillip | Social Support & Recreation Access (SSARA) | HACC eligible clients with complex issues who are socially isolated or at risk of social isolation | 1 EFT | HACC Social Support | Recreation focus linking older people to community recreation and social activities and programs; providing information about activities to a large network of service providers and community members; actively working to develop new activities to meet gaps and meet individual need. |
| Yarra | Willowview Social Support Program | HACC eligible clients identified on assessment as at risk of social isolation | 8 hours per week | HACC Social Support | Working one-on-one with more 'at risk' HACC recipients, linking them to PAG program and activities at Willowview centre, and building on local knowledge to make improvements to a more age supportive environment and get access for older people to wider community resources. |
| Boroondara | Social Connections Program | HACC eligible clients identified on assessment as at risk of social isolation | 1 EFT | Council | Recreation focus - both planning and networking to improve access to a wide range of suitable local community activities for older people. |
| Greater Dandenong | Community Care Social Connections | HACC eligible clients identified on assessment as at risk of social isolation | .5 EFT | HACC Assessment funding and council funding from rate revenue | Community development, building community resources and linking older people at risk of social isolation to programs and activities |

**Case Study Example 1:**

City of Port Phillip
*Social Support and Recreation Access (SSARA) program -Improving the social connections of seniors and younger people with disabilities at risk of social isolation*

HACC recurrent funding supports the basic salary costs of one full time staff position to develop and coordinate the program. Council funds all other costs including a vehicle and administration.

The position evolved from an earlier Supported Residential Service (SRS) Recreation Development Project and has retained a strong recreation focus.

People engaged in the SSARA program must face complex issues, be aged over 55 years, isolated or with a carer, pension only SRS residents of any age or a younger person who receives HACC services.

The program has three key components:

- Service delivery
- Service development
- Information Strategy

*Service Delivery*

- No more than 8 clients are involved in the program at any one time due to the intensity of the work required
- The assessment tools used focus on recreation interests and outcomes to build an individual recreation plan. Referral to local recreation and social services in the community are a key strategic direction of the program along with ongoing support and assistance for the client.
- The SSARA project worker provides support and follow up with clients
- Developing a philosophy that supporting older or vulnerable people is a community affair not just the responsibility of HACC services
- The SSARA Project worker provides information and support to the recreation providers throughout the municipality

*Service Development*

- Socially inclusive community groups have been identified including neighbourhood house, community centres, churches, community health centre, senior citizens and community groups and agency programs and clients are referred to any of the programs of interest
- Community resources are identified and used where possible to engage clients in existing activities
- The individual outcomes from involvement in events and activities are:
    - Recognition
    - Greetings
    - Friendship
    - Supportive relationships
    - Help during a crisis/emergency
    - Increased confidence to stay living at home

*Information strategy*

The aim of the information strategy is to develop an 'informed community' about recreation and service options for older people. The strategy involves:

An INFORMED Community:

- The production of a bimonthly newsletter
- An information service on seniors inclusive activities and opportunities
- A database of program participants
- An email network of service and activity providers
- A database of activities

A CONNECTED community through:

- Resource sharing
- Developing networks within council
- Mapping of activities
- Bringing HACC services, service providers, recreation providers, churches, community groups and businesses together
- Using festivals and events to promote activities for and to older residents
- Promoting a range of activities through council facilities – libraries, community hub notice boards

*The Challenges of the Program*

- The program takes time, working with older vulnerable people, gaining their confidence, developing a plan, getting them to attend, arranging transport etc
- There are changing demographics in Port Phillip
- Getting people to understand and support the service
    - Referrers often want assertive engagement, "discharge" of a client to the community and expect client behavioural problems to be fixed by linking them into community groups
    - Clients often want free activities and free door to door transport, a friend to take them out for coffee, to the movies or for drives
    - Recreation providers often want recurrent funding to set up something new

