Induction Resource for HACC Assessment Services

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MUNICIPAL ASSOCIATION OF VICTORIA

The MAV can provide this publication in an alternative format upon request, including large print, Braille and audio.

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FOREWORD

The Municipal Association of Victoria (MAV) with the support of the Victorian Government Department of Health, has undertaken to assist councils with implementing the Assessment Framework and Active Service Model – new policy directions in the Home and Community Care (HACC) program.

Based on feedback received from a MAV workshop and survey, councils identified the need for updated resources to assist them in the areas of recruitment, induction and training of assessment staff. Although there are numerous publications about the Home and Community Care Program (HACC) and related programs, it was felt that there was no uniform approach to which of these documents were routinely provided to new assessment staff in different councils, nor common agreement about the essential elements and scope of the policy and service system knowledge considered necessary to begin practice as a HACC assessor.

This project has thus sought to provide an easy to use resource for inducting new HACC assessment staff, to ensure they have a common understanding of the policy and program context for their work, and links to the more detailed reports they need to read. Although the induction resource has been developed to meet the expressed needs of those councils who are designated HACC assessment services, it is intended that it will also be used by other HACC assessment services and be useful to a range of HACC service providers.

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- Aged Service Branch, Department of Health (DH)
- Royal District Nursing Service (RDNS)
- Victorian Health Care Association (VHA)
- Aged and Community Care Victoria (ACCV)
- Victorian Indigenous Committee for Aged Care and Disability (VICACD)
- City of Frankston; City of Greater Dandenong; City of Monash; City of Maribyrnong; City of Banyule; Ballarat City Council; Latrobe City Council; City of Greater Shepparton; Colac Otway Shire; Campaspe Shire.

Section 1. Introduction

1.1 Purpose of the induction resource

This resource is designed to induct Home and Community Care (HACC) assessors to:

- the HACC program
- the HACC assessment role
- the HACC program within the broader service system.

1.2 Who is the induction resource for?

The key audience for this resource is the newly appointed HACC assessor working in a designated HACC Assessment Service.

It can also serve to:

- refresh or update the knowledge of experienced HACC assessors
- provide an overview of HACC and related programs for team leaders and community care workers who will benefit from this information.

1.3 Why is it needed?

The HACC assessor plays a critical role in connecting people in the community to the services and supports they require to live safely at home, which can make a significant contribution to their quality of life.

However, a survey conducted by the Municipal Association of Victoria (MAV), representing local government, the largest single employer of HACC assessors in Victoria, found that:

- Two thirds of local governments responding had appointed new assessment staff in 2008.
- Just over half the assessment staff had three years or less experience in their current or a similar role.
- Assessment staff may have any one of sixteen or more primary qualifications.

Feedback from local government managers reinforced the need for standardised, accessible induction materials to orient new workers into the HACC policy and program context.

In addition, the HACC program -and HACC assessment in particular-has undergone significant policy development and change over the past few years.

At the Commonwealth level, *A New Strategy for Community Care: The Way Forward*, (released in 2004) established a significant national reform agenda for the community care sector, including the HACC program and the assessment function.

In Victoria over the last three years, important policy development work in the HACC program includes:

- the implementation of the Victorian HACC Assessment Framework
- the Active Service Model project
- the HACC Diversity Framework, including Strengthening HACC in Aboriginal Communities strategy.

HACC assessors are required to have a demanding combination of 'big picture' knowledge and operational detail, including:

- the HACC Program – the history and philosophy of the program and its operation
- HACC assessment – the HACC Assessment Framework, the role of the HACC Assessment Service and the role of the HACC assessor
- the program's current and future clients
- current policy context and the broader health, community and aged care service system that HACC operates in
- the services and systems which intersect with HACC
- the local service system their organisation works within and how it supports individual clients, particularly those with chronic diseases.

The induction resource is both a reference and a learning tool to help assessment staff make sense of the complex service system in which they operate while providing the best assessment service possible to clients.

1.4 What the induction resource is (and is not)

To serve its purpose of inducting HACC assessors, the resource provides:

- information on the HACC program and policy context
- information on where HACC fits in the broader service system
- links to further information sources
- practical learning tasks designed to reinforce knowledge and develop understanding.

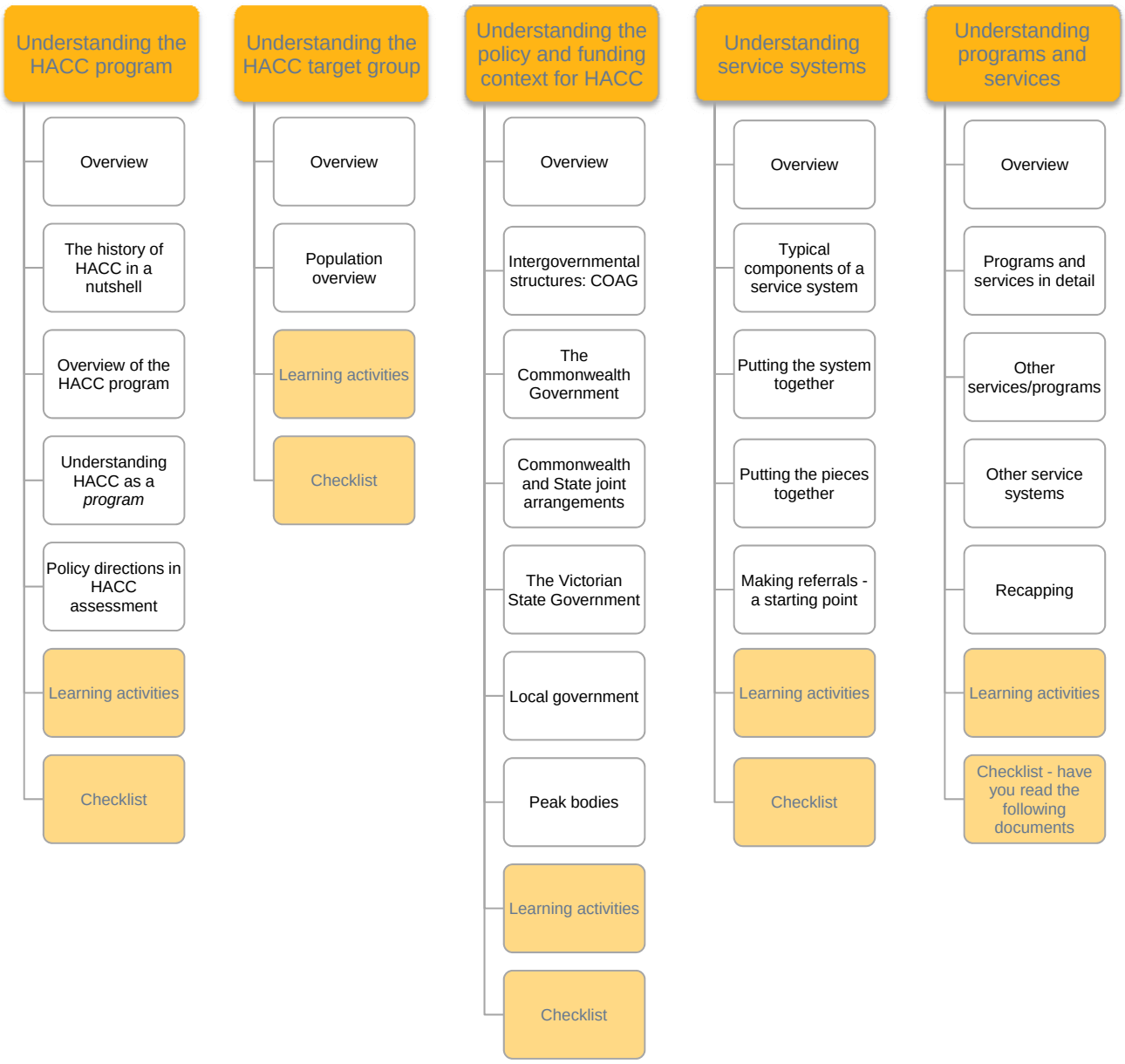
The information is provided as summaries or quotes from a large number of sources to describe policies and programs. It is intended to provide an overview or introduction to the topic and direct weblinks are included as references and to facilitate further reading from the original documents.

This resource is *not* a program manual. *The Victorian HACC Program Manual*, prepared by the Department of Health, provides program policy. The resource refers to the Victorian HACC Program Manual and is consistent with it.

This resource is *not* a manual documenting assessment practice. The Department of Health has produced a practice guide describing assessment and care planning skills and techniques, *'Strengthening assessment and care planning: A Guide for HACC Assessment Services in Victoria'.*

This resource is *not* an operational policy and procedure manual. It is expected that HACC Assessment Services will have their own internal policies and procedures. It is intended to support an organisation's own orientation and induction processes.

1.5 Structure of the induction resource



1.6 How does the induction resource work?

1.6.1 Assessors

The resource is divided into five core areas of knowledge and understanding, as per the structure above. In some instances, such as the funding and policy context, assessors will only require overview information. Other areas require more detailed knowledge.

The document is designed as a web-based resource. Links are provided throughout which will allow you to connect to the primary source of information, be that a website or a report.

While the document follows a conventional structure, moving from the general to the more specific, it can be navigated easily through the links in the document. Users can structure their own learning sequence.

The self-paced learning activities are designed to be practical and will help build your own resources, while also giving you the chance to investigate areas of the HACC program or HACC assessment in more detail. Discuss and plan the learning activities in consultation with your manager. It may make sense to modify or adapt some of the activities to fit in with team priorities or workplace resources. Extracting demographic data on an LGA or catchment area, for example, may be a time consuming activity for limited benefit. In other organisations, this may be a straightforward and useful task. The learning activities are intended to promote discussion about the HACC program and assessment with your manager and some themes will be relevant for team discussions.

1.6.2 Managers

Managers should have an electronic version of this resource. As part of the induction process, it is recommended that the learning activities to be undertaken are discussed and agreed prior to commencement. The learning activities provide new assessors with the opportunity for some 'real world practice'. If alternative activities would achieve the same end, or the suggested activities would be too resource intensive, then negotiate another activity.

The principles of adult learning recognise that adults come with a range of life and educational experiences; that their previous experience will influence their current learning and that they are generally motivated to learn. Adults learn best when individual learning styles are respected, there is a variety of activities and the learning builds on previous knowledge and experience.

The learning activities may best be completed over a period of time and used to integrate theory into practice.

1.7 Glossary and Acronyms

The language of the community care sector may be quite foreign to the new staff member, which can be confusing. Programs and organisations can commonly be referred to by a shorthand title, phrase or acronym. Refer to this glossary and the list of acronyms as you work through the resource and be aware that new terms and acronyms are constantly emerging. Your organisation may also have specific terms or acronyms which you could add here.

To cover the range of HAS organisations, the term 'HACC assessor' has been used through this resource to refer to the person conducting Living at Home assessments. The term 'manager' has been used to refer to the line manager or supervisor of the HACC assessor.

Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or as both. Aboriginal organisations are those that receive HACC funding to provide services to the Aboriginal community.

1.7.1 Glossary

Term	Definition
Active service philosophy	Active service philosophy refers to the principles underpinning the Active Service Model, including that "People have the potential to improve their capacity." (see HACC Active Service Model Discussion Paper, pp. 10–11). Experience in Victoria, interstate and internationally indicates that Active Service Model approaches represent a specific way of thinking about and providing services to the HACC target group. The shorthand version of this is "Doing with, not doing for." With this as the underpinning philosophy, it can prompt different ways of thinking about relationships with clients, direct practice,

Term	Definition
	service systems and strategies, as well as partnerships with other organisations.
Active Service Model	The quality improvement initiative currently used in the HACC program in Victoria, which explicitly focuses on promoting capacity building and restorative care in service delivery.
Allied health	Allied health includes a wide range of clinical services, including podiatry, occupational therapy, physiotherapy, social work and dietetics.
Ambulatory services	Care delivered on an outpatient basis.
Care coordination	Activities undertaken following a Living at Home assessment for a subgroup of clients with complex needs and circumstances. People needing care coordination include clients receiving services from multiple organisations who are not receiving case management as part of a package of care.
Care Coordination Plan	A Service Coordination Tool Template which documents issues/problems for a client, their goals, actions to be taken to achieve these goals, and identifies a key worker responsible for liaising between relevant organisations. A Care Coordination Plan is developed for clients with complex needs and/or multi-agency involvement. However the template itself can be used for any HACC clients to summarise their care plan and goals.
Care recipient or Client	A person who receives HACC services due to frailty or disability.
Carer	Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or who are aged and frail. In assessing eligibility for the HACC program, someone is defined as a carer if they receive HACC services because they care for a frail or disabled person.
Case management	Assistance provided by a formally identified agency worker to a client with complex care needs. The case manager will coordinate the planning and delivery of services from more than one agency. A case manager is different to a care coordinator in that they usually manage brokerage funds which purchase services on behalf of the client (such as in a Linkages package).
Diversity planning	A quality improvement initiative which promotes a holistic, person-centred approach to service planning, delivery and evaluation.
HACC activity types	The types of service funded by the HACC program.
HACC service provider	An organisation providing HACC funded services.
Key worker	The nominated person who works with the client/carer and other organisations to facilitate inter-agency care-planning and care coordination. Key workers are only nominated for clients with complex needs and/or multi-agency involvement.

Term	Definition
Linkages	Linkages is a HACC funded case management service which has brokerage funds to purchase additional services for people whose needs cannot be met entirely by the usual level of HACC services. This constitutes a package of care for the consumer.
Living at Home Assessment	A Living at Home assessment is a broad, holistic needs-based assessment, which occurs in the client's home. A Living at Home assessment includes service-specific assessment(s) for service provided by the assessing organisation, an occupational health and safety assessment (OHS), care planning and care coordination.
Packaged Care	HACC funded Linkages or case managed Commonwealth funded services – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACHD). Eligibility for Commonwealth packages is determined by the Aged Care Assessment Service.
Primary Care Partnership	A Primary Care Partnership (PCP) is a group of services that has formed a voluntary alliance to work together to improve health and wellbeing in their local community. Consistent with State Government policy, PCPs usually cover several municipalities.
Referral Action Plan	The Referral Action Plan outlines the referrals that will be made and actions taken for the client as determined through the Living at Home assessment and agreed with the client and/or their carer. The Summary and Referral Template for the SCTT tools contain a template for documenting referral actions.
Relative Resource Equity Formula	Per capita based method for allocating HACC funds equitably between regions.
Service coordination	Service coordination places clients at the centre of service delivery, to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes. Service coordination enables organisations to remain independent of each other, while working in a cohesive and coordinated way to give clients a seamless and integrated response.
Service Coordination Tool Template (SCTT)	The Service Coordination Tool Templates (SCTT) is a suite of templates developed to facilitate and support service coordination, and is part of Victoria's service coordination strategy. The SCTT tools support the collection and recording of initial contact, initial needs identification, referral and coordinated care planning information in a standardised way. Usiing SCTT should improve communication, information sharing, and the quality of referrals and feedback between service providers.
Service-specific assessment	An assessment for a specific service type such as home care, delivered meals, nursing or allied health.
Service-specific care plan	A care plan which is developed and documented using specific program or agency tools, and may be referred to as a Client Care Plan, an Individual

Term	Definition
	Treatment Plan, a Self-management Plan, a Personal Action Plan, a Service Plan or a GP Management Plan.

Table 1.1: Glossary

1.7.2 Your Personal Glossary

Create your own glossary in the table below, recording new terms as you encounter them.

Term	Definition

Table 1.2: Your personal glossary

1.7.3 Acronyms

Acronym	
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAS	Aged Care Assessment Service
ACCO	Aboriginal Community Controlled Organisation
AIHW	Australian Institute of Health and Welfare
CACP	Community Aged Care Package
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
CSHITB	Community Services and Health Industry Training Board
DADL	Domestic Activities of Daily Living
DEEWR	Department of Education, Employment and Workplace Relations
DH	Department of Health (Victoria)
DoHA	Department of Health and Ageing (Commonwealth)
DHS	Department of Human Services (Victoria)
DVA	Department of Veterans' Affairs (Commonwealth)

Acronym	
EACH	Extended Aged Care at Home
EACH D	Extended Aged Care at Home - Dementia
EIiCD	Early Intervention in Chronic Disease
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs (Commonwealth)
FASA	Funding and Service Agreement
HACC	Home and Community Care
HARP CDM	Hospital Admission Risk Program Chronic Disease Management
HAS	HACC Assessment Service
HREOC	Human Rights and Equal Opportunity Commission
IC	Initial Contact
INI	Initial Needs Identification
LGA	Local Government Authority (Council)
MDS	Minimum Data Set
MAV	Municipal Association of Victoria
NHS	National Health Survey
OH & S	Occupational Health and Safety
NRCP	National Respite for Carers Program
PAG	Planned Activity Group
PAV	Personal Alert Victoria
PAC	Post Acute Care
PASA	Program and Service Advisor
PCP	Primary Care Partnerships
RDNS	Royal District Nursing Service
RREF	Relative Resource Equity Formula
SCTT	Service Coordination Tool Template
SRS	Supported Residential Services
SDAC	Survey of Disability, Ageing and Carers (ABS)
SHAC	Strengthening Home and Community Care in Aboriginal Communities Strategy
VHC	Veterans' Home Care

Table 1.3: Acronyms

1.7.4 Your List of Acronyms

Create your own list of acronyms in the table below, including both statewide and local networks and services.

Acronym	

Table 1.4: Your list of acronyms

Section 2. Understanding the HACC Program

2.1 Overview

This section presents a general overview of the HACC program – an essential requirement for HACC assessors.

Key Points

- Created in 1984, the HACC program is the main provider of home-based care services in Australia.
- The program is jointly funded by the Commonwealth and State Government in Victoria.
- In Victoria, local government is both a key provider of HACC services and a funding contributor.
- The program funds a range of basic maintenance and support services for frail aged people, people with a disability and their carers.

2.2 The history of HACC (in a nutshell)

The Home and Community Care (HACC) Program is the main funder of home-based care services in Australia. It provides a range of services to both frail older people and younger people with a disability as well as their carers.

The HACC program was created in 1984 (through an Agreement with the Commonwealth, State and Territories and the Home and Community Care Act 1985), following a report of the House of Representatives Standing Committee on Expenditure in 1982. It brought together, into the one system, a range of separately funded State and Commonwealth programs. These included the Home Nursing Subsidy Act of 1957, the States Grants (Home Care) Act of 1969, the Delivered Meals Subsidy Act of 1970 and the States Grants (Paramedical Services) Act of 1969.

While HACC (as a national program) has now generated its own rich history over the past quarter of a century, it is useful to understand HACC's origins in the state and local services created to respond to community needs over the previous century. The Royal District Nursing Service (RDNS) commenced in 1885 with a single nurse visiting the homes of the sick poor, providing care to mothers with new babies and the frail aged. The need for the service was soon obvious and in 1892 a midwifery service commenced. By 1906 the service had extended to the suburbs and nurses were using bicycles to visit over 28,000 homes per annum. Cars were introduced as patient numbers exploded with the influenza epidemic of 1919. By 1926, the After Care hospital had been opened by RDNS and the forerunner of maternal and child health centres was opened. Shortly after World War Two, RDNS care was extended to all of the community. By 1970 the service also included social workers and a physiotherapist, allowing the very frail aged to stay at home longer. Specialist services were added in the 1970's and 80's with the service being extended to 24 hours a day, 365 days a year.

Housekeeping services first grew out of the need for support of mothers during wartime. This need had been identified by the maternal and child health services, which had been established by the State Government across Victoria in partnership with local government, from the late 1920's. Home help for older people was established as a funded state program from 1955, following inner Melbourne local council examples and expanded to include respite for families with disabled children in 1974. South Melbourne Council, with its many older people in boarding houses, also pioneered senior citizens centres and delivered meals. The first delivered meals in 1953 were carried in a box on the back of a tricycle. The service, heavily reliant on volunteers and a "good neighbour" ethos, was taken up across Victoria by other councils. The Old People's Welfare Council was founded in 1951 and later became COTA (Council on the Ageing). It actively encouraged the establishment of local senior citizen centres as places for voluntary self help amongst older people and places for social activity and services such as meals, podiatry and hairdressing. The buildings were jointly funded by local fundraising, State Government and local councils, and by the 1970s also received Commonwealth subsidies. Home maintenance services were piloted in Fitzroy in the late 1970s using Commonwealth employment scheme funding (the RED scheme) and then included in the HACC program in the mid 1980s.

Literature searches have not identified a consolidated written history of the HACC program, however there would be a plethora of reports in every state and territory of Australia tracking the evolution of the program. In developing a working understanding of the history of the HACC program, there are two key points which are particularly important:

- HACC brought together a number of separate programs and services under one umbrella, maintaining a strong philosophy about providing care in the community to people who would otherwise be vulnerable
- Whilst HACC is a national program, each state has had scope to build on its own history and develop the program to meet state needs. The Victorian Government has played a key strategic role in shaping the HACC program. Over the past decade, the introduction of service coordination, the new framework for HACC assessment and the introduction of the Active Service Model are examples of Victorian initiatives.

The history of the HACC program over the past 25 years shows that it has evolved quite rapidly and remains a key investment priority for governments, with a sophisticated program and management structure. History and current policy trends suggest that the HACC program will undoubtedly continue to be reformed and improved to meet the contemporary needs of the Australian community.

2.2.1 HACC Program Milestones

Year	Milestone
1985	HACC program commences with an agreement between the Commonwealth, States and Territories and the Commonwealth Home and Community Care Act
1991	Development of '*Getting it Right*' – HACC program national standards
1992	Introduction in Victoria of a method of distributing growth funds more equitably across regions (Relative Resource Equity Formula)
1993	Introduction of the Victorian *HACC Program Manual*
1998	Introduction of unit pricing (Victoria)
2001	Introduction of the Minimum Data Set (MDS) V1
2002	Introduction of the Victorian Service Coordination Tool Template

Year	Milestone
2003	Revised Victorian *HACC Program Manual*
2003	Introduction of the Victorian HACC quality improvement strategy
2003	Introduction of triennial funding and planning in Victoria
2003	Culturally Equitable Gateways Strategy (CEGS) Initiative
2006	Introduction of MDS V2
2007	Introduction of the Victorian HACC Assessment Framework
2008	100 HACC organisations designated as HACC Assessment Services
2008	Victorian HACC Active Service Model Discussion Paper
2010	Diversity Planning
2010	COAG agreement reached on reforms of Health and Aged Care in Australia

Table 2.1: HACC program milestones

2.3 Overview of the HACC Program

The overall objective of the HACC Program is to enhance the independence of people in the target group and to avoid their premature or inappropriate admission to residential care.

The range of services funded through the HACC Program includes nursing, allied health, delivered meals, home care, personal care, respite care, property maintenance, planned activity groups, linkages, volunteer coordination and assessment. Local government, health services, community health centres and district nursing services represent most of Home and Community Care (HACC) service providers in Victoria. Councils and district nursing services together provide the majority of the home based community care.

The HACC Program aims to:

- Provide a coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers (friends or family).
- Support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing inappropriate admission to long term residential care.
- Provide flexible, timely services that respond to the needs of clients (and their carers).[1]

The HACC Program is a joint Commonwealth and State Government program. COAG decided in April 2010 that the Commonwealth government would take full funding and policy responsibility for aged care in other states and territories (except WA) from June, 2012, as part of the reform of Health and Aged Care in Australia. The Victorian Government, however, will retain responsibility for jointly funding and managing HACC services in Victoria.

The Victorian Department of Health (the Department) is responsible for managing HACC in Victoria in accordance with national objectives and guidelines. This includes the approval and funding of individual HACC services. The Department is responsible for state level policy setting, program management and

[1] Victorian HACC Program Manual February 2003 page 4

service development. It has a central office (located in the City of Melbourne) and regional offices located in each of the eight geographical regions.

There are three metropolitan regions:

- Eastern Metropolitan Region
- North & West Metropolitan Region
- Southern Metropolitan Region

and five rural regions:

- Barwon-South Western Region
- Gippsland Region
- Grampians Region
- Hume Region
- Loddon Mallee Region

Within central office, the Wellbeing, Integrated Care and Ageing division is responsible for prevention, chronic disease and integration of care, health management and aged care services, including the HACC program. The division develops strategic priorities, implements policy, and funds and monitors service delivery. It is also responsible for workforce policy and planning in the health and aged care sector.

Regional offices have a key role in planning, funding, relationship management and contract management. They develop strong partnerships with agencies to collaboratively plan local services. The regional office manages and monitors the Funding and Service Agreement (FASA) between the Department and the HACC service provider.

The HACC program funds approximately 500 organisations across Victoria to deliver HACC services. Among them are:

- 73 local councils
- the Royal District Nursing Service (RDNS)
- 32 community health services and 94 hospitals

- 13 bush nursing services
- 25 Aboriginal community controlled organisations (ACCOs)
- 55 ethno-specific and multicultural organisations
- more than 180 other non-government organisations (NGOs).

Of these 500 agencies, 100 are designated as HACC Assessment Services. These include:

- 73 local councils
- RDNS
- 20 non-metropolitan health services
- 2 ACCOs,
- 4 other NGOs.

The HACC Program is part of a broader framework incorporating a wide range of health and community services, such as: community health services, public and private hospitals, general medical practitioners, mental health services, residential and community based respite services, disability services, residential aged care facilities, disability support services and packaged services. *Section 5: Understanding service systems* provides an overview of these systems and their relationship to the HACC program. HACC services can be accessed via any one of these organisations. This is termed the 'no wrong door' approach to service delivery.

References and Resources

- The Victorian HACC Program Manual:
  www.health.vic.gov.au/hacc/prog_manual/
- The HACC Assessment Framework and Active Service Model:
  www.health.vic.gov.au/hacc/downloads/pdf/framework.pdf
  www.health.vic.gov.au/hacc/downloads/pdf/asm_discussion_paper.pdf
- List of HACC Assessment Services:
  www.health.vic.gov.au/hacc/assessment.htm

2.4 Understanding HACC as a program

For staff new to HACC or to the assessment role, it can be daunting initially to get an overall 'picture' of such a detailed and long-running program with its own terminology. In addition to information provided by your workplace, the Victorian *HACC Program Manual* (2003) and the amendments to the manual are the places to start. The HACC home page on the Department of Health's website is also essential reading, especially for the latest updates. Follow the links above to access this information.

The table below breaks the program into its key elements and summarises the key points you need to know. This is your starting point for understanding the overall program.

2.4.1 The HACC Program

Program element	Summary
Objective	To enhance the independence of frail aged people and younger people with disabilities and their carers and to avoid premature or inappropriate admission to long term residential care.
Aims	◆ Provide a coordinated and integrated range of basic maintenance and

Program element	Summary
	support services for frail aged people, people with a disability and their carers. ◆ Support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing inappropriate admission to long term residential care. ◆ Provide flexible, timely services that respond to the needs of clients.
Target group	Persons living in the community who, in the absence of basic maintenance and support services provided, or to be provided, within the scope of the Program are at risk of premature or inappropriate long term residential care including: (i) older and frail persons, with moderate, severe or profound disabilities (ii) younger persons with moderate, severe or profound disabilities and (iii) such other classes of persons as are agreed upon by the Commonwealth Minister and the State Minister and (iv) the carers of (these) persons
Special needs groups	◆ People from culturally and linguistically diverse backgrounds ◆ Aboriginal and Torres Strait Islander people aged 50 and above ◆ People with dementia ◆ People who are financially disadvantaged ◆ People living in remote and isolated areas In Victoria the focus on all special needs groups will sit within a broader Diversity planning framework, acknowledging that barriers are experienced by many people who are marginalised or disadvantaged, for a range of reasons.
Services provided	Basic maintenance and support services essential to a person's continued independence, for example, home care and personal care.
National Quality Assurance Framework	Comprises: ◆ Community Care Common Standards and Quality Reporting Instrument ◆ HACC Program National Complaints Policy ◆ Statement of Rights and Responsibilities
Rights and responsibilities	HACC Program Statement of Rights and Responsibilities comprises: ◆ Consumer rights ◆ Consumer responsibilities ◆ Service provider responsibilities
Service coordination	In Victoria all funded agencies are expected to: ◆ act as an entry point for clients to both the HACC and the broader service system ◆ receive referrals from all sources including self-referral ◆ receive from, or make timely referrals to, other services on an approved Service Coordination Tool Template ◆ provide clients with information on service options ◆ explain agency's role to clients and how information gathered will be used ◆ monitor and review clients' conditions and circumstances ◆ have complaint and grievance handling procedures

Program element	Summary
	◆ manage risk and ensure OHS safety checks occur ◆ implement policies to ensure client privacy and confidentiality in service coordination
HACC activities	The following service types are funded by HACC: ◆ assessment ◆ home care ◆ property maintenance (and minor modifications) ◆ personal care ◆ delivered meals (and centre based meals) ◆ Planned Activity Group ◆ allied health ◆ respite – home and community ◆ respite - overnight ◆ volunteer coordination ◆ Linkages ◆ nursing In addition there is flexible funding through : ◆ service system resourcing ◆ flexible service response
Data collection	The objectives of the HACC Minimum Data Set (MDS) are to: ◆ provide data required for policy development, strategic planning and performance monitoring against agreed output/outcome criteria; ◆ facilitate improvements in the internal management of HACC funded service delivery ◆ facilitate consistency and comparability between HACC data and other aged, community care and health data collections. The HACC Minimum Data Set reflects an agreement to collect and report a prescribed set of data elements for each HACC client. These are clearly defined in a Data Dictionary. The national HACC MDS v2.0 includes all those data elements that HACC providers are required to report consistently on an ongoing basis in all states and territories. Both Commonwealth and state and territory governments compile HACC service user and usage profiles from the MDS.

Table 2.2: The HACC Program

2.4.2 Eligibility

Services funded by HACC are only provided to people within the target group, subject to assessed and prioritised need. People are not entitled to a service simply because they are eligible. ‘Eligibility’ means that the person is in the HACC Program’s target group and is eligible to be assessed and prioritised for service provision. Services may not be able to be provided if other people are assessed as a higher priority and/or resources are not available. Agencies need to regularly review existing clients.

2.4.3 HACC Program quality and standards

The HACC Program National Service Standards were introduced in 1991 to provide agencies with a common reference point for internal quality control by defining particular aspects of service quality and expected outcomes.

Since 2004, HACC funded organisations providing direct services to clients have been assessed against these standards by independent quality assessors in two rounds of assessments.

The new HACC Agreement (2007) articulated a number of proposed reforms to the HACC Program, including the need to reduce the administrative burden on funded organisations and develop 'common arrangements' for community care programs, where possible. As part of this commitment, work has been underway to develop and pilot test a new quality system to apply to all community care programs including HACC, Community Aged Care Packages, National Respite for Carers Program and Extended Aged Care at Home packages.

The new Community Care Common Standards and Quality Reporting instrument will replace the HACC National Standards Instrument for the next round of quality audits. Funded organisations providing multiple community care programs should be able to have a joint quality audit conducted.

Over 2010 a series of information forums will be run across Victoria to introduce funded organisations to the new system. Following this a contracting process will secure quality assessors to run training sessions in the new process, conduct audits (including pre-audit processes) and jointly develop quality action plans with the funded organisations.

Essential Resources

The Community Care Common Standards and Quality Reporting Instrument and other documentation will be made available on the Department of Health website as they are finalised.

2.5 Policy directions in HACC assessment

Key Points

- The HACC Assessment Framework, the Active Service Model and HACC Diversity Planning set the policy frameworks for HACC assessment practice.
- Designated HACC Assessment Services are the only organisations funded to undertake HACC Living at Home assessments.
- Living at Home assessments aim to understand the range of needs, and assistance required to enable people to live at home, and not just those that can be met by the assessing organisation.
- Assessment is an on-going process.
- Service coordination models promote a streamlined approach to client care.
- The Active Service Model aims to increase client independence.

This section introduces the latest policy directions for the HACC program and provides detail on their implementation and links to further information:

- the HACC Assessment Framework
- the Active Service Model
- HACC Diversity Planning

2.5.1 Victorian HACC Assessment Framework

Released in 2007, the *Framework for Assessment in the HACC Program* is the essential policy document for new assessors. It sets out program policy for assessment as a HACC funded activity.

Assessment is the gateway to HACC Services, the mechanism by which organisations discover what clients and their carers need and want in order to live as independently as possible. It establishes the expectations and understandings of the person and their families and identifies the service that best meets their needs. The role of assessment in managing client pathways through HACC and the broader health and community care system is a challenging one. Care planning, coordination, monitoring, review and reassessment are processes that ensure that the service system is responsive to the changing circumstances of a client and/or carer in the context of available resources.

The HACC Assessment Framework introduced a range of new developments including:

- Living at Home assessments
- designated HACC Assessment Services: the only services funded to undertake HACC Living at Home assessments
- transition towards assessment staff having relevant tertiary qualifications and a staff group with a mix of expertise creating a team approach
- an active service approach to assessment and care planning
- the building of partnerships with key referral partners to enable access to relevant health professionals and expertise when it is not available in the assessing organisation
- the development of HACC Assessment Alliances to promote a coordinated and streamlined approach to assessment.

The first step in implementation of the HACC Assessment Framework was to designate 100 HACC funded organisations as HACC Assessment Services. A mix of local councils, health and community health services, nursing services, Aboriginal community controlled organisations and community service organisations were designated in early 2008.

Living at Home Assessment

As a HACC assessor, you will be employed by a HACC Assessment Service. Your role will be to undertake Living at Home assessments, develop care plans and monitor and review client and carer needs.

A Living at Home assessment is the only assessment that is funded by the HACC Program as a separate activity. The purpose of a Living at Home Assessment is to gain a broad understanding of the type and range of client and carer's needs for community based services in the context of the person's current living environment. Components of a Living at Home Assessment are:

Principles
The Framework details the principles that an assessor should follow when conducting a Living at Home assessment:

- person centred
- carer focused
- promote independence
- use a partnership approach
- lead to care planning and service delivery
- be system focused

Elements
Key elements of a Living at Home assessment are:

- understanding the person's and carer's needs in their own right and in their usual environment, as opposed to interpreting their needs only in relation to the responses that can be provided by the assessing organisation.
- building on the client's strengths and capacities.
- identifying opportunities for maximising functional capacity, prevention and early intervention in meeting individual support needs in their usual environment, thus reducing the risk of the person's loss of independence
- maximising opportunities for clients to participate in social and community activities
- coordination of the assessment process with other organisations in order to access specific expertise as required
- providing information and advice about service options available to meet needs
- developing and implementing care plans (including making referrals to a wide range of organisations and services) based on identified needs and goals
- contributing to a reduction in the OHS risks for paid staff, volunteers, clients and friend or family carers

Key Stages

Initial contact and initial needs identification

A holistic needs assessment which focuses on:

- identifying strengths as well as areas of need for assistance
- taking a capacity building and restorative approach
- assessment of carer needs.

Service specific assessments for services provided by the assessing organisation (including an Occupational Health & Safety assessment and a HACC fees assessment).

Care Planning which takes a goal setting approach, and includes:

- a referral action plan for referrals to other agencies
- service specific care plans for services provided by the assessing organisation
- information provision on health promotion and social activities.

Care Coordination for people with more complex needs.

Care coordination describes activities undertaken following a Living at Home assessment for a subgroup of clients with complex needs and circumstances, including clients receiving services from multiple organisations who are not receiving case management as part of a package of care. Client care coordination may include tasks such as:

- facilitating inter-agency care planning with multiple agencies delivering services to a client
- facilitating development and reviews of the service coordination plan
- more frequent monitoring and review of the service-specific care plans
- assistance with accessing services from program areas outside the HACC Program.

See Section 5 'Understanding Service Systems' for detail about Service Coordination and Tool Templates.

Assessment pathways for HACC clients (person centred approach)

The HACC Program provides a broad reach of service to a large client population. The majority of clients receive low levels of service and a smaller group of clients receive medium to high levels of service. For this reason, the assessment experience in HACC needs to be tailored to fit client need and circumstances and take into account prior assessments that have already been undertaken.

Assessment as an on-going process

Assessment is not a one-off event. It is an ongoing process of building a relationship with a client and carer that begins at the first contact and continues through to service delivery, review and reassessment as circumstances change. Assessment is an interactive process between clients and providers, not a one-way communication.

Staff working in HACC Assessment Services need to have a clear understanding of the different types of assessments that occur along this continuum. Understanding the different assessments your clients may have had and their purpose and intended outcomes should ensure that:

- it is the right assessment at the right time
- clients with basic, one-off or short term needs are not over assessed
- clients are assessed by assessment staff with the appropriate expertise
- duplication of assessments for the same purpose is minimised; assessments build on each other but do not duplicate, particularly for clients with complex needs and chronic conditions who may already have had a holistic assessment of their needs
- clients at the interface with Aged Care Assessment Services do not have holistic assessments repeated
- repetitive information gathering is minimised.

Aged Care Assessment Services

Specialist aged care assessments are carried out by the Aged Care Assessment Services (ACAS). They are an important part of the client pathway for many HACC clients with high and complex needs who need to transition to more intensive levels of service, particularly case managed packages of care or residential care. A protocol to guide the relationships and interactions between HACC Assessment Services and Aged Care Assessment Services is currently being developed. When finalised, it will be available from the HACC website. For more detail on Aged Care Assessment Services refer to:
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-secure.htm

Designated HACC Assessment Services and Assessment Alliances

HACC Assessment Services are required to build alliances with key organisations that contribute to client assessment including other HACC Assessment Services; Aboriginal and ethno –specific organisations providing supported access; allied health services and ACAS. The purpose of the HACC Assessment Alliances is to:

- promote a coordinated and streamlined approach to client assessment
- promote a joint understanding of priority of access criteria for assessment for service and agreement about timeliness of response

- promote a better understanding of assessment processes and enhance capacity to share assessment information
- embed an Active Service Model approach into assessment practice; for example, through shared orientation and training programs; identifying local assessor skill mix across assessment services; promoting the use of secondary consultations; enhancing planning and service development.
- develop lead agency and key worker protocols for clients with complex needs and multi-agency involvement needing inter-agency care planning.

Links to Allied Health providers

One of the most important service links for HACC Assessment Services is the partnership with allied health providers. Allied health and nursing providers working with people in the HACC target group develop service-specific care plans for their own clinical interventions. These care plans contribute important clinical information to the development of overall care plans by HACC Assessment Services, assisting in maximising the client's independence and functional capacity.

Future support for HAS and assessment organisations

In the short term, a number of guides and resources will be released to further support the implementation of the HACC Assessment Framework and the Active Service Model approach. The Department of Health will advise all HACC service providers as new documents are released; however it is worthwhile regularly checking the HACC website for new material.

References and Resources

- Assessment page of the HACC website: www.health.vic.gov.au/hacc/assessment.htm
- Framework for Assessment in the HACC Program and Living at Home Assessment: www.health.vic.gov.au/hacc/downloads/pdf/framework.pdf

2.5.2 The Victorian Active Service Model

The aim of the Active Service Model (ASM) is to increase the Victorian HACC Program's effectiveness in maximising client independence through person-centred and capacity building approaches to service delivery.

Principles

The principles underpinning the Active Service Model are:

- people want to remain autonomous
- people have the potential to improve their capacity
- people's needs should be viewed in a holistic way
- HACC services should be organised around the person and carer; the person should not just be "slotted" into existing services
- needs are best met where there are strong partnerships and collaborative working relationships between the person, their carers and family, support workers and between service providers.

Components

The key components of the Active Service Model include:

- an emphasis on capacity building or restorative care to maintain or promote a client's capacity to live as independently as possible. The overall aim is to improve functional independence, quality of life and social participation.
- an emphasis on a holistic 'person-centred' approach to care, promoting client's wellness and active

participation in decisions about their care
- an attempt to provide more timely, flexible and targeted services capable of maximising the client's independence.

Through the delivery of Living at Home Assessments, HACC Assessment Services will be key agents in the implementation of Victoria's Active Service Model approach.

The Framework for HACC Assessment anticipated the following as some of the expected outcomes from an Active Service Model approach:

- increased referral to a range of allied health professionals for interventions designed to improve clients' capacity to undertake domestic and personal care activities. This will involve active collaboration with HACC funded allied health services in order to gain timely access to the relevant clinical interventions to maximise functional gain
- increased use of aids, equipment and new domestic products and assistive technologies in addition and/or alternative to HACC services for low level needs clients
- incorporation of "Well for Life" principles into assessment and care planning practice; that is, understanding and promoting the inter-relationship and benefits of good nutrition, physical activity and social participation to independence and healthy ageing
- increased referrals to GPs and specialist services such as rehabilitation and ambulatory services to investigate clinical/medical issues that may be identified at assessment as impacting on function
- increased referrals to Early Intervention in Chronic Disease Management services to enable improved self management for clients with chronic and complex needs
- advocacy for client and carer involvement in local prevention, health promotion activities, social and recreational activities.

ASM PREPARE

ASM PREPARE is a practice review and planning tool. It has been developed to assist HACC funded organisations:

- develop a structured view of their current strengths and areas for improvement in delivering an Active Service Model (ASM) approach
- identify current practices that are already consistent with an Active Service philosophy of care
- identify changes in structure and practice required to move to an Active Service Model approach
- prioritise and plan their implementation strategies.

References and resources

- The Active Service Model page of the HACC website, including ASM PREPARE information: www.health.vic.gov.au/hacc/projects/asm_project.htm
- Well for Life information: www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm
- Living at home, your choices. A guide for older Victorians: www.health.vic.gov.au/agedcare/publications/livingathome/index.htm

2.5.3 HACC Diversity Planning

Diversity planning is a quality improvement initiative which promotes a holistic, person-centred approach to HACC service planning, delivery and evaluation. HACC funded agencies will be required to undertake diversity planning to increase service access and responsive service delivery for those who may be at a disadvantage in accessing HACC services.

Diversity planning is about making sure we take action to better meet the needs of all HACC eligible people. It encourages us to recognise the commonality between people as well as the difference within groups, and to respond to this difference. Diversity includes consideration of factors such as:

- age
- gender and sexual identity
- physical and cognitive ability
- emotional, spiritual, religious and cultural background and beliefs
- ethnicity
- Indigenous status
- refugee status
- language
- socio-economic circumstances and needs

This includes the following HACC special needs groups, but is also a wider understanding of diversity:

- people from culturally and linguistically diverse backgrounds
- people from Aboriginal and Torres Strait islander backgrounds
- people with dementia
- people who are financially disadvantaged
- people living in rural and remote areas

Diversity planning is aligned with other initiatives such as the Active Service Model and the HACC Assessment Framework.

Ethno-specific services, multicultural organisations and Aboriginal community controlled organisations play a very important role linking their communities into the service system, assisting clients to gain access to needed services and supporting them, as required, through the assessment, care planning and service implementation processes. A number of targeted strategies and pilot projects such as the Supported Access Pilot project have been funded by the department to achieve better coordination between generic and specialised services. In 2008, the department developed the Strengthening HACC in Aboriginal Communities strategy in close consultation with Aboriginal organisations, particularly the Victorian Committee for Aboriginal Aged Care and Disability (VCAACD). The strategy is the department's key plan for improving access to HACC services for Aboriginal people.

The strategy aims to:

- increase access to a range of services for HACC eligible Aboriginal people
- strengthen HACC service responses to Aboriginal communities from generic organisations,
- support sustainable service delivery of HACC services by Aboriginal community controlled organisations to Aboriginal communities.

The HACC Aboriginal Service Coordination project is a key part of the strategy. This project aims to improve Service Coordination practices between HACC funded Aboriginal and generic organisations.

References and resources

- The HACC Diversity Framework: www.health.vic.gov.au/hacc/projects/diversity_framework.htm

2.6 Learning activities

Learning activities #1

Choose two activities from the following options:

1. Discuss with your manager the history of your agency's involvement with the HACC program, eg. What services/programs were originally provided by your organisation? What services / programs are provided now? How has the profile of clients changed over the years – have numbers increased? Has the cultural diversity of clients changed?

   In negotiation with your manager:

   Identify the staff member in your agency who has been working with the HACC program the longest and discuss with them what changes they have seen in the program.

2. Discuss with your manager what you understand have been the changes to the home care worker/home nursing role since 1984.

3. When was your organisation designated as a HACC Assessment Service? Are there other HAS organisations in your area?

   Discuss with your manager how the implementation of Living at Home Assessments has changed assessment processes in your organisation and in your catchment area. eg. Are there new partnerships, alliances or protocols between assessment services?

4. How is the Active Service Model changing assessment and other practices in your organisation?

5. Discuss with your manager some examples of care coordination provided to clients by your organisation.

2.7 Checklist

Do you know about and understand:

- [ ] Who sets the policy guidelines for the HACC program?
- [ ] When the HACC program started and how is it funded?
- [ ] What is Diversity Planning?
- [ ] Which are the Special Needs Groups in the HACC program?
- [ ] What activities are funded through HACC?
- [ ] What a Living at Home assessment entails?
- [ ] What is the philosophy behind the Active Service Model?
- [ ] Which clients may need care coordination?

Section 3. Understanding the HACC target group

Key Points

- The HACC target group comprises the frail aged with moderate, severe or profound disabilities, younger people with moderate, severe or profound disabilities, and their carers.
- Around Australia, 3.9 percent of the total population receive a HACC service.
- Over 256,000 Victorians received a service from the HACC Program in 2007-08.
- More than two thirds of the HACC clients in Victoria are aged 65 years and over and 64 percent are female.
- In 2007-2008, one per cent of HACC clients were Aboriginal.
- Almost one quarter of HACC clients came from one of 85 nations classified as non-English speaking countries.

3.1 Overview

This section presents a general overview of the HACC target group.

The people who are eligible for HACC services are defined in the HACC Amending Agreement as:

"persons living in the community who, in the absence of basic maintenance and support services provided, or to be provided, within the scope of the Program, are at risk of premature or inappropriate long term residential care including:
(i) older and frail persons, with moderate, severe or profound disabilities
(ii) younger persons with moderate, severe or profound disabilities, and
(iii) such other classes of persons as are agreed upon by the Commonwealth Minister and the State Minister, and
(iv) the carers of persons specified in sub-clause (a)"[2]

Within the broad HACC target population, there are some special needs groups who may experience particular difficulties in gaining access to HACC services appropriate to their needs. 'Special needs' does not mean that at the individual level one person is prioritised for service provision over another. At the service level however, it is recognised that strategies may be required to design services which are respectful, responsive and appropriate. The following are the nominated special needs groups in the HACC Review Agreement 2007:[3]

- people from Aboriginal and Torres Strait Islander backgrounds (ATSI)
- people from culturally and linguistically diverse backgrounds (CALD)

[2] Victorian HACC Program Manual February 2003 page 5
[3] National Program Guidelines for the Home and Community Care Program 2007 page 6

- people with dementia
- people who are financially disadvantaged
- people living in remote and isolated areas

Special Needs Groups are considered in regional and statewide program planning and additional resources may be provided.

The following references and resources have been used as source documents for this section:

- MDS definition and collection: www.health.vic.gov.au/hacc/data_collection/index.htm
- National statistics on HACC: www.health.gov.au/internet/main/publishing.nsf/Content/hacc-pub_mds_sb_07-08.htm~hacc-pub_mds_sb_07-08-1.htm
- Victoria: Facts about HACC users www.health.vic.gov.au/hacc/hacc_victoria/facts.htm
- Victoria: Who gets HACC? www.health.vic.gov.au/hacc/downloads/pdf/who_gets_hacc2003_04.pdf
- Use of HACC services by people born in non-English speaking countries: www.health.vic.gov.au/hacc/publications/cald_hacc_services.htm

3.1.1 Who gets HACC?

- In 2007–2008, 831,500 Australians received a HACC service. This represents 3.9 percent of the total population.
- Over 256,000 Victorians received a service from the HACC Program in 2007-08. Almost one third (30 percent) of all HACC clients live in Victoria.

In Victoria, in 2007-08:

- 65 percent of clients were aged 70-plus
- 64 percent were female
- 23 percent of clients came from 85 nations classified as non English speaking countries
- 1 percent of clients were Aboriginal.
- about 61 percent of clients lived in greater Melbourne and 39 percent lived in rural and regional Victoria
- 43 percent of clients lived alone
- around one third of clients (34 percent) had a carer, typically a spouse or daughter; this is around 100,000 carers.

3.1.2 What services do HACC clients receive?

The 2007-08 HACC data collection provides the following information about HACC usage in Victoria:

- home care is the service most commonly used, with over 87,500 clients (34 percent).
- across all service types, average provision of service was just on 47.5 hours per person per annum, or around one hour per week
- 55 percent of clients (140,600 people) received only one kind of HACC service. This was most likely to be a Planned Activity Group (PAG), nursing or allied health.
- 27 percent of clients (around 55,500 clients) received two types of service. The most common combination of services was home care and property maintenance.

- about 3 percent or 6,600 clients received five or more services.

From this data we can see that the HACC program provides a basic level of service to the large majority of clients, with 55 percent receiving only one kind of service.

3.1.3 Where does the data come from?

Under their service agreements, all HACC service providers in Australia are required to provide statistical reports on their clients using the HACC Minimum Data Set (MDS). Considerable work has been invested in improving data collection on the HACC program over the past decade. Good quality data is extremely useful for individual organisations in their planning, monitoring and review of service provision. The aggregate data cited above gives a sense of the importance of data collection in understanding the program and the client profile.

3.2 Population overview

The primary role of the HACC assessor is to focus on the needs of the individuals being assessed. As part of your induction, this resource provides you with the opportunity to take a step back and reflect on some of the broader demographic issues relevant to the target and special needs groups, before you become engrossed in the detail of assessing people on a one to one basis.

3.2.1 Older people in Australia

Key Points

- The health of older Australians is one of the most important medical and economic challenges facing Australia.
- As of December 2006, Australia's population was 20,701,488 – 13 percent of whom were aged 65 years or more.
- By 2040, 21 percent of the population will be aged over 65 years.
- Australia's men can now expect to live to 78.5 years and women to 83.3 years.
- In contrast, the life expectancy for Aboriginal people is 17 years less on average.
- Proportionally the population of seniors from CALD backgrounds is increasing in age and size more rapidly than the average population.
- The age profile of Victoria's culturally diverse communities varies considerably from community to community.
- The home is increasingly the site of service delivery of aged care services in the community.

The following references and resources have been used as source documents for this section:

- The Intergenerational Report 2010 Australia to 2050: future challenges: www.treasury.gov.au/igr/igr2010/report/html/02_Chapter_1_Economic_and_demographic.asp
- Australian Institute of Health and Welfare 2007, Older Australia at a glance: 4th edition. Cat. no. AGE 52. Canberra: AIHW www.aihw.gov.au/publications/index.cfm/title/10402

- Economic Implications of an Ageing Australia 2005: www.pc.gov.au/projects/study/ageing/docs/finalreport
- Aged care information: www.agedcareaustralia.gov.au
- www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features12003?OpenDocument

Overview

Australia's total population is projected to increase over the next few decades. However, it is also ageing, meaning that the number and proportion of older people in the population is increasing. In Australia, this is the result of sustained levels of low fertility and increasing life expectancy. Population ageing in Australia is a well-recognised demographic change. It is projected to have major effects on the future size and composition of the Australian population, and consequently on economic growth and government expenditure, especially for health services. Australians enjoy one of the highest life expectancies in the world. From 2006-08 figures, life expectancy at birth for men has risen to 78.5 years and for women to 83.3 years, which is about 2 years more than for the early 1900s. Most of these gains in life expectancy among older Australians occurred during the latter three decades of the twentieth century, when deaths from cardiovascular diseases (notably heart disease and stroke) fell rapidly.

Mature-age and older Australians are not a homogenous group. The health, family circumstances, physical abilities, economic circumstances and service needs of an average 65 year old are likely to be very different from those of a 90 year old. In addition, within this group, there is considerable diversity in backgrounds, lifestyles, living arrangements, family circumstances and cultural, social and religious practices. The proportion of seniors from culturally diverse backgrounds is growing more rapidly than the average population of Australian-born older people.[4]

Population history and projections

There will be an increasing number of older Australians in coming decades and there will be personal and national benefits if they are healthy and active. Healthy older Australians are less likely to leave the workforce for health reasons, and are more likely to enjoy retirement, with fewer health-care needs and less chronic disease and disability, hence placing less pressure on the national health budget[5]. Population ageing is not a new phenomenon in Australia but has been occurring over most of the twentieth century (except during the high-fertility post-war baby boom). At 30 June 2006, 2.7 million Australians were aged 65 years and over[6], representing 13 percent of the population. The 2010 *Intergenerational Report*[7] projections show that in the next 20 - 30 years, the number of people aged 65 years and over is expected to almost double, from 3 million to 5.6 million in 2030 and 6.9 million in 2040. As can be seen in the table below, by 2040, 21.2 percent of the population will be over 65.

Over the next 30 years, the older population will also continue to change in its internal age structure. The number of older Australians aged 85 years and over, among whom the need for services and assistance is greatest, doubled over the past 20 years and is projected to increase more rapidly than other age groups[8]. People aged 85 years and over are also projected to increase their share of the total older population from 12 percent of older Australians in 2006 to 18 percent in 2036. Over this period, the number of people over 100 years of age is projected to increase from fewer than 5,000 to more than 25,000.

[4] Australia's welfare 2009, Australian Institute of Health and Welfare 2009
[5] Older Australia at a glance: 4th edition. Cat.no. AGE 52.Canberra: Australian Institute of Health and Welfare 2007
[6] ibid
[7] Intergenerational Report 2010, Australia to 2050: future challenges, Australian Government, The Treasury
[8] AIHW op cit

Age Range	1970	2010	2020	2030	2040	2050
0-14	3.6	4.2	4.9	5.4	5.7	6.2
15-64	7.9	15.0	16.6	18.2	20.0	21.6
65-84	1.0	2.6	3.7	4.8	5.6	6.3
85 and over	0.1	0.4	0.5	0.8	1.3	1.8
Total Population as at 30 June (millions of people)	**12.5**	**22.2**	**25.7**	**29.2**	**32.6**	**35.9**
Percentage of total population						
0-14	28.8	19.1	19.0	18.3	17.4	17.2
15-64	62.8	67.4	64.7	62.4	61.3	60.2
65-84	7.8	11.7	14.3	16.6	17.2	17.6
85 and over	0.5	1.8	2.1	2.7	4.0	5.1

Table 3.1: Australian population history and projections
Source: ABS cat. no. 3105.0.65.001 (2008) and Treasury projections
www.treasury.gov.au/igr/igr2010/report/html/02_Chapter_1_Economic_and_demographic.asp

Living arrangements

Living arrangements are an important factor in the general health and wellbeing of older people, as they are for Australians generally. The majority of people aged 65 years and over live in a private dwelling with a partner. The last 30 years in Australia have witnessed large changes in the stability and longevity of marital relationships, with increasing rates of separation, divorce and remarriage. These changes are beginning to be reflected in the marital status of current older Australians with consequences for living arrangements. Marital status and living arrangements may affect an individual's perception of vulnerability and their feelings of safety at home. Older people are less likely than others in the community to feel safe or very safe when at home alone, either after dark or during the day. Being married and/or living with someone else may contribute to a sense of protection from potential harm.

Secure and appropriate housing is fundamental to the health and wellbeing of older Australians. As well as meeting basic human needs for shelter, the home is a major store of household wealth, particularly for older people. For certain groups of older people (those in the private rental market) housing costs are a significant budget item and insecure housing contributes to vulnerability. The home is also increasingly the site of delivery for aged care services in the community. Its' physical amenity and safety are important environmental factors that need to be considered (and perhaps modified) to reduce the risk of falls and injury among older people, and more generally, to facilitate independent living among older people with disability.

3.2.2 Aboriginal People

The following references and resources have been used as source documents for this section:

- www.abs.gov.au/ausstats/abs@.nsf/39433889d406eeb9ca2570610019e9a5/E3FAB932D407C106CA25743900149C7E?opendocument
- www.aihw.gov.au/indigenous/health/index.cfm
- Strengthening Home and Community Care (HACC) in Aboriginal Communities Strategy: www.health.vic.gov.au/hacc/publications/shac.htm
- Bringing Them Home Report – Victorian section: www.humanrights.gov.au/social_justice/bth_report/index.html

Overview

In 2006, Aboriginal people in Australia aged 65 years and over constituted only 0.5 percent of all older people, much smaller than their representation among the population generally (2.5 percent). This is the

result of a much lower life expectancy—approximately 17 years lower than for the total population. The 14,000 Aboriginal people aged 65 years and over represented just 2.8 percent of the Aboriginal population as at June 2006.[9] Because of the life expectancy gap between Aboriginal and non-Aboriginal Australians, and the very low proportion of the Aboriginal population who are aged 65 years and over, the 'older Aboriginal' population is generally considered to include all those who are aged 50 years and over. In 2006, 11 percent of Aboriginal people were aged 50 years and over. Women made up 54 percent of Aboriginal people aged 50 years and over, and 58 percent of those aged 65 years and over.[10]

The available evidence suggests that Aboriginal people in Australia continue to suffer a greater burden of ill health than the rest of the population. Overall, Aboriginal people experience lower levels of access to health services than the general population, are more likely than non-Aboriginal people to be hospitalised for most diseases and conditions, and are more likely to experience disability and reduced quality of life due to ill health and to die at younger ages. Aboriginal people also suffer a higher burden of emotional distress and possible mental illness than that experienced by the wider community.

3.2.3 People from culturally and linguistically diverse backgrounds

The following references and resources have been used as source documents for this section:

- www.aihw.gov.au/publications/age/oag04/oag04-c01.pdf
- www.multicultural.vic.gov.au/population-and-migration/how-victoria-was-settled/diac-publication-project
- www.multicultural.vic.gov.au/population-and-migration/victorias-diversity/population-diversity-in-local-councils
- 'Cultural diversity, ageing and HACC: trends in Victoria in the next 15 years' 2006, DHS. Anna L Howe: www.health.vic.gov.au/hacc/projects/cegs_reports.htm#cultural
- ECCV Multicultural Aged Care Services Directory 2009 – order form accessible at www.eccv.org.au
- Seniors from a Culturally and Linguistically Diverse Background (Dec 2008) Demography of the 50 years plus Victorian population for 2006 Census: http://www.mav.asn.au/CA256C2B000B597A/ListMaker?ReadForm&1=10-None~&2=0-PP+-+HS+-+Ageing+-+CEGS+-+TOC~&3=~&V=Listing~&K=TOC+CEGS~&REFUNID=F828BAAD7F13483AC
- Projections of Older Immigrants: People from a culturally and linguistically diverse background, 1996-2026 Australia, AIHW. Gibson, D. et al: www.aihw.gov.au/publications/index.cfm/title/6786

Overview

The cultural diversity of the older population in Australia has been growing, reflecting successive immigration policies since the Second World War. In 2006, 35 percent (953,702 people) of older people were born overseas, with 39 percent of these coming from English-speaking countries, and 61 percent from non-English-speaking countries. The mix of cultural backgrounds varies between age groups. The proportion of older overseas-born people from English-speaking countries was highest among the very old (47 percent for those aged 85 and over but only 38 percent each for people aged 65–74 years and 75–84 years). In contrast, the proportion of older overseas born people from non-English-speaking backgrounds was highest among the age groups 65–74 years and 75–84 years (62 percent each), with the comparable figure for those aged 85 and over being 53 percent. Among mature-age people (aged 50–64 years), 34 percent (1,249,231) were born overseas, with 40 percent born in English-speaking countries.[11]

[9] The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2008, ABS
[10] ABS census data 2006
[11] Gibson, D. et al, 2001, Projections of Older Immigrants – People from Culturally and Linguistically Diverse Backgrounds, 1996 – 2026, Australia, p.xvii ,Australian Institute of Health and Welfare 2001.

The older Australian population from culturally and linguistically diverse (CALD) backgrounds is increasing more quickly than the Australian-born population in terms of size. For example, from 1996 to 2011 the population of CALD seniors experienced a 66 percent growth rate compared with 23 percent for the Australian born population. In addition the number of people over 65 years with a CALD background will grow by 44 percent over the fifteen year period from 2011 to 2026. The older CALD population is also ageing more rapidly than the average population of seniors. From 2011 to 2026, the CALD population aged over 80 years is projected to increase by 59 percent compared with 29 percent for the Australian born population. By 2026 one in every four people aged 80 years and over will be from CALD backgrounds.[12]

For older people born overseas in countries where the main language is not English, the most common countries were Italy, Greece, Germany, the Netherlands and China. However, the proportions of older people born in each country were not consistent across the age groups, reflecting the waves of immigration that have occurred at different points in time. For instance, people from Greece are more strongly represented among the 65–74 year age group than other age groups. The Polish population has one of the older population profiles (4 percent of people aged 75–84 were born in Poland compared with only 1 percent in the 65–74 and 50–64 year age groups). In contrast, the Vietnamese have a younger age profile with 3 percent of people aged 50–64 born in Vietnam compared with smaller proportions of older age groups (1.5 percent to 1.6 percent). This pattern will change over the next two decades as various immigrant groups reach the older age groups.[13]

Importantly, some older people either never gain, or lose proficiency in using English. In the 2006 Census 9.45 percent of Victorians aged over 70 years reported that they spoke English 'not well or not at all'.[14]

3.2.4 People with a Disability

Key Points

- As of December 2003, one in five people in Australia had a reported disability.
- The overall disability rate increased with age, reaching 92 percent of those aged 90 years and over.
- Those with a profound level of core-activity limitation had a much lower labour force participation rate than people without a disability.
- Physical conditions were the most common main health conditions of persons with a disability (84 percent).

The following references and resources have been used as source documents for this section:

- Australian Institute of Health and Welfare (AIHW) 2008, Disability in Australia: trends in prevalence, education, employment and community living: www.aihw.gov.au/publications/aus/bulletin61/bulletin61.pdf
- McIntosh. G & Phillips. J, 2002, 'Disability Support and Services in Australia': www.aph.gov.au/library/intguide/SP/disability.htm
- Disability, Ageing and Carers, Australia: Summary of Findings 2003: www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features12003?OpenDocument
- www.hreoc.gov.au/disability_rights/
- www.australia.gov.au/people/people-with-disabilities

[12] Ibid
[13] ibid
[14] ABS census data 2006

Overview

Disability is defined as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss, which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision.

Disability is a multidimensional experience for the person involved. There may be effects on organs or body parts and there may be effects on a person's participation in all areas of life. The World Health Organisation's (WHO) framework for measuring health and disability, *the International Classification of Functioning, Disability and Health*[15] recognises three dimensions of disability: body structure and function (and impairment thereof), activity (and activity restrictions) and participation (and participation restrictions)[16]. The classification also recognises the role of physical and social environmental factors in affecting disability outcomes.

The main Commonwealth legislation covering the rights of people with a disability is the *Disability Discrimination Act 1992* and the main body charged with protecting the rights of disabled people and advocating on their behalf is the Human Rights and Equal Opportunity Commission (HREOC).
In the 2003 Australian Bureau of Statistics (ABS) *Survey of Disability, Ageing and Carers (SDAC)* one in five people in Australia (3,958,300 or 20 percent) had a reported disability. The disability rate increased with age, reaching 92 percent for those aged 90 years and over. The pattern of prevalence of profound or severe core-activity limitation gradually increased from three percent for age groups 0-4 years through to ten percent for 65-69 years but it then increased sharply to 74 percent for those aged 90 years and over. (A severe or profound core activity limitation is defined as sometimes or always requiring personal assistance or supervision with self-care, mobility or communication). This contrasted with the overall disability rate, which increased steadily from four percent of 0-4 year olds to 41 percent of 65-69 year olds and 92 percent of those aged 90 years and over.

Physical conditions were the most common main health conditions of persons with a disability (84 percent). The remaining 16 percent had a mental or behavioural disorder as their main condition. However, those whose main condition was a mental or behavioural disorder were more likely to have a profound or severe core-activity limitation than those with a physical condition (46 percent compared to 29 percent).[17]

Health and disabilities in older people

The most common long-term conditions affecting the health of older people (over 65 years) in Australia in 2001 were diseases of the eye, osteoarthritis, hypertensive disease and deafness.

When looking at health conditions amongst older people that are most likely to be associated with disability (profound or severe core activity limitation), dementia (98 percent) was the most common. Other conditions that were rated as highly disabling were problems with speech (87 percent) and Parkinson's disease (79 percent). When looking at older people reporting a profound or severe limitation in 2003, arthritis was the most common associated health condition. This was followed by hearing disorders, hypertension, heart diseases and stroke. Although dementia and Parkinson's disease were highly likely to be associated with profound or severe limitations, their lesser prevalence in the community means that other conditions (arthritis, hearing disorders, hypertension, heart disease and stroke) result in a greater burden on the community.[18] Amongst the HACC group of clients these are probably the conditions most likely to limit their ability to be independent.

[15] The International Classification of Functioning, Disability and Health. The ICF is the World Health Organisation's (WHO) framework for measuring health and disability at both individual and population levels and was officially endorsed by all member states in 2001. www.who.int/classifications/icf/en/

[16] McIntosh.G & Phillips. J, 2002, 'Disability Support and Services in Australia', www.aph.gov.au/library/intguide/SP/disability.htm

[17] Disability, Ageing and Carers, Australia: Summary of Findings 2003

[18] ibid

3.2.5 Carers

Key Points

- In 2003, there were 2.6 million friend or family carers who provided some assistance to those who needed help because of disability or age.
- Primary carers had a lower labour force participation rate than people who were not carers.
- Most older carers are caring for a spouse or partner.
- Primary carers of a spouse or partner are the least likely of all primary carers to seek help.
- Older people living in households most commonly reported needing assistance with property maintenance and health care because of disability or age.
- Families and friends are the main providers of care to HACC eligible people.

The following references and resources have been used as source documents for this section:

- Australian Institute of Health and Welfare 2007, Older Australia at a glance: 4th edition. Cat. no. AGE 52. Canberra: AIHW: www.aihw.gov.au/publications/index.cfm/title/10402
- McIntosh. G & Phillips.J, 2002, 'Disability Support and Services in Australia': www.aph.gov.au/library/intguide/SP/disability.htm
- Disability, Ageing and Carers, Australia: Summary of Findings 2003: www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features12003?OpenDocument
- Recognising and supporting care relationships for older Victorians: www.health.vic.gov.au/agedcare/downloads/agedcare_action_plan_0806.pdf
- Cummins. R, et al, 2007, Wellbeing of Australians: carer health and well being: www.deakin.edu.au/dro/view/DU:30010534

Overview

In 2003, there were 2.6 million friend or family carers who provided some assistance to those who needed help because of disability or age. About one fifth of these (19 percent) were primary carers – who provided the majority of the informal help needed. Most primary carers (78 percent) cared for a person living in the same household and just over half (54 percent) of all carers were women. Women were also more likely (71 percent) to be primary carers. Of those providing care, 1.0 million (39 percent) were in the 35-54 year age range. This age group's caring responsibilities involved children, partners and/or ageing parents. Including carers in the HACC program acknowledges their need for support and assistance in their role.

Other findings on friend or family carers from the *Disability, Ageing and Carers study*[19] included:

- The most common reasons given by primary carers for taking on the caring role were 'family responsibility', 'could provide better care' and 'emotional obligation'.
- Primary carers had a lower labour force participation rate (39%) than people who were not carers (68 percent).
- 37 percent of primary carers spent on average 40 hours or more per week providing care and 18 percent spent 20 to 39 hours per week.

Older people living in households most commonly reported needing assistance with property maintenance and health care because of disability or age. Other common areas of need were transport, housework,

[19] Disability, Ageing and Carers, Australia: Summary of Findings, 2003

mobility and self-care. Family and friends were the main providers of assistance, although 61 percent received formal help from providers such as doctors, nurses and gardeners. Partners, children and immediate family were the most common providers of help to older people. Of the 959,400 receiving informal assistance, 452,900 (47 percent) were assisted by partners who were likely to be old themselves. Of those providing primary care for their partner, 48 percent were aged 65 years and older.

Care-giving is bound up with interpersonal relationships and role expectations and many carers see their role as a natural expression of their relationship with a family member or friend. This may at times result in reluctance to seek help or support. Those who provided care to people with a disability were more likely themselves to be older and/or have a disability than those who did not provide care. Most older carers are caring for a spouse or partner (83percent). Since primary carers of a spouse or partner are the least likely of all primary carers to seek help, they may be at risk of not receiving support when it is needed. They can also be reluctant to get treatment for their own medical or psychological conditions. Studies have shown that people who care are twice as likely to be in poor physical health compared to the general population. The 2007 report by Cummins et al , showed that those caring had significantly higher incidences of chronic diseases than the general population. Of those living with the people they care for, the disability rates were 40 percent for primary carers, 35 percent for all carers and 20 percent for non-carers. Well being decreases as the number of hours caring increases. [20]

3.3 Learning activities

Choose one set of the following three sets of learning activities about the HACC population and special needs groups, people with disabilities and their carers.

Before you answer these questions, locate your information sources. Find out if your organisation has:

- a social planning team (or equivalent) which analyses and reports on the local demographic data and trends, such as a community profile
- any strategic plans targeting older adults, such as a Positive Ageing Plan or generic population plans, such as in a Municipal Health and Wellbeing Plan.

If not, where does the organisation usually source this information from?

[20] Disability, Ageing and Carers, Australia: Summary of Findings, 2003

Learning activities #1

1. The national census data provides an overview of the Australian population, but this information is averaged across the country. There are significant variations between and within states. What is the ageing profile of your LGA or catchment area? How does it compare to state and national trends?

2. What is the size of the Aboriginal population in your LGA or catchment area? What proportion of the population is aged? What proportion is HACC eligible? Is this data available? If not, how does your agency plan and deliver services to Aboriginal clients?

3. What proportion of your HACC clients were born in non-English speaking countries?

4. What proportion of the 65+ population in your LGA or catchment area:
   - live in private dwellings?
   - live alone?
   - and of those living alone, are they more likely to be male or female?

Learning Activities #2

1. What is the profile of people with a disability in your LGA or catchment area? How does it compare to state and national trends?

2. Continuing from the previous activity on older people, what proportion of people aged 65 and over in your LGA or catchment area live with a disability?

3. What proportion of people aged under 65 years in your LGA or catchment area live with a disability?

4. What proportion of your organisation's HACC clients are younger people with a disability (ie. younger than 65 years)?

5. What agencies in your catchment area are delivering services to people with disabilities?

Learning Activities #3

1. What is the profile of friend or family carers in your LGA or catchment area? How does it compare to state and national trends? For example:

    a. males and females
    b. caring for younger or older person
    c. living with the care recipient
    d. partner / spouse of the care recipient
    e. with or without a disability

2. (Continuing from the activity on older people,) What proportion of people aged 65 and over in your LGA or catchment can be identified as a friend or family carer?

3. What proportion of friend or family carers in your LGA or catchment area are employed?

4. What services targeting friend or family carers exist in your LGA or catchment area, including those provided by your organisation?

5. What are some of the health and well being issues for friends or family who are carers? Discuss with your manager.

    Discuss your responses with your manager. What are the implications of the demographic trends for friend or family carers in your LGA or catchment area? What are the implications of this information for assessment for HACC services?

3.4 Checklist

Do you know about and understand:

- [ ] Who is eligible for HACC services?
- [ ] How many Aboriginal people are receiving HACC services from your agency?
- [ ] At what age are Aboriginal people considered ‘old’?
- [ ] Which non-English speaking countries are represented within your HACC clientele?
- [ ] What is the definition of ‘disability’?
- [ ] What services does your agency provide to people with disabilities?
- [ ] How many of your HACC clients have friend or family carers?
- [ ] What are some issues that may be present for friend or family carers?

Section 4. Understanding the HACC policy and funding context

4.1 Overview

The HACC program is part of a broader framework of community and health services funded either through the Victorian Government or the Commonwealth Government, or jointly. The services within this broader framework include community health services, public and private hospitals, general medical practitioners, residential and community based respite services, disability services, residential aged care facilities, disability support services, and packaged services.

The system of Australian government sets the context for policy development and funding of the HACC program. The policy and funding environment includes:

- Inter-governmental forums, such as the Council of Australian Governments (COAG)
- Commonwealth and state arrangements, such as the joint agreements for the HACC program
- the Commonwealth Government and Commonwealth Government departments
- the State Government and State Government departments
- local government
- peak advisory and advocacy groups

Understanding this information is not necessarily part of the core role of a HACC assessor, but a broad overview of this context is very helpful. As the HACC program intersects with so many other aspects of broader health and community services, it is useful to know how these services are governed. Understanding the structures enables you to source information about current policies and programs. Government priorities, ministerial responsibilities and the structure of the public service regularly change. An easy way in to either the Commonwealth or the State Government is via the generic web addresses: www.gov.au and www.vic.gov.au.

4.2 Intergovernmental structures: COAG and Ministerial Councils

Established in 1992, the Council of Australian Governments (COAG) is the peak inter-governmental forum in Australia. COAG comprises the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA). The Prime Minister chairs COAG[21].

The role of COAG is to initiate, develop and monitor the implementation of policy reforms that are of national significance and which require cooperative action by Australian governments (for example, National Competition Policy, water reform).

The Health, Ageing, Community and Disability Services Ministerial Council is one of COAG's 40 councils. It comprises all Australian Health Ministers and the role of the Council is to address issues on health, community or disability services. Other relevant intergovernmental fora include the Australian Health

[21] www.coag.gov.au/about_coag/index.cfm

Ministers' Conference, the Community and Disability Services Ministers' Conference and the Ministerial Conference on Ageing. Forums of senior officials from Commonwealth, State and Territory governments support the work of COAG and the Ministerial Councils.

COAG's health and ageing reform agenda proposed for implementation from 2009 includes a substantial program of health reform. Other significant reforms include the National Indigenous Reform Agenda, chronic disease management and preventative health care[22].

- www.coag.gov.au/about_coag/index.cfm

4.3 The Commonwealth Government

4.3.1 The Department of Health and Ageing (DoHA)

The Department of Health and Ageing's vision is for *Better health and active ageing for all Australians.* The department has responsibility for aged care services in Victoria which include:

- packaged services (CACPs, EACH, EACHD)
- residential aged care facilities
- National Respite for Carers Program
- Hearing Services Program
- Commonwealth Respite and Carelink Centres
- Continence Aids Assistance Scheme
- day therapy centres.

Other services are funded jointly by DoHA and the Victorian Department of Health:

- Transition Care
- Aged Care Assessment Program
- Home and Community Care Program
- State Residential Aged Care

4.3.2 Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)

The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is the Commonwealth's Government's main source of advice on social policy and manages about one fifth of the federal budget. FaHCSIA's strategic responsibilities of relevance for the HACC program include:

- Closing the Gap in health between Aboriginal and non-Aboriginal Australians
- National Disability Strategy with state and territory governments
- National Disability Action Plan
- Commonwealth State Territory Disability Agreement (CSTDA)
- volunteering
- delivering the National Compact to work towards an improved relationship between the third sector (not-for-profit sector) and government and help to deliver responsive and integrated services that meet community needs
- Family Support Program

[22] www.coag.gov.au/coag_meeting_outcomes/2008-07-03/index.cfm#health

- support initiatives to meet the government's target to reduce homelessness

4.3.3 Department of Veterans' Affairs

The Department of Veterans' Affairs (DVA) is responsible for providing support to veterans and their dependents. DVA is responsible for Veterans' Home Care – essentially parallel services for veterans to the HACC program - designed to assist those eligible veterans and war widows or widowers who wish to continue living at home, but who need a small amount of practical help. Other programs provided to veterans include nursing and home modifications. Veterans' Home Care is part of a broader Commonwealth Government strategy to ensure veterans and war widows or widowers maintain optimal health, well-being and independence.

The Department of Veterans' Affairs' contracts service providers via a tendering process to deliver services in specified regions. These providers may change depending on the tendering process.

- www.dva.gov.au/service_providers/veterans_homecare/Pages/index.aspx
- www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Veterans-3

4.4 Commonwealth and State joint arrangements

4.4.1 HACC Program

Commonwealth/state arrangements for the HACC Program are set out in a bilateral agreement between the Commonwealth and Victorian Governments. The Review Agreement to continue management of the Home and Community Care (HACC) Program was signed by the Commonwealth, and State and Territory Governments in May 2007. The Review Agreement, which took effect from 1 July 2007, details the management arrangements for the HACC Program. The Agreement recognises the commitment of both the Australian government and the Victorian government to work together to achieve better outcomes for people who are eligible to receive HACC Services.

4.4.2 Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) is funded by both the Commonwealth and Victorian governments, and is an integral part of the health and aged care system in Victoria. The core objective of the Aged Care Assessment Service (ACAS) is to comprehensively assess the needs of frail older people and to facilitate access to available care services appropriate to their needs. In meeting this objective, ACAS also determine eligibility for Commonwealth Government subsidised residential aged care, Community Aged Care Packages and some flexible care services, including Extended Aged Care at Home (EACH) Extended Aged Care at Home Dementia (EACHD) and Transition Care. The Aged Care Assessment Program's Operational Guidelines outline the policy for implementing the ACAP through ACAS. The eighteen ACAS in Victoria are located in public hospitals or community health services and each covers a sub-regional catchment.

- www.health.gov.au/internet/main/Publishing.nsf/Content/ageing-acat-acapopgu.htm

4.5 Victorian State Government

The Victorian State Government articulates its policy agenda through an Annual Statement of Intentions. The most recent statement, released in February 2010, contains priorities for:

- supporting senior Victorians

- delivering for people with a disability
- delivering for indigenous Victorians
- delivering for veterans

4.5.1 State Government oversight of programs relevant to the HACC Program

Government Department or Agency	Programs
Department of Health (DH)	The Wellbeing, Integrated Care and Ageing Division (WICA) is responsible for the following: Aged Care: ◆ HACC and assessment (including the Aged Care Assessment Program) ◆ public sector aged care residential services and SRS ◆ service development ◆ policy and analysis Integrated Care: ◆ ambulatory and coordinated care ◆ Primary Care Partnerships and integration ◆ Cancer Action Plan and palliative care ◆ clinical streams Aboriginal Health Other Branches include: Chief Health Officer and Health Protection, Prevention and Population Health, Workforce and Leadership Development Other Divisions in the Department are: ◆ Hospital and Health Service Performance ◆ Mental Health, Drugs and Regions ◆ Strategy, Policy and Finance
Department of Human Services (DHS)	◆ Disability and Disability Services ◆ Children, Youth and Family Services ◆ Housing Services
Department of Planning and Community Development (DPCD)	◆ Office for Disability ◆ Office of Senior Victorians
Victorian Multicultural Commission (VMC)	◆ The main link between Victoria's culturally and linguistically diverse (CALD) communities and the government

Table 4.1: State Government Oversight of Programs Relevant to the HACC Program

4.5.2 HACC Program

The Aged Care Branch of the Department of Health is responsible for the policy and planning for the Victorian HACC program. Since 2003, a three year strategic plan has been developed for the program. The current Strategic Directions and Expenditure Priorities in Victoria cover the period 2008 – 2011. The Department convenes a HACC Departmental Advisory Committee, with broad representation from peak bodies associated with HACC, to advise on the strategic plan.

> www.health.vic.gov.au/hacc/plan_fund/strategicdirections.htm

4.5.3 Disability Services

Disability Services is a division of the Department of Human Services (DHS). Disability Services' role is to fund providers across the non-government sector to provide direct support and care for Victorians with an intellectual, physical, sensory and/or neurological disability, or acquired brain injury. The division also provides some care and support services directly to people with a range of other disabilities. These services and supports are governed by the provisions of the *Disability Act 2006.*

The division also operates in line with the Commonwealth State Territory Disability Agreement (CSTDA).

Disability Services' strategies, including the Victorian State Disability Plan 2002–2012, work in partnership with people with disabilities, their families, carers and support providers, to improve quality of life by increasing opportunities for independence, choice and community participation, and promoting the rights of people with a disability.

> www.dhs.vic.gov.au/disability

4.6 Local government

Local councils are recognized as a distinct and essential tier of government by the Victorian Constitution. The Victorian Local Government Act 1989, and its amendments, defines the purposes and functions of local government as well as providing the legal framework for establishing and administering councils. Democratically elected councils are to ensure the peace, order and good government of each municipal district and the promotion of social, economic and environmental sustainability. In broad terms, council sets the overall direction for the municipality through long-term planning.

There are 79 councils in Victoria. They maintain significant infrastructure, provide a range of services and enforce various laws for their communities. Community infrastructure provided and maintained by councils includes roads, footpaths, bridges, drains, town halls, libraries, recreation and meeting facilities, parks and gardens. Services include property, economic, human, recreational, cultural and health services. Councils also enforce state and local laws relating to such matters as land use planning, environment protection, public health, emergency management, traffic and parking and animal management.

In order to finance their activities, councils raise funds, particularly through the levying of municipal rates and also via grant funding from the Commonwealth and State Governments for municipal purposes, as well as specific program grants.

To ensure the responsible management of resources under their control, and to provide public accountability, councils are required by law to undertake various planning and reporting functions. Exercise of these functions includes public consultation.

4.6.1 HACC Program

In Victoria, councils have had a long involvement with community care services and most provide the core HACC services of assessment, home care, personal care, respite care, home maintenance and delivered meals. They are the largest public sector provider of HACC services, contribute significant additional funds, and also have an advocacy, planning and co-ordination role. They also provide much of the local infrastructure necessary to support people living at home and community life, for example, buildings and resources to support seniors' group activities and community transport. Most councils undertake planning around the broad needs of their older populations, sometimes linked to Municipal Public Health and Wellbeing Plans, and also included in specific strategies, eg. housing, leisure or transport plans. More recently councils have undertaken Positive Ageing Plans and these are generally available from individual council and/or on their websites.

Information on local government can be sourced through:

- Municipal Association of Victoria (www.mav.asn.au)
- Department of Planning and Community Development (www.localgovernment.vic.gov.au)
- individual councils - usually following the protocol of the name of the council.vic.gov.au eg. www.darebin.vic.gov.au

4.7 Peak bodies and advocacy groups

In addition to the governments and government departments, HACC policy is also shaped by the contribution of peak bodies and advocacy groups. These groups generally have a role in undertaking research on behalf of a particular interest group or community so that they can support their members, contribute to the evidence base and lobby on behalf of their constituents. Larger groups often have a national office and a state office. Some of the key peak bodies that are relevant to the HACC Program include:

Older People

- COTA – Council on the Ageing: www.cotavic.org.au

Carers

- Carers Victoria: www.carersaustralia.com.au
- Alzheimer's Association www.alzheimers.org.au

Aboriginal People

- VACCHO – Victorian Aboriginal Community Controlled Health Organisation: www.vaccho.org.au
- VICACD - Victorian Indigenous Committee for Aged Care and Disability www.health.vic.gov.au/hacc/downloads/pdf/shac_strategy_jan08.pdf

CALD Groups

- ECCV – Ethnic Communities' Council of Victoria: www.eccv.org.au

Service Providers – Professional and Industry Groups

- ACCV – Aged and Community Care Victoria: www.accv.com.au
- VHA – Victorian Healthcare Association www.vha.org.au
- AAG – Australian Association of Gerontology www.aag.asn.au/

Local Government

- MAV - Municipal Association of Victoria www.mav.asn.au
- LGPro - Local Government Professionals: www.lgpro.com

4.8 Learning activities

Learning activities #1

Choose two activities from the following options:

1. Familiarise yourself with the key peak bodies relevant to the HACC program by reviewing their websites and discuss their role with your manager.

   How does your organisation connect with these bodies?

2 In consultation with your manager choose some local services you are *least* familiar with and arrange to visit eg.:
   - Aged Care Assessment Service
   - community health service
   - district nursing service

3 Discuss with your Intake worker how they decide if a referral is suitable for a HACC assessment or whether it should be referred directly to ACAS.

4 What is the difference between a HACC assessment and an ACAS assessment? Review inter-agency protocols then discuss with your manager.

4.9 Checklist

Do you know about and understand:

- [ ] What is COAG and what does it do?
- [ ] Which Commonwealth and State Government departments have responsibility for HACC?
- [ ] Which Victorian Government department is responsible for disability services?
- [ ] The role of ACAS?
- [ ] The role of local government in the HACC program in Victoria?
- [ ] The peak bodies for older people and friend or family carers in Victoria?

Section 5. Understanding service systems

5.1 Overview

When we think about a 'service system' – any service system, a useful way to understand it is to think of the system in two major parts:

- the back stage – aspects that are probably not apparent to the client such as funding sources, data management or IT systems, and
- the front stage – where there is direct contact with the client.

When you stay at a hotel, you will be aware of the quality of the service that you receive from the reception staff and the quality of the room service you receive. These are the 'front stage' components of their systems. But it's unlikely you will give much thought to the hotel's booking systems or staff training- the 'back stage' systems. However, receiving a quality service requires that both front and back stages of the system work well together.

As a HACC assessor, you will be working directly with clients and carers. You will be at the front stage of the system. In order to provide clients with a quality service, it is important that you understand firstly, the components of the HACC service system and secondly, how the HACC service system is really a system within multiple systems and that all the systems coordinate their work in the best interests of the client.

5.2 Typical components of a service system

In order to think about the HACC service system, we can break it down to its back stage and front stage components. What goes into the system to create the service you deliver to clients? The HACC service system is described below. *Section 5.3 Putting the system* together summarises this information.

5.2.1 The back stage of the HACC service system

Funding

Funding is the essential component of delivering a public service. Funding for the HACC program in Victoria comes from the Commonwealth, State and local governments, as well as client fees. It is important to note that governments fund services based on evidence of need in the community. There is never sufficient funds to meet all demands in the community, so it essential that governments are transparent in the way they allocate public money. 'Need' is determined on information from a range of sources such as demographic information, population projections, health data as well as program reporting, negotiations between governments, research from government departments and peak bodies. Each year, additional funds are provided to the HACC program to deal with the growth in the target population and annual cost increases based on an indexation formula. In Victoria, there is a commitment to allocate this annual growth funding equitably, so a population based planning model – the Relative Resource Equity Formula (RREF) is applied to ensure that equivalent resources are provided to each region and local area in the state, relative to its share of the HACC target population. The method for calculating the RREF is periodically reviewed and updated.

Individual service providers receive funding based on an agreed amount of services to be delivered ('targets'). The price for each service is determined by the State Government and is referred to as the 'unit price'. Three yearly funding and service agreements (FASA) are developed between the Department of Health and the agency which reflect the amount of services to be delivered at the specific price and the levels of quality. This FASA is managed and monitored by regional DH staff (eg. through reviewing the data on services provided by the organisation). Any variations between service targets and actual services are identified by regional staff and discussed with the organisation.

Planning

In 2007, the Commonwealth and all State and Territory Governments agreed to develop triennial (three year) plans for the allocation of growth HACC funds. As Victoria had been planning on a triennial basis since 2003, this brought planning cycles for all jurisdictions into the same cycle. A state triennial plan is developed which indicates the priorities for allocation of growth funds for that period. The current Victorian triennial plan covers the period of 2008 – 2011. Each DH region also develops a regional triennial plan, which is consistent with the overarching state priorities.

Policies

Like any service system, the HACC service system requires rules and guidelines in order to function effectively. At the macro level, the Commonwealth Government determines national policies for the HACC program and the Victorian Government determines policies for the operation of the program within the state. Broadly speaking, the national policies provide generic guidance and Victoria has discretion to develop policies within the national directions. At the micro level, HACC service providers also develop their own local policies to comply with program standards and legal requirements. For example:

Occupational Health and Safety
The *Occupational Health and Safety Act 2004* (OH&S Act) outlines obligations for employers and employees in ensuring a safe working environment. The Act also sets out requirements for consultation with employees and the powers of elected occupational health and safety (OHS) representatives. Under the OH&S Act, the employer must provide, as far as is reasonably practicable, a safe and healthy workplace for all employees, clients, contractors and visitors.

Privacy, confidentiality and record keeping
The Victorian *Information Privacy Act 2000* and the *Health Records Act 2001* contain privacy principles that are the minimum standards in relation to handling personal and health information. Personal information constitutes identifying information, and health information constitutes identifying information about a person's health or disability.

Freedom of Information
The Victorian *Freedom of Information Act 1982* gives people the right to:

- access documents about their personal affairs and the activities of government agencies
- request that incorrect or misleading information held by an agency about them be amended or removed.

References and resources

- For information about the HACC Victorian Triennial Plan see: www.health.vic.gov.au/hacc/plan_fund/strategicdirections.htm
- For information about the Department of Human Services Information Privacy Policy see: www.dhs.vic.gov.au/privacy-statement,
- For information about the Victorian Health Records Act see: www.health.vic.gov.au/healthrecords/

- For information about OH&S in home care see: www.health.vic.gov.au/hacc/publications/vic_homecare.htm
- The HACC Program Manual: www.health.vic.gov.au/hacc/prog_manual/

Quality

While receiving a quality service is intended as an outcome for clients receiving a HACC service, this requires sound quality management systems and principles. One of the key components of a quality management system is to define 'quality'. This is done through the Community Care Common Standards, which inform all HACC service providers of the minimum level of acceptable service. To ensure that this standard of service is achieved, performance must be monitored. HACC service providers monitor and improve the quality of their own services. But to ensure that standards are consistent across the state, in Victoria, independent audits of HACC service providers are undertaken by trained auditors every three years.

On a more regular basis, the HACC Program and Service Advisers (PASAs) based in regional offices of the Department of Health have contact with and receive reports from service providers about their performance. This process allows 'flags' to be raised prior to major problems arising and for discussion between the department and the provider about how issues can be rectified. The aim of quality management systems is to continually improve the way organisations do business. Feedback from assessments and from other sources, most importantly clients and carers, or other family members, should channel back into quality improvement processes within the organisation.

Communication

With three levels of government, 500 HACC service providers and over a quarter of a million clients, communication must be managed to ensure that the right messages get to the right people. State and Commonwealth public servants working on joint programs will have regular contact with each other. The regional offices of the Department of Health are the main conduit of information to, and from, service providers. The Funded Agency Channel (FAC) is the department's primary online business and communication tool with agencies it funds. Individual agencies determine who in their agency has access to secure information within FAC. Service providers typically have contact with formal and informal networks of other service providers. Primary Care Partnerships are a good example of networks that all HACC service providers can access. Back stage communication concerns the management and operation of the program. Ensuring that there are systems to protect confidentiality and privacy of client information are key aspects of the back stages of communication, especially when the information contains health and personal information.

Data management

Data management is a good example of a back stage process of a service system. For clients, the main concerns will be to ensure that an appropriate level of data is collected, that data is recorded accurately, stored and protected and that information does not have to be given multiple times. To achieve this for a program the size of the HACC program, sophisticated data management systems are required. The data collected through the minimum data set feeds into a national data set which can be aggregated by state or other characteristics, such as living arrangements. This provides the program with rich data for performance management, identifying trends, responding to community wide issues and planning for future demand.

Workforce development

Workforce development is a good example of a back stage process that requires a number of sectors to work together. Both the Commonwealth and State Governments lead a number of programs and initiatives focused on the health and aged care workforce supply issues, and through COAG, there is also a national partnership agreement on health workforce reform. In terms of the HACC workforce, the Department of Health develops policies and resources to develop the workforce and identifies issues around recruitment and retention. The HACC Assessment Framework, www.health.vic.gov.au/hacc/assessment.htm for

example, outlines the qualifications required by HACC assessors. Individual organisations are responsible for the training, recruitment and retention of staff, and peak bodies, such as the MAV and the ACCV, respond to common issues of their constituents. This induction resource is an example of a document developed in response to common issues identified by the MAV and supported by the Department of Health.

5.2.2 The front stage of the service system

The front stage of the HACC service system involves contact between the client and the HACC services. How this occurs is clearly documented in the HACC Program Manual, HACC Practice Guide, Service Coordination Practice Standards, and supporting resources around good practice and continuous improvement. Links to these resources are provided below. Standardising work flows, work processes and work tools where possible also contributes to the quality of a service system. The Victorian service coordination system is a good example of this. Through service coordination, best practice standards have been developed and resources are available to support organisations to coordinate services. These include the Service Coordination Tool Templates, which support systematic approaches to collecting and sharing client information, in order to provide better access to services.

In summary, the front stage of the service system – the way HACC services connect with the client - involve the following process steps.

Initial contact with the client

This typically may be a phone enquiry from a client or carer which would be responded to via reception and the intake service. The first conversations with the client will also determine their eligibility for HACC services.

Initial needs identification

Identifying the enquirer's needs involves some screening questioning about the presenting problem that has prompted the telephone call. Other questions will be asked which are designed to uncover any other health concerns, need for assistance and other services they may already be receiving. The level of priority for access to assessment will be determined at this stage.

Assessment

Living at Home assessments are undertaken by suitably qualified HACC assessors from designated HACC assessment services. This is the key focus of your role. As the name implies, Living at Home assessments typically take place in the client's home and focus on what is needed to continue to live at home. Designated HACC Assessment Services operate within catchment areas. When you are assessing potential clients, there is no requirement that they take up a service provided by your agency. Your role is to assist the client and/or carer to identify their needs and help them to navigate the service system by referring to the most appropriate service, even if that is provided by another organisation. As part of the Active Service Model, HACC assessments take a strengths-based, goal directed approach, assisting the client to identify what they can do and what may motivate them to develop greater independence.

Care planning

Care planning involves gathering and interpreting assessment, informant and client self reported information in order to make care decisions with the client and the carer. Care planning involves discussion, negotiation and decision-making between assessor and client, to define their goals, priorities and strategies, then identifying actions and services to meet those goals. This includes developing a referral action plan and a service specific care plan.

Service specific care plan

A service specific care plan is part of a Living at Home assessment. The client's need for service(s) is identified. Service specific care plans are developed for each service that is delivered by the HAS. Referrals are then made to other services not provided by the HAS.

Referral

Following an assessment and care plan, if a client or carer requires services which cannot be provided by your organisation, you will need to refer the client to another organisation. For example, a client may require home care services which your organisation can provide and allied health services, which your organisation does not provide. In this case, the assessor will refer the client for the allied health services using the service coordination referral templates. Subject to the client consenting, the information collected at the assessment will be shared with the allied health provider. Alternatively, you may determine, for example, that the client's or carer's needs exceed the scope of HACC and that they require an ACAS assessment rather than a Living at Home assessment. In that case you would refer the client to your local Aged Care Assessment Service.

Care coordination

Coordinated care planning between services is particularly important for clients with multiple or complex needs, such as those with a chronic condition, high or ongoing support needs. A single contact person will be nominated to ensure that the care plan is delivered and monitored, review dates are set, re-assessments are initiated and feedback is given to referring service providers.

Service closure

This occurs when the client leaves the service and happens for a range of reasons. For example, the client may have only required a short term intervention, such as physiotherapy, or to recover from a spell in hospital, and may not require on-going home based services. Alternatively, the client's care needs may have increased and they require a referral for a higher level of HACC services or different types of services, such as a Commonwealth package of care or aged residential care.

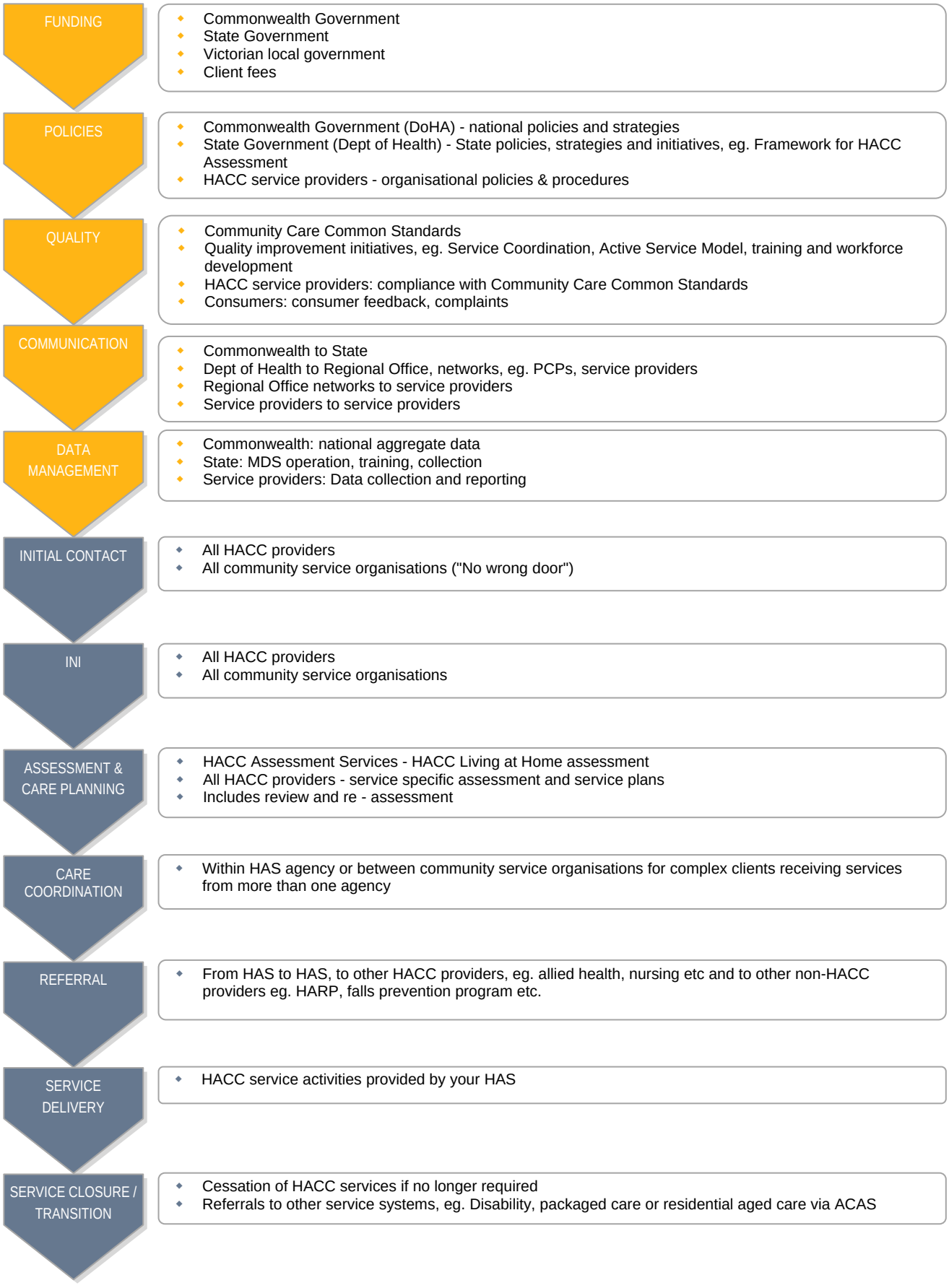
Service coordination documents:

- 2009 Tool Template User Guide
  www.health.vic.gov.au/pcps/downloads/sctt_user_guide09.pdf
- 2009 Optional and Supplementary Templates
  www.health.vic.gov.au/pcps/downloads/sctt_user_guide09_other.pdf
- Victorian Service Coordination Practice Manual
  www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm
- Poster of Client's Pathway through Service Coordination
  www.health.vic.gov.au/pcps/publications/consumer_pathway.htm
- Good Practice Guide
  www.health.vic.gov.au/pcps/publications/goodpractice.htm
- Continuous Improvement Framework
  www.health.vic.gov.au/pcps/publications/continuous.htm

Active Service Model documents:

- www.health.vic.gov.au/hacc/projects/asm_project

5.3 Putting the system together



5.4 Putting the pieces together

If we return to the hotel analogy from the introduction to this section for a minute, we can start to think about how one service system links with another. Just imagine – that for two weeks, you are staying in a hotel in Paris (it doesn't cost anything to imagine!) The quality of the hotel service will influence your holiday experience, but it won't be the only factor. Let's imagine you're a typical tourist. You will seek information from the hotel reception, you'll find out about public transport – you might use the trains, but not the buses. You might use taxis. You will probably visit museums, galleries, shops. You will go to restaurants and cafes. You will leave the city by plane, train or automobile.

While the people you meet, the weather and the experiences you have will all contribute to your overall impression of your holiday, consciously or unconsciously, you will also make an assessment based on how well the service systems 'work' together. How well does the transport system work – especially for a tourist? How well does the tourism sector work – especially for English-only speakers? How easy or difficult is it to access museums, galleries, entertainment?

Now … let's transport ourselves back to the HACC program.

A HACC client will have their experience of the services provided by your organisation. But think about some typical clients. Three quarters of your organisation's clients will only be receiving one to two HACC services. But most will have a General Practitioner and quite probably a regular pharmacist. All will live within a specified local government area. Many will access the services of local government, such as a library or maybe a senior citizen's group. Some will be making a transition in their life from living independently, to needing to find some support to get around or to attend medical appointments. While many of your clients will be in sound health, as people age, their likelihood of being admitted to hospital for some procedure increases. They may experience a short period of time where rehabilitation services are required, or this may mark the onset of more regular medical interventions.

Either way, we know that the HACC client is not a 'hypothetical person', just receiving HACC services. HACC clients have a broad range of needs and so, as an assessor you need to think about your role in terms of connecting people into the broad system of health and community services. Sometimes people will need intensive supports for a limited amount of time, such as after a hospital stay for a broken hip, followed by rehabilitation and maybe attending a falls and balance clinic. Sometimes their health status will change permanently, with the diagnosis of a chronic disease.

The key for you as an assessor is to understand that you are often the link between the HACC client and the rest of the health and community care system. This is the 'no wrong door' policy. When you are discussing with someone their needs for support, irrespective of whether your organisation can provide that service or not, it is part of the HACC assessor's role to 'put the pieces together' and assist that person navigate the service system, matching needs to the service or support available. In order to do this, you need to develop a sound understanding of:

- HACC services provided by your organisation
- other HACC services provided generally around your catchment for people whose needs can't be met by your own organisation, such as HACC funded allied health services provided by community health services
- organisations that provide specialist support or work with particular target groups eg. CALD and Aboriginal health and community services around your catchment area
- other key professionals in the life of the HACC client, especially that of the GP
- the range of service systems which intersect with HACC services, such as acute care, disability support services or residential care

- how to refer someone into one of these abutting service systems, such as referring someone to the Aged Care Assessment Service when they require a residential aged care service or residential respite.

5.4.1 Initiatives to help the service systems work together

Reducing the complexity of the multiple services in health and community services is a major policy priority for the Commonwealth and Victorian Governments. As an assessor, you don't need to feel that making the services all work together is your responsibility alone!

The Commonwealth's Way Forward strategy, for example, is explicitly about improving the way clients access service systems and reducing barriers and duplications.

The Victorian and Commonwealth Governments are working together to improve people's access to community care services. To this end, two access point demonstration projects have been set up in each state and territory. The initiative is known as Direct2Care in Victoria.

The aim of Direct2Care is to improve the ease with which frail older people, younger people with disabilities, their carers, families and friends find their way around what is sometimes a confusing system. The trained staff operating Direct2Care inform people about the range of aged and community care services, offer advice and help answer a variety of questions and concerns. Direct referrals can be made by Direct2Care to relevant service providers in the locality, as well as advice on medium or longer term pathways through the service system.

As a demonstration project, Direct2Care is currently serving only people living in the Eastern Metropolitan region and the Grampians region. Decisions regarding expansion of the service to other regions will be made following the completion of the Victorian evaluation.

5.4.2 Primary Care Partnerships

In Victoria, Primary Care Partnerships have been funded to help build a more effective primary health care system. There are thirty – one Primary Care Partnerships in Victoria, each represents a specific region within Victoria (usually comprising several LGAs, although some are larger) and reflects alliances formed between a range of service providers.

Primary Care Partnerships (PCPs) are made up of a diverse range of member agencies. All PCPs include hospitals, community health, local government and divisions of general practice as core members of the partnerships. Other types of agencies such as area mental health, drug treatment and disability services are also members of PCPs. The relationships can also be specific to local issues and needs. For example, some PCPs have engaged with the police, schools and community groups.

The initial work of PCPs was to implement the Better Access to Services (BATS) strategy. Service coordination models have been developed to provide a seamless continuum of care for clients across the service system. The principles underpinning service coordination models are:

- a central focus on clients
- partnerships and collaboration
- the social model of health
- competent staff
- a duty of care
- protection of client information
- engagement of other sectors

Service Coordination Tool Templates

As part of the Better Access to Services strategy, in 2002 the Service Coordination Tool Templates (SCTT) were introduced. This suite of templates enable a standardised collection of initial contact, initial needs identification, referral and coordinated care planning information and facilitate both consistency in the transmission of referral data between agencies and a reduction of duplication in the gathering of client information. HACC agencies are mandated to use the SCTT tools when making referrals.

References and resources

- Service Coordination Tool Templates: www.health.vic.gov.au/pcps/coordination/sctt2009

5.5 Making referrals – a starting point

As a HACC assessor, you will encounter people with a range of needs from low to high, as well as those requiring services outside the scope of HACC. After developing your understanding of HACC services and the broader health and community service system, the next step is to understand the directions in which you can refer people you assess. Table 5.1 below provides the starting point for understanding some of the multiple referral options which you have available to you. The following section of the resource provides greater detail on some of these programs and services you will need to be aware of. Your organisation will have a more locality specific list of the organisations providing these services in your area.

5.5.1 Range of community - based services

Client requirement	Consider referral to:
Social and recreational needs	◆ community-based activities, such as seniors groups, U3A, library, leisure centre, neighbourhood houses, interest based or hobby groups, volunteering
Information needs	◆ specialised support services, eg. Diabetes Victoria, MS Society, Arthritis Vic ◆ specialised advocacy services, eg. Council on the Ageing (COTA), Office of the Public Advocate (OPA)
Basic support and maintenance needs (HACC)	◆ HACC services provided by your organisation, eg. nursing, home care, home maintenance ◆ HACC services provided by another organisation, eg: - allied health - Aboriginal or CALD-specific organisations providing a Planned Activity Group - respite care - community transport
Aligned services	◆ Post-acute or Transition Care for support after hospitalisation ◆ Veterans' Home Care for eligible returned service members or war widows ◆ palliative care ◆ disability-specific services
General health needs	◆ general practice, eg. for a medication review or referral to a specialist ◆ community health services, eg. allied health, chronic disease self management

Client requirement	Consider referral to:
Specific health needs	◆ specific clinics or services, eg. Falls and Balance, Cognitive Dementia and Memory (CDAMS) or Continence clinics, Victorian Eyecare Services, hearing loss services.
Safety	◆ Aids and Equipment programs ◆ Personal Alert Victoria for a personal alarm
Culture/language	◆ bilingual supported access workers – contact details via Ethnic Communities' Council of Victoria and MAV websites ◆ Aboriginal community controlled organisations ◆ multicultural resource centres
Carer support	◆ Commonwealth Respite and Carelink Centre ◆ Carer Counselling and Advisory Service ◆ Alzheimer's Australia
Other service systems	◆ rehabilitation services ◆ disability services (under 65 years) ◆ mental health services ◆ problem gambling ◆ alcohol and other drugs services ◆ ambulatory care ◆ family or children's services ◆ child protection services ◆ education ◆ housing / accommodation services, such as Supported Residential Services
Services for those with high needs	◆ Aged Care Assessment Service for an assessment for residential aged care, packaged care, transition care, respite care or otherwise complex clients ◆ HARP – Hospital Admission Risk Program

Table 5.1: Range of community based services

5.6 Learning activities

Learning activities #1

Choose two activities from the following options:

1. Is your organisation a member of a PCP?
   Which one?
   Who attends PCPs meetings?

   Find your PCP's website:
   What activities is the PCP working on?
   What is your organisation involved with?

   Find the statewide service coordination website:
   What does the acronym BATS stand for?

2. Discuss with your manager how your organisation connects with each level of the PCP and in particular ,the level of contact you, as a HACC assessor may (or may not) have with the PCP.

3. Does your organisation belong to a HACC Assessment Alliance? Who else is involved? How does this operate?

4. Discuss with your manager how the HACC annual planning and funding process works in your region. What are the local and regional priorities? How are these determined? Is your organisation consulted? How does your organisation participate in planning processes?

Learning activities #2

1. What is the name of your local Aboriginal tribe or nation?

2. Identify local and regional/statewide groups or agencies providing services or support to the Aboriginal community.

3. Investigate whether your organisation has links with the local Aboriginal community eg Aboriginal Liaison Officer, a “Closing the Gap” or other representative committee etc.

4. If you were allocated an Aboriginal client to assess, how would you approach this differently to an assessment with a non-Aboriginal client?

5. Identify regional/statewide groups providing support or services to CALD groups in your area.

6. Investigate whether your organisation has any committees/working parties representing the interests of the CALD community.

7. Discuss with your manager ways that you may be able to become involved with any of these groups.

5.7 Checklist

Do you know about and understand:

- [ ] The ‘no wrong door’ concept?
- [ ] Approximately how many HACC service providers there are in Victoria?
- [ ] Apart from those provided by your organisation, other HACC funded services provided in your catchment area?
- [ ] The role of specialist clinics?
- [ ] Some of the ‘back-stage’ activities that happen in the HACC program?
- [ ] How HACC data is collected in your organisation?
- [ ] What happens to this data?
- [ ] The purpose of Primary Care Partnerships? How many PCPs are there in Victoria?
- [ ] The purpose of the Service Coordination Tool Template (SCTT)?

Section 6. Understanding programs and services

6.1 Overview

As a HACC assessor you will come across clients who have needs that can be met within your service and others that require referral to other services. As stated earlier, 77 percent of HACC clients receive only one or two types of HACC service. It is important that you recognise which of your clients have complex needs and may be referred to the Aged Care Assessment Service for a specialist assessment. In order to effectively assess people with either low, medium or high needs, you need a good working knowledge of a wide range of programs and services.

6.2 Programs and services in detail

Below are *some* of the general areas of need that people may present with, and the common services they are likely to also be using, or that you may refer on to. This list focuses mainly on public services – those provided or funded by governments to meet their policy objectives and with program guidelines and accountabilities managed by government departments. In understanding the types of service generally available, you will also need to follow up locally to identify which organisation provides that service to people living in your area, and the details about eligibility, access and referral processes. In understanding the level of government and the department responsible for the service, you can also follow up the details on the policy scope and intent of the program or service (i.e. who it intends to benefit, how and why) and how the program and funding guidelines shape the type of services organisations can reasonably be expected to deliver. This can be important when you are trying to get a service to respond more flexibly to a person's individual need. Barriers can sometimes lie either within the service provider's control or within government program constraints. To work effectively within the service system, and have it work well for your clients, you need to know the difference and what advocacy strategies are needed. The table below contains a list of programs and services under the following headings:

Index

This framework, taken from individual program and services websites, can only be current at a point in time. The service system is frequently developing and adding new initiatives, so be aware of new programs and services or changes to existing ones by regularly checking websites.

Need	Service/Program
General health	[Return to Index]
General Practitioners	In Australia, people can choose their own GP and/or change GPs. General Practitioners usually operate as private individual or group businesses, or in a community health service. Large 24 hour multi disciplinary services called "GP Super Clinics" are being introduced in some areas as part of current Commonwealth Government policy to better service growth areas and reduce reliance on hospital emergency services. The Commonwealth Government rebates a proportion of the doctor's fees (based on an agreed schedule of fees) through the Medicare scheme for out of hospital expenses and in public hospitals. Some GPs bulk bill pensioners and other low income patients so that they do not have to pay the gap fee, or pay the full fee up front and re claim the Medicare rebate. For more details regarding services covered by Medicare: www.medicareaustralia.gov.au/public/claims/what-cover.jsp
Divisions of General Practice	There are 29 Divisions of General Practice in Victoria, which act as an organisational interface between government and other stakeholders and GPs. Divisions build capacity in general practice, working at the local level towards a skilled, viable and effective general practice sector to improve the health and well-being of Victorian communities. General Practice Victoria (GPV) works at the state level to support Victorian divisions of general practice. Much of their funding comes from the Commonwealth Government, and the 2010 primary health care reforms include proposals for the development of new primary care organisations with wider than GP membership, also being referred to as Medicare Locals. More information: www.gpv.org.au
Ambulance	Since 2008 there has been one statewide ambulance service in Victoria. Ambulance Victoria is operated under the *Ambulance Services Act 1986*, by a Board appointed by the State Health Minister and reports to the Minister. Medicare **does not** cover ambulance transport and treatment, and although the service does get Victorian Government financial support it also charges a fee for its services, unless individuals and families join and pay an annual membership fee. Some private health insurers reimburse ambulance membership fees. All holders of Health Care cards and Pensioner Concession cards are entitled to free ambulance and air ambulance travel anywhere in Australia. OOO is the Emergency Phone Number for contacting an ambulance. More information: www.ambulance.vic.gov.au/index.html

Need	Service/Program
Nursing	HACC-funded nursing includes services provided by district nurses, bush nurses, community nurses, visiting nurses and clinical nurse consultants. Services include direct clinical care, clinical assessment and the provision of education and information. The majority of the care provided is to the frail and aged. Care and support ranges from personal care, medication management, dementia care, counselling, advice, referral, support to friend or family carers, advocacy, health promotion and education. The Royal District Nursing Service (RDNS), servicing the metropolitan area, also provides specialised services in: aged care; continence management; cystic fibrosis services; diabetes services; haemophilia care; HIV/AIDS support services; hospital liaison; palliative care and stomal therapy. The Homeless Person's Program (HPP) delivers care to people experiencing homelessness. More information: www.rdns.com.au District nursing services are located in health services and community health services in rural areas and can also provide many of these services. 'Nurse on Call', is funded by the Victorian Government to provide a 24 hours a day, 7 days a week phone service with immediate, expert health advice from a registered nurse, Call 1300 606 024. More information: www.health.vic.gov.au/nurseoncall/about.htm
Community health services	Community health services are located in every local government area in Victoria (94 community health services in Victoria operate from approximately 400 sites). The type and scope of services managed and delivered by community health services varies throughout the state. Community Health Program funded services include: health promotion and prevention; early identification and intervention; assessment and treatment (eg. allied health services such as audiology, dietetics, occupational therapy, physiotherapy, podiatry, speech therapy, nursing, counselling/casework) and coordinated care with GPs, other primary providers, the acute, aged care and mental health sectors. Community health services also provide a platform for the delivery of a range of other primary health services including drug and alcohol, dental, medical, post acute care, home and community care, community rehabilitation and day centres. More information: www.health.vic.gov.au/communityhealth
Chronic disease program: Hospital Admission Risk Program Chronic Disease Management (HARP CDM)	The Hospital Admission Risk Program Chronic Disease Management (HARP CDM) was designed to develop preventive models of care involving hospitals and community agencies which focussed on people with chronic and complex conditions and gave priority to high volume and/or frequent users of the acute public hospital system. The target population for HARP CDM are frequent hospital attendees who are most likely to benefit from integrated care and have the potential to reduce avoidable hospital use. This includes: people

Need	Service/Program
	with chronic heart disease; people with chronic respiratory disease; people with Diabetes; older people with complex needs; and people with complex psychosocial needs. HARP clients receive intensive community care coordination to enhance the usual care they receive from existing community services. More information: www.health.vic.gov.au/harp-cdm/
Chronic Disease program: Early Intervention in Chronic Disease in Community Health (EIiCD)	Early Intervention in Chronic Disease in Community Health (EIiCD) focuses upon community based early intervention services for people with chronic diseases (with or without complex needs) who may require hospitalisation in the medium to long term. Clients can access a range of health and medical services including community health funded integrated care coordination, nursing, allied health, counselling and self-management interventions. More information: www.health.vic.gov.au/communityhealth/cdm/early_intervention.htm
Pharmacists	Through the Pharmaceutical Benefits Scheme (PBS), the Commonwealth Government subsidises the cost of prescription medicine, making it more affordable for all Australians and eligible overseas visitors. Medicare Australia administers the PBS which includes processing claims and paying benefits under the PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS). Domiciliary Medication Management Review (DMMR – MBS Item 900) is a service to patients living at home in the community. The goal of a DMMR is to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy. It may also involve other relevant members of the healthcare team, such as nurses in community practice or carers. The DMMR process utilises the specific knowledge and expertise of each of the health care professionals involved. In collaboration with the GP, a pharmacist comprehensively reviews the patient's medication regimen in a home visit. After discussion of the visit findings and report with the pharmacist, the GP and patient agree on a medication management plan. The patient is central to the development and implementation of this plan with their GP. More information: www.health.gov.au/internet/main/publishing.nsf/Content/medication_management_reviews.htm
Specialist clinics	Specialist clinics provide specialist assessment, diagnosis, intervention, management, education, advice and support to clients with specific conditions. Clinics commonly provide time-limited, specialist diagnosis and intervention to the client and referral onto appropriate mainstream services for ongoing management. They also provide consultancy, education and support to carers, relatives and professional service providers. Specialist clinics are delivered in a number of settings, including a client's home and at a centre. Specialist clinics include: CDAMS (Cognitive Dementia and Memory

Need	Service/Program
	Service), Continence, Falls & Mobility, Pain management, Wounds and Movement Disorders. More information: www.health.vic.gov.au/subacute/overview.htm#special
Allied health services through GPs	The new Medicare allied health initiative allows chronically ill people who are being managed by their GP under an Enhanced Primary Care (EPC) plan access to Medicare rebates for allied health services. A chronic medical condition is one that has been (or is likely to be) present for six months or longer. It includes, but is not limited to, conditions such as asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke. The Medicare rebate is for a maximum of five services per patient each calendar year, with out-of-pocket costs counting towards the extended Medicare safety net. The five services can be provided by a single allied health professional or shared across different professionals. The patient must have a GP Management Plan (GPMP) and Team Care Arrangements (TCAs) (or a multidisciplinary care plan for residents of an aged care facility). Allied health professionals must be registered with Medicare Australia. Eligible allied health professionals are: Aboriginal health workers, audiologists, chiropractors, diabetes educators, dieticians, exercise physiologists, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists, speech pathologists. More information: www.medicareaustralia.gov.au/provider/incentives/allied-health.jsp
Dental	Public dental services are provided through community dental clinics in community health centres and hospitals and at school dental clinics. Health Care and Pensioner Concession Card holders and their dependants over the age of eighteen are eligible for public dental and denture services. The service charges $23 per visit, up to a maximum of $92 for a complete course of care. Dentures will generally cost around $115. More information: www.health.vic.gov.au/dentistry/clients/dental_system
Hearing	The Commonwealth Office of Hearing Services issues vouchers for eligible clients to access hearing assessments and devices from hearing service providers of their choice. It also administers the provision of hearing services for eligible clients with special needs. Payments are made to hearing service providers for the delivery of services under the voucher system to eligible clients. The services include hearing assessments, the cost of the hearing device and its fitting, and the government contribution to the maintenance and repair of hearing devices. More information: www.health.gov.au/hear
Vision	The Victorian Eyecare Service (VES) is funded by the State Government to provide subsidised eye care at nominal cost for permanent residents of Victoria who hold a Pensioner Concession Card or have held a Health Care

Need	Service/Program
	Card for at least six months. Melbourne metropolitan residents can access these services from the Victorian College of Optometry's (VCO) Melbourne Optometry Clinic. Their main site is located in Carlton with several other sites, located in community health facilities across metropolitan Melbourne including Frankston. Rural services are provided through private practice optometrists and ophthalmologists who are subsidised by the scheme. More information: www.health.vic.gov.au/agedcare/services/ves Vision Australia provide a range of services to people with low vision to enhance independence in the community and home, including; equipment solutions, independent living services, low vision services and mobility training. