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A special thank you to the lead agencies, partners, project managers, project officers, steering group members, staff and volunteers involved in the Eastern Metropolitan Region round one seeding grant projects.

Online resources

The executive summary report for each of the Eastern Metropolitan Region round one seeding grant projects is located at:

Www..epcp.org.au/active-service-model-emr-asm-alliance
www.oehcsa.infoxchange.net.au/library/public/

Active Service Model

April 2012

Seeding Grant round one Summary Report

Eastern Metropolitan Region (EMR)
- a resource to help all EMR HACC funded services implement an ASM approach.

The HACC program is supported by funding
from the Commonwealth and Victorian Governments

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Remodelling the HACC Journey

Lead Agency: Yarra Valley Community Health
Partner Agencies: Yarra Ranges Council, Ranges community Health
Project contact: Joanne Mapes
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Project Description

This project builds on existing work with EliCDM to assist with implementing the ASM approach in service coordination and care planning".

The project sought to develop a client pathway that could be applied to a range of conditions and disciplines.

Project Activities

Recognising that EliCDM is currently limited to one condition for a defined period, the project activities involved:

- Refining intake procedures and demand management strategies (and associated tools) to assist in identifying HACC clients who will benefit from a goal setting/care planning approach
- Introduction of a Key Worker approach that can be useful at any point along the care continuum
- Documenting the shared development of goals across previously disconnected disciplines /agencies
- Multi disciplinary assessments for clients identified as having potential for improvement
- Staff training/professional development

Project Learning's

- Keep focused on a client centred approach and client outcome
- Ensure to document goals and share with all stakeholders
- Take time to put good governance arrangements in place
- Maintaining service delivery and achievement of HACC targets during initial set up and early implementation can been challenging
- Change takes time and cannot be rushed
- Ensure any working group has a strategy to gain "buy in" and ownership of the process by a range of disciplines and stake-holders
- Identification sufficient staff to undertake scoping, planning and early intervention rather than relying on the few members of the working group. Share the work load
- Ensure accountability for meeting

Introduction

Please find enclosed the Eastern Metropolitan Region (EMR) Active Service Model (ASM) seeding grant round one, Summary Report.

As we know, putting the ASM approach into practice requires a significant change management process and an incremental shift in the way services are delivered. To support the transition to an ASM approach, the Department of Health (DH) funded a series of seeding grants across the state.

14 projects established in the EMR addressed key focus areas around:

1 Strengthening Partnerships involving HACC Assessment services with Allied health, Aboriginal Organisations and/or District Nursing
2 Strengthening Partnerships to Build Sustainability for Well for Life and Making a Move Projects
3 Building on existing work: Supporting planned implementation approaches

This document provides a summary of the EMR round one seeding grant projects. These projects provide valuable learning's for all EMR HACC agencies about developing partnerships, working together, and new ways of working with HACC clients.

I encourage you to review the seeding grant projects and to share the learning's and recommendations with your colleagues and to consider how the learning's can support your own agencies Implementation Plans. You may also wish to contact the relevant project officer to discuss any areas of interest in more detail and/or to access the full project report.

We will continue to follow up with these agencies regarding the implementation and sustainability of project recommendations and look forward to sharing these findings with you at the ASM Alliance.

The executive summaries for these reports are available at:

http://www.iepcp.org.au/active-service-model-emr-asm-alliance
http://www.oehcsa.infoxchange.net.au/library/public/

Summary - EMR Seeding Grants round one

Fourteen projects were undertaken in the EMR as part of Round 1 Seeding Grant funding provided by the Department of Health. Some projects built on existing ASM work, while a number focused primarily on strengthening partnerships as a strategy to further an ASM approach.

Project	Lead Agency
Sustainability for Life: Professional training for exercise instructors Provide opportunities for people aged over 60 years, not currently involved in group exercise, to join a new exercise program. Includes simultaneous training of staff to deliver fitness instruction to older people.	Balwyn Welfare Association
Helping clients through our health associates network Development of a referral pathway and client monitoring system to support complex clients participate in individually tailored exercise programs.	Balwyn Welfare Association
Integrated Care Framework (Stage 2) *(two projects)* Collaboration between the City of Boroondara and Inner East Community Health Service to establish a framework for delivering HACC services in a team approach and incorporating the ASM principles. Co location of project officer.	City of Boroondara & Inner East Community Health Service
Person centred pathway resource - "A guide to an active PAG service" Development of a transferable resource to assist partnering PAG organisations to implement a culture of Active Service.	Caladenia Dementia Care
Improving access to OT services in the City of Knox Improve HACC client access to Occupational Therapists through aligned demand management processes . Includes the trial of an OT screen questionnaire.	Knox Community Health Service (with City of Knox).
Strengthening Partnerships - Knox Community Health Service, City of Knox, RDNS Establish a greater understanding of each organisations roles and services; development of agreed common protocols; and an inter-agency orientation resource.	Knox Community Health Service (with City of Knox & RDNS)

Strengthening Partnerships

Lead Agency: Yarra Ranges Council, Yarra Valley Community Health, Ranges Community Health,

Project contact: Cheryl McInnes
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Project Description

This project sought to strengthen the partnership arrangements between Ranges Community Health Service, Yarra Ranges Council and Yarra Valley Community Health by developing a shared understanding of each others practices, approaches, skills and knowledge with the view to providing a consistent approach to the application of ASM across the 3 services. The project also sought to develop appropriate approaches to in-home joint assessments and care planning activities.

Project Activities

Strategies implemented to support project outcomes included:

- The review of Intake practices to ensure services are capturing the right information to enable a person centred approach.
- The review of Priority of Access tools
- Conduct of joint visits for shared clients
- Providing opportunities for 'shadow' assessments to increase staff understanding about approaches to assessment and client care

Project Learning's

- Don't over-theorise practices but find (or develop) the simplest solution that will achieve the outcome required
- Understand your partners language and don't make assumptions about what you (or others know)
- Find out what the structure is that staff work within and then find ways of working within it
- Be practical—don't spend too much time on discussions, get into the practicalities and find what works and then share learning's and experiences so that all can benefit
- Trial what you develop and then identify strengths and weaknesses and improvements

Strengthening Partnerships in Care

Lead Agency: Whitehorse Community Health
Partner Agencies: RDNS
Project contact: Janine Scott
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Project Description

This project builds on the 2009/10 joint project between Whitehorse Community Health Service (WCHS), Royal District Nursing Service (RDNS) Box Hill and Whitehorse City Council WCC) Strengthening Partnerships in Care: A joint ASM Project. The project aims to support enhanced referral pathways and processes; to build staff capacity; and promote a collaborative approach to client care.

Project Activities

The project involved a number of activities including:

- Consultation with staff to map current referral processes which resulted in the development of a Referral Resource Guide and flow charts demonstrating referral pathways
- Case studies involving 3 shared clients where joint assessment and care coordination activities were tested
- Trial orientation sessions at each agency from reciprocal agency and joint professional development around Occupational Therapy, Dietetics services, The *Good Life Club* program and services, and E referral (S2S)
- Two 'meet and greet' networking sessions involving 40 staff
- Development of proposed inter-agency care coordination Protocol

Project Learning's

- Ensure evaluation strategies involving client feedback provide opportunity for elaboration by the client
- Don't be too ambitious in terms of change - be realistic about what can be achieved within a limited timeframe and resources
- Be sure to take into account the limitations of internal systems and process as part of the change process (i.e. IT capability)
- Acknowledge that potential (unintended) outcomes may develop as a result of changes to processes or practices and be open to address these as they arise
- Look for opportunities to embed partnership activities beyond the time limited project (i.e. The RDNS /WCHS 'Partnership Development' roles assuming responsibility for ongoing initiatives around shared staff networking, orientation and professional development)

Developing collaborative joint assessment protocols Further develop collaborative arrangements for client care, including assessments, care planning and protocols. Includes conducting trial joint-assessments. Co location of project officer.	City of Manningham (with Manningham Community Health)
Strengthening Partnerships - Manningham City Council and RDNS Reviewing and revising a protocol agreement. Building capacity of Council staff to provide hygiene assessments.	Manningham City Council and RDNS
Monash Falls prevention in the home program Trialling joint physiotherapist and Council assessments. Building capacity of Direct Care Workers to help clients complete physiotherapy prescribed home exercise programs.	Monash Link Community Health (with City of Monash)
Strengthening Partnerships - focus on OT waitlist management Develop a service coordination system with clear referral pathways, including electronic tools and systems and joint assessment approaches.	Lead agency: Ranges Community Health
Strengthening Partnerships in Care - Whitehorse Community Health and RDNS Strengthen the partnerships, and understanding of the role and services provided . Includes improving referral pathways and systems and exploring joint care planning.	Whitehorse Community Health and RDNS
Strengthening Partnerships - Ranges Community Health, Yarra Ranges Council & Yarra Valley Community Health Develop relationships between assessment and allied health that support collaborate client care.	Ranges Community Health, Yarra Ranges Council & Yarra Valley Community Health
Remodelling the HACC journey Using an EiCD multidisciplinary model, implement service coordination and system improvements for HACC clients and services.	Lead agency: Yarra Valley Community Health

Helping Clients through our Health Associates Network

Lead Agency: Balwyn Welfare Association
Partner Agencies: YMCA, Local Medical Centres
Project contact: Gillian Roebuck
p: 9836 9681 e: mcs@balwynwelfare.org.au

Project Description

Helping Clients through our Health Associates Network sought to develop referral pathways for older people (whose Doctors believe they would benefit from exercise) to participate in a fifteen week 'Introduction to Exercise' program.

Project Activities

The key activities of this project involved:

- Developing relationships and engagement with Doctors and Physiotherapists from 3 local medical centres
- Management and development of referral processes from heath professional (contributing to the 30 older people involved in the Introduction to Exercise trial)
- 15 week Introduction to Exercise trial
- Developing and trialling a client monitoring system which included:
  - ⇒ Establishing client fitness goals within individual lifestyle limitations
  - ⇒ fitness testing & regularly reviewing client progress
  - ⇒ client feedback

Project Learning's

- Research & understand the opportunities and potential constraints associated with developing new partnerships. Strategies to instil trust and the credibility of your program with potential partners will support positive involvement
- Seek feedback and test new referral processes with potential referral sources - keep the process simple
- Use promotional strategies to remind referral sources about you services:
  - ⇒ Place material in key places (i.e. in the GP's waiting room)
  - ⇒Submit newspaper articles and advertisements
- Test and refine new partnership relationships, communication, processes and practices

Strengthening Partnerships—focus on OT waitlist management

Lead Agency: Ranges Community Health
Partner Agencies: Yarra Ranges Council
Project contact: Tracey Higgins
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Project Description

This project sought to strengthen referral pathways, tools, systems and approaches in relation for Occupational Therapy service within the Ranges Community Health. Primarily, the project reviewed current practice with the view to supporting the appropriate prioritisation, and timely response to OT referrals. The project involved strengthening partnership development between Ranges Community Health (RCH), Yarra Ranges Council (YRC) and Yarra Valley Community Health Service (YVCHS).

Project Activities

The tri-agency partnerships implemented a number of strategies to support partnership development including:

- Information sharing sessions where current practice and experiences were discussed and reviewed
- Delivery of motivational Interviewing training
- Use of the Vic Health Partnership Tool
- Use, and discussion of case examples at Program meetings and Tri agency Case Conferencing Forum
- Review of existing referrals into Ranges OT services including the tools
- Delivery of the *Active at Home* Program in partnership with YRC which is a 10 week information and exercise program
- Trialled joint assessments and shadow assessments

Project Learning's

- Even with solid ground work in place, changes to protocols and processes need to be tested
- Don't assume staff will be able to translate written protocols and process into practice. Consider opportunities for staff to better understand changes by providing time to work through real life case studies, provide time for reflective practice and shadowing
- Test new processes by providing 'real time' understanding of your partners role and restrictions of service
- Think about strategies to deal with potential organisational restructuring during a change initiative

Monash Falls Prevention the Home Program

Lead Agency: Monash Link Community Health
Partner Agencies: City of Monash
Project contact: Linda Fiddes
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Project Description

MonashLink Community Health Service Ltd in partnership with the City of Monash HACC services developed and delivered the Monash Making a Move Program (MMMP) pilot. The MMMP is a home-based falls prevention initiative aimed at elderly (>75 years) HACC eligible, clients living in their own homes (with or without services) in the City of Monash.

Project Activities

The project involved the capacity building of 20 City of Monash HACC Direct Care Workers in supervising home exercise programs and identifying and reporting on falls risk factors in clients' homes. Fourteen clients participated in the project. They received 4 joint visits from the physiotherapist and up to 3 visits per week from their assigned DCW over an 8-10 week period. The program components included:

- Falls prevention education
- Falls risk factor identification and reporting
- Client-centred goal-setting and home exercise (validated model - Otago Exercise Program.

Project Learning's

- Identify opportunity to seek client feedback when testing new processes and practices. The feedback will provide evidence to support project outcomes
- Involve staff in the development of training and ensure it is delivered in a way that is meaningful to the target audience (i.e. task focused Direct Care Workers are likely to prefer and benefit from practical learning activities)
- Ensure clarity regarding program roles for both project development and change initiatives. Develop clearly defined program roles to avoid operational issues
- Don't overly complicate communication pathways

Sustainability for Life: Professional training for exercise instructors

Lead Agency: Balwyn Welfare Association
Partner Agencies: YMCA
Project contact: Gillian Roebuck,
p: 9836 9681 e: mcs@balwynwelfare.org.au

Project Description

This project builds on the goals of the "Helping Clients through Health Associates Network' Seeding grant project and aims to support sustainable processes that provide HACC clients with a long term, independent and individual understanding of, and commitment to exercise.

Project Activities

Project activities supported Balwyn Welfare Association's (BWA) commitment to ensuring that all centre based PAG exercise groups are led by a professional fitness instructor (currently arranged via the YMCA), with contingencies in place to support staff absence and backfill.

Three staff members completed the Certificate III/IV in Fitness with the Australian YMCA Institute of Education and Training and actively supported BWA exercise groups.

A collaborative partnership with YMCA was pursued with staff being able to access ongoing professional development and through the YMCA.

A further project activity involved the development of a Memorandum of Understanding with Inner East Community Health Service around referral for clients exiting the Falls Prevention Program.

Project Learning's

- When engaging new staff/ personnel as part of a change program, ensure selection criteria includes a commitment to the values of your service
- Support staff to consider the implications of choices in relation to change initiatives
- Seek approval and/or commitment from senior management and/or Board of Management to lead new initiatives

Integrated Care Framework (stage 2)

Lead Agency: City of Boroondara & Inner East Community Health Service
Partner Agencies: as above
Project contact: Genevieve Moloney
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Project Description

This collaborative project between City of Boroondara (COB) and Inner East Community Health Service (IECHS) aimed to improve the continuums of care for shared clients through the development of an Integrated Care Framework.

Project Activities

The project involved the development of an Integrated Care Framework between COB & IECHS which was informed by a series of 6 workshops held with staff from both services. The workshops reviewed current practices, identifying strengths and weaknesses and opportunities to enhanced collaboration.

The project also:

- Enabled formal and informal contact between agencies through team meetings, morning teas
- Improved communication channels though the development contact lists with photo recognition
- Scoped and conducted joint ASM training
- Identified and implemented common ASM elements within position descriptions across the two services
- Developed an ASM Induction Program led by the Integration OT for all staff
- Provided an ASM keep cup to all staff as a prompt tool
- Created a book of ASM case examples

Project Learning's

- Don't underestimate the power of providing space and time for staff to spend face to face time together to share service provider information (organisational processes and practices, etc).
- Developing a theoretical framework alone may not engage staff. Clinical and service specific staff are generally task oriented and want to see concrete action. Build in small wins that actively involve staff along the way.
- Develop shared vision —it provides a statement to return to if and when challenges arises
- Change takes time

Strengthening Partnerships

Lead Agency: City of Manningham
Partner Agencies: Manningham Community Health
Project contact: Robyn Spoor
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Project Description

This project was developed to strengthen the relationship between the two Manningham HACC Assessment Services (HAS), Royal District Nursing Service (RDNS) and Manningham City Council (MCC) with the aim to enhancing referral pathways, reducing duplication of assessment practice and seeking opportunities for sharing knowledge, expertise and good practice. MCC further sought to review and enhance its current practices for personal care assessments.

Project Activities

The key activities of the project involved the review of current documentation used by MCC and RDNS in conducting personal care assessment and where this information may be shared; training of Assessments Officers in CHCICS401A Facilitate support for personal care needs; the development of draft indicators and protocols for referral between MCC and RDNS.

The project involved a practical trial to enable Assessment staff to conduct simulated personal care assessments with low needs clients and complete client care plans incorporating OH&S instructions for Home Support staff. Concurrent to this, a new screening practice was introduced at Intake to better identify referrals where the client information indicated RDNS HAS may be the more appropriate organisation to conduct the initial assessment.

A Draft referral and practice Protocol was developed.

Project Learning's

- Conduct a practice trial for staff to test competencies gained as part of a change project. Staff self evaluation may identify opportunities/need for further training
- Shared discussion between services reinforces the need to work towards a common service delivery language and protocol so all levels of service delivery understand and adopt same practice
- Joint review of the partner agency tools is a valuable exercise in building trust and confidence in the referral process and exchange of client information
- If possible, be flexible with the timelines for client trials– clients may not be readily available when you want them
- Keep a log of issues and potential risks associated with sustaining outcomes

Developing Collaborative Joint Assessment Protocols

Lead Agency: City of Manningham
Partner Agencies: Manningham Community Health
Project contact: Robyn Spoor
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Project Description

This project planned to consolidate and strengthen the developmental work already commenced between Manningham City Council (MCC) and Manningham Community Health Service Ltd. (MCHS) in the area of referral and practice protocols for referral and access to Occupational Therapy services.

Project Activities

Key activities involved an MCC HACC Assessment Officer and an MCHS Occupational Therapist undertaking a review of the current referral and assessment pathway for clients referred for both services including processes at Intake, collection and sharing of client information, timelines for assessment and feedback mechanisms.

A trial process for referral and collaborative assessment was developed and tested by a small client trial of nine participants. The trial included clients identified as requiring intervention for essential function or who would benefit from education in adaptive strategies for domestic activities.

Project Learning's

- Use of the Vic Health Partnership tool supports the identification of common goals and interests
- The availability of participants for client trials is often out of the projects control. Where possible, identify potential to link with concurrent projects that can enhance project outcomes and be realistic about timeframes
- Consider regular meeting times between practitioners as a means of supporting open communication
- Arranging a social event/gathering is a great way to get to know staff across partnering organisations
- Seek agreement and be clear about 'where to from here' at the conclusion of the fixed term project

Person Centred Pathway Resource - A Guide to an active PAG service

Lead Agency: Caladenia Dementia Care
Partner Agencies: Yarra Ranges Council, Golden Wattle
Project contact: Sarah Yeate
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Project Description

A collaboration of three HACC agencies (Yarra Ranges Council, Caladenia Dementia Care and EACH *Social and Community Health— Golden Wattle House*) formed to produce a resource guide specifically designed to support the understanding, and implementation of the active service model for PAG workers. The project also sought to strengthen the partnership between the 3 organisations involved, and document 'how' to embed the ASM principles with the PAG culture, philosophy and policy development.

Project Activities

PAG staff and volunteers were surveyed twice during the course of the project and the survey findings provided the basis for training delivered to 29 PAG staff and volunteers.

The Person Centred Pathway Resource is designed to be a companion and reference for all staff and volunteers supporting people and their carers who attend PAG. The resource manual can be used as a quick and easy reference guide and includes information about:

- What are PAGs
- Well For Life
- ASM
- Person Centred Planning
- Review of the 4 key ASM PAG Procedures
  - ⇒ Intake/Assessment
  - ⇒ Social Profile/Care Plans (including goal setting)
  - ⇒ Service Delivery (including training for staff and volunteers that can be delivered by PAG leaders)
  - ⇒ Discharge (both person and service initiated)
- Useful resources and where to find information and local services
- Sample forms

Project Learning's

- Staff and volunteers directly affected by change need to be involved in the change process and their opinions actively sought
- Test newly developed resources and training programs and be prepared to refine them accordingly
- Its worth taking the time to develop service specific case studies and learning material
- Staff expectations of change vary - help them to understand the 'language' and how it reinforces their role

Improving Access to OT services in the City of Knox

Lead Agency: Knox Community Health Service
Partner Agencies: City of Knox
Project contact: Ann Elkins
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Project Description

This collaborative project between Knox Community Health Service (KCHS) and Knox City Council (KCC) sought to develop and implement practical and creative ways to improve HACC eligible client access to occupational therapy services. Specifically, the project sought to improve inter-organisational practices around client flow and throughput.

Project Activities

Key elements of the project involved:

- Reviewing the appropriateness and timeliness of referral information and how information is shared
- Review of Triage, Waitlist management and OT processes including the use of an electronic tablet to enter OT data, diagrams and drawings as part of the OT assessment
- Trial of an administration assistant support role
- Client feedback

Project Learning's

- The collection of client feedback as part of change project provides direction in regards to improving processes and practices
- Identifying change champions within an organisation is a good way to ensure consistency of messages across services
- Cross organisational education and up-skilling supports timely access to services by reducing the potential for inappropriate referrals
- Need to ensure all stages of project activity are communicated in a timely manner
- Take small steps with the big picture in mind

Strengthening Partnerships

Lead Agency: Knox Community Health Service
Partner Agencies: City of Knox, RDNS
Project contact: Ann Elkins
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Project Description

This project aimed to build and sustain interdisciplinary practice between Knox Community Health Service (KCHS), Knox City Council (KCC) and Royal District Nursing Service (RDNS) with the view to promoting greater understanding of inter-organisational roles and services and establishing agreed common protocols and process for care.

Project Activities

Key activities of the project involved:

- Interagency activities which enabled staff to share stories, information, practice and learning's including:
  - ⇒ Delivery of a person centred workshop (conducted by NARI) to reinforce collaborative problem solving and practice reflection
  - ⇒ Peer to peer lunches
  - ⇒ Attendance at team meetings
- Development and implementation of a Partnership Protocol shared at an interagency protocol workshop session attended by 27 staff
- Continuation of joint visits by KCC OT and KCC HACC Assessment

Project Learning's

- Undertaking cross organisational shared learning opportunities in different environments (shared meetings, workshops and training, joint home visits) provides an impetus for staff to better understand partner organisation role/ responsibilities and organisational capacities
- Develop face to face relationships
- Problem solve and brainstorm how effective learning and collaboration between organisations can occur
- Formalising relationships (i.e. via Protocols) is an effective way to positively demonstrate commitment at an organisational level. They do, however, require ongoing review or refinement
- Organisational relationships do not always develop naturally—they need to be practiced!
- Effective collaborative research and practice takes time, patience, commitment, and even a sense of humour!