*Key Factors of Success*

- Focusing on recreation and working with a community development approach
- Having a quality assessment tool which focuses on recreation participation, individual's goals and interests
- Using a model of ongoing and extensive networking, resourcing and empowering recreation providers through collaborative work and information in return for working with clients who present with particular and difficult problems
- The location of the SSARA program within council's structure fosters good resources, networks, funding opportunities, engagement with community, access to a car and support services
- Active Service Model principles are embedded in the service delivery
- The service is free of charge

**Case Study Example 2:**

| City of Yarra<br>Willowview Activity Centre for Seniors – *support for HACC clients at risk of social isolation* |
|---|

HACC funding supports an ASM worker for 8 hours per week to work with HACC clients identified as being at risk of social isolation. Funding for the project was initially for 3 months but has been extended for a longer period.

The ASM worker is located at the Willowview centre which offers a range of programs for frail older people and older people with disabilities. The centre offers activities and provides hot meals for participants: activities include discussions, gentle exercise, trips and outings, arts and crafts, board games, cards and bingo, guest speakers, special events, celebrations, cooking, gardening and BBQ's .

The program at Yarra has found that clients most at risk of social isolation are often frail, depressed, have few family connections and suffer from chronic pain.

The ASM project worker is located at Willowview whilst the PAG program is operating, enabling follow up with clients and opportunities to link new clients into the PAG or particular activities. The ASM worker spends time with each referred client, working with them to establish personal goals, what support is required to meet them and how assistance can be best provided.

The ASM worker has developed relationships with local agencies including neighbourhood houses and community health centres. Clients are referred to particular programs and activities as appropriate. A wide range of information on health and well-being is sourced to provide to clients and some material has been specifically developed to assist with exercising.

Clients referred to the ASM Social Connections worker at Willowview are provided with on-on-one support as they work towards achieving their goals. The connection of clients to Willowview provides opportunities for social interaction and engagement with the established PAG.

Transport has been identified as a key issue affecting people's engagement in activities. Council provides some community transport services and the ASM worker has also had success in linking program participants who drive with non-drivers.

*Key Factors of Success*

- Time to build relationships - one-on-one approach - time is dedicated to support each client in working toward their goals. Having time for one-on-one follow up offers further encouragement for people to stay focused
- Links to the PAG – the social opportunities and support from PAG participants provides incentive and encouragement to new clients
- Peer support - Clients are actively encouraged to report to the group on their experiences as they progress through their plan. This process has helped inform others about programs, activities and health & wellbeing initiatives and assists in breaking down barriers to participation. It uses peer experience and credibility to inform, encourage and support one another.

- Referral to local agencies - referring clients to Neighbourhood House activities has generally been very successful because they provide a high level of support to people to integrate into their activities
- Internal links with other council departments have facilitated timely changes such as strategic placement of seats to support walking to shops
- Community transport – transport is provided to Willowview and other venues to offer encouragement to participate
- Pain management program – finding solutions to moderate chronic pain through community health centre programs has assisted some people in progressing toward their goals
- Information – Willowview News provides a range of information to participants, connecting people to other opportunities in their community
- Supportive team – the HACC team provides a supportive environment for the ASM project worker

*The challenges for the program*

- Sufficient time to achieve the goals of the project with just 8 hours per week allocated to social connections
- Keeping people motivated to achieve their goals

**Case Study Example 3:**

City of Boroondara - Social Support Project

A full-time position deals with social support assessments and a part time position, funded from council resources, has been created to deal with clients with more complex problems and at risk of social isolation. The position was established because of a lack of capacity within the HACC assessment team to provide the extra support for clients with more complex issues, or needing more assistance to achieve social connection or recreation goals. Working from a community development approach, clients are assessed and personal plans developed with a focus on recreation participation. The key focus of the social support program is to enhance health and wellbeing, strengthen friendships and reduce social isolation and loneliness.

Approaching goal setting with individuals with complex issues requires particular skills. A holistic assessment of a client's issues enables the social support officer to identify a client's potential interests in social, health and well being activities. One-on-one support and regular follow up are needed to keep clients motivated in working toward their goals. Transport issues are addressed in the program to reduce barriers to participation.

