Partnerships and Possibilities

Local Government and Health organisations working together to expand their capacity to provide person-centred services

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The story so far…

- $7.4 million of HACC growth funding was allocated to Occupational Therapy (OT) and Personal Care (PC) across all local government areas in Victoria
- Funds have been allocated to health services and councils to expand the capacity to deliver the Active Service Model (ASM)
- In the Loddon Mallee Region this capacity building focus has not only considered expanding the amount of OT service being delivered to HACC clients, but also building the capacity of all staff to work according to the ASM practice principles
- Project Officer roles were established as a resource to the LGA partnerships to progress the necessary planning for the joint work of OTs with HACC assessment and personal care staff

What we aimed to achieve…

- The OT/HACC assessment partnership is leading to improved outcomes for HACC eligible clients in line with the ASM.
- Partnerships are strengthened to support HACC assessment and service provision to clients.
- An increased understanding of the enablers and challenges impacting on the implementation of the ASM and interdisciplinary practice. Strategies have been identified to address these issues – both within and across the LGAs if relevant.
- An increase in knowledge/experience about the use of less formal staff learning experiences on the implementation of the ASM, including mentoring, reflective practice and peer support.

2 key ingredients for building partnerships…

<u>Development of partnership agreements</u>

- This documentation has been a key strategy towards supporting the sustainability of the work. Agreements may be attachments to existing Memorandum's of Understanding, a Protocol between agencies or a separate document.

<u>Joint meetings between partner organisations</u>

- LGA's were supported by the Project Officer and other Department of Health (DH) staff to meet together for planning both around their partnership and around the work on the ground.

A local approach…

- Home & Community Care (HACC) organisations in the Campaspe LGA that received additional funding were REDHS, Shire of Campaspe and Echuca Regional Health
- Bendigo Health are also involved in the partnership due to the involvement of the Rural Health Team with HACC clients
- Development of an MOU, pathways, protocols and guidelines has been an integral part of the partnership process

HOW WE HAVE WORKED TOGETHER

SHIRE OF CAMPASPE

Echuca Regional Health

redhs

hacc
home and community care

INTAKE MEETING
* Held fortnightly, attended by OTs and Assessment Officers
* Discuss clients identified by the Assessment Officers as being potential candidates for the program.
* If appropriate clients identified, discuss OT availability for joint assessments
Assessment officers make the booking and send referral to OT via Connecting Care

OT INITIATED REFERRALS
* Client presented at Intake Meeting by OT
* OT discusses with client and arranges joint assessment (if appropriate), then sends referral to HACC Assessment Service via Connecting Care

JOINT ASSESSMENTS
* To date, assessment officer leads assessment
* OT provides input as appropriate to clarify functional issues, determine motivation/insight/potential OT goals.
* If client goals determine a need for OT input, OT will complete follow up visits independently.
* OT and client establish a care plan which is forwarded to the assessment officer and integrated into the Shire care plan.
* Client progress is discussed at intake meeting.

STRENGTHS
* Networking between organisations.
* Greater understanding of each other's roles and how we can all work together for the best outcomes for our clients
* Capacity for Occupational Therapists to support and work directly with staff delivering the services
* The partnership has highlighted the importance of working together and sharing appropriate information between staff and inter agency
* Development of clear documentation to support the work eg agency protocols and communication pathways

CHALLENGES
These challenges have arisen throughout the partnership. It is important to remember that the partnership and the way in which we all work together is ever evolving and many of these issues have been addressed and the challenge overcome.

* The need to revise screening tools to ensure a comprehensive but realistic list of potential clients is discussed at intake
* Agreement of allocation of client
* Different operational structure, processes and expectations of the partnership driven from management
* Logistics of co-location
* Initial time and resources required to set up the partnership
* Coordination of joint assessments – EFT, other work commitments, flexibility of clients
* Clear understanding of fee structure and charging in the beginning was not clear
* Preconceived ideas and expectations of potential clients. Need high level of engagement and motivation from the client for a restorative approach.
* 'Buy-in' of Support Workers has been challenging moving away from "doing for" to "doing with"

"Getting back on track"

Background:

"Bob" is an 82 year old man living at home alone in Echuca. Bob initially contacted the Shire to increase services as he was finding it hard to manage tasks at home due to vertigo, decreased mobility and a recent fall. Intake flagged this assessment to be a potential for Occupational Therapy (OT) input and a joint assessment was scheduled with Assessment Officer (AO), OT and Bob.

Co-location in action:

A joint assessment was completed and additional services were implemented. Unfortunately, before further OT input, the client was admitted to hospital and in turn rehabilitation before extra services were put into place. The OT on the project was also working in the rehab ward so was able to follow Bob through his stay and support safe discharge home. On initial return home Bob was managing well with homecare only, and attending local exercise groups through the Shire and ERH Community Rehab Centre. After some time at home following an appointment with his vascular specialist, Bob was recommended to wear groin height compression stockings. Bob was unable to manage donning and doffing the stockings independently for several reasons so contacted the OT for assistance.

The OT made a visit to Bob and provided him with several aides to consider and provided education and practice on how to use each one. The OT then contacted the Assessment Officer at the Shire to notify of change in care plan goals. The Shire arranged for a 15 minute pop in service to assist Bob with donning and doffing his stockings using the aides provided by the OT.

An education session was scheduled with Bob, the OT and Community Care Workers (CCW) that would be rostered to assist Bob with the task. During the session it was explained that Bob was working towards a goal of being able to independently complete the task and not require the service. The aides were shown and demonstrated, and workers were then encouraged to give them a go and get that practical knowledge. It was recommended that CCW then encouraged Bob and provide assistance where needed rather than coming in and doing the task for him.

Regular contact between Bob and the OT was made during the early stages of the service to ensure Bob was participating and increasing his skill. Contact was also made between the OT & Shire to provide feedback on the CCW.

A positive outcome:

After the service provided for approximately 4 weeks Bob is now able to independently complete the task using an aide that he has since purchased with guidance from the OT.