The social support program works closely with recreation staff within council and links people to a range of community based activities and clubs.

Boroondara HACC services have benefitted from a long standing and strong local council led network of community agencies. Case managers and other workers from these groups meet bi-monthly to exchange information and ideas, identify gaps and look at ways of improving options. This network has enhanced knowledge across the sector about the range of programs and activities that are available to HACC clients.

The program uses a range of information materials but the project has identified a need for more ‘client friendly’ material on health and well being, recreation and social programs.

*Key Factors of Success*

- A dedicated staff position to social connections enables time consuming one-on-one work with clients to be undertaken
- Regular review of personal goals with individuals to keep them focused and motivated
- The dedicated position enables the development of a specialist skills base to assist clients with special and complex needs
- A wide up to date knowledge of community based social and recreation options
- The network of agencies and organizations provides shared knowledge, and understanding of clients’ needs and provides trusted contacts to assist in placing HACC clients into suitable recreation and social activities
- Using a focus on recreation and linking internally to council’s recreation resources
- The project builds on a council’s strong community development direction to update and enrich the local Senior Citizens Centres to offer a broad range and choice of activities and programs from the local centres.

**Case Study Example 4:**

| City of Greater Dandenong - Community Care Social Connections Project |
| --- |

The social connections project has created an Assessment and Social Connections position within the HACC assessment team. The position is HACC funded and focuses on clients at risk of social isolation who have complex issues. The position combines an assessment and support role and a community development role in one full-time position.

The key elements of the role include consultation, program development, program evaluation, risk management and promotion.

The community development role has seen partnerships established with community based groups and organizations to develop their capacity to include people with additional needs and to successfully link them into the social connections program.

Neighbourhood houses have provided an excellent resource for meeting the needs of HACC clients.

The position also focused on establishing programs which could meet the social needs of clients. Some of the programs developed through the position have taken a considerable length of time to achieve outcomes, reflecting the reality of community development work.

*Key Factors of Success*

- One-on-one work with HACC clients
- Developing strong connections with community agencies

- Developing new community activities where no suitable existing program exists

*Key Challenges for the Project*

- Combining two roles (community development and case work) into one position – the skills required are not always equally well developed in one person nor is it always easy to balance the different demands of the 2 parts of the role.
- Having sufficient time for community development work to produce results ie requires continuity of relationships over time

# Appendix 2

## Case Study - from the Moreland Independent Living Project

Mrs Gandolfo resides in her own home with her husband. She is 82, has raised two children and worked in a variety of manual labour jobs throughout her life. She has non - insulin dependent diabetes (type 2), shortness of breath upon exertion, high blood pressure, back and neck pain and has experienced two falls in the last three months that she is unable to explain, one whilst vacuuming and one while walking down the street. Mr and Mrs Gandolfo do not receive any ongoing services, although they have both used podiatry and some district nursing after surgery several years ago.

The daughter rang the local council to refer her for assistance with the housework and shopping. They have not previously had a Living at Home Assessment or ACAS assessment, or recent health based assessment.

The council assessment officer spoke with the daughter at length by phone to ascertain her views on her parent's situation and her own needs in relation to supporting her parents. Mr and Mrs Gandolfo speak Italian at home, and although they both speak English, they are more comfortable using Italian and an interpreter was used to ensure ease, understanding and clarity.

Upon entering the home, the assessment officer noticed that it was generally in good order. There were many photos of children and grandchildren and a thriving vegetable and fruit garden. The Gandolphos were encouraged to tell their story in their own way and relate to the assessment officer:

- why they thought they may need some services now
- what had changed for them recently - what was different and why
- what their strengths were – what they did well and liked doing
- what they were finding challenging – what they worried about
- what they were interested in achieving from the assessment.

The assessment officer used questions and observations to cover areas, such as:

- Health and medical background
- Self management of health issues
- Diet
- Medication management
- History of falls
- Mobility
- Foot care
- Personal, domestic and instrumental activities of daily living
- Mental health
- Cognition
- Financial management
- Contact with family and neighbours
- Social participation
- Interests and hobbies
- Participation in physical and capacity building activities
- Use of services

After this discussion, the assessment officer understood that:

- Mr and Mrs Gandolfo worked together well as partners to share and manage as many tasks as possible
- They had frequent contact with family and neighbours, but were having less contact with some of their friends
- They ate well and still enjoyed cooking - using a lot of their own produce which they also shared with neighbours and family
- They were able to make their own decisions, although it was observed that Mr Gandolfo appeared forgetful. Mrs Gandolfo reported that he regularly left the hose running in the garden
- They were starting to lose confidence in their capacity to continue managing all the tasks to maintain themselves and their home, particularly home maintenance and irregular, larger cleaning tasks
- Mrs Gandolfo had limited knowledge on how to manage her diabetes
- Mrs Gandolfo lived with back and neck pain that she had sought no treatment for, believing that she just had to live with it
- Mrs Gandolfo had sustained an injury to her right shoulder from a fall and again had sought no treatment. This was impacting on her ability to complete ADL tasks and participation in bocce which she loved
- They had stopped going to social outings as much since Mr Gandolfo had given away driving recently, at his family's insistence
- They didn't really want any significant help, but the daughter thought they needed it – she often took them shopping or did it for them

They talked more about why Mr Gandolfo could no longer manage maintaining things around the house, why they no longer were able to travel, how this could be different and what needed to be done for it to be so.

They showed the assessor the equipment they used and how they would normally clean the house. The assessor advised that a lighter weight vacuum cleaner and different techniques would make it easier for them to manage.

The assessment officer explained the type of services available, how the services were funded and what the fees would be and asked them for more details about their financial situation, explaining why they needed this information.

The assessment officer explained to them that before a worker could come to help, they and the council, had a legal duty to ensure that their home would be a safe workplace.

They set three goals they wished to achieve over the next three months:

- **Goal One**: They wanted to be able to manage as much of their own home activities as possible including home maintenance, home care and their garden. To achieve this the Gandolfo's decided that they needed to continue working together on tasks, learn simpler ways of doing things, trial some alternative lighter equipment, improve their physical capacity, and ask for help on tasks they found too challenging or risky.

- **Goal Two**: They wanted to be able to participate in social activities again including bocce, and resume most of their own shopping. To achieve this the Gandolfo's wanted to explore and gain confidence to use community and public

transport options, improve their physical functioning, and connect to the local Italian seniors club.

- **Goal Three**: They wanted to have some better understanding and control of their own health.

To achieve these goals a range of options were discussed with them including:

- Follow up and liaison with their GP to advise re falls, physio assessment and for diabetes management and cognitive screening.
    - Referral to the diabetes educator at the community health service
    - Referral to physiotherapy to assess and treat back and neck pain and provide advice on suitable physical activity to maximise function and reduce ongoing pain for both Mr and Mrs Gandolfo
    - Referral to physiotherapy to treat the shoulder injury and an assessment for Mrs Gandolfo relating to her falls and advice re a suitable shopping trolley to provide some stability when shopping
- Referral to Community Health Services for physio and diabetes education as above and HACC occupational therapist for strategies to assist with gardening
- Council HACC services
    - Provision of home maintenance for assistance with cleaning the gutters and minor non trade repairs as required, some initial help with installing a tap timer
    - Provision of a spring clean (including bathroom scrub, window clean and removal of some heavy dusty curtains) to bring the house up to a standard where they could maintain it with the alternative methods and improved functioning
    - Demonstrate task simplification and energy saving techniques for housework, plus the trial of alternative equipment.
    - Referral for weekly community transport to shopping centre and bocce
- Provision of maps of local public transport routes/times and assistance with familiarisation with using public transport
- Providing information for joining the local Italian seniors club and bocce
- Discussion with their children about their plan and wish to try and retain as much independence as possible

Review date set for three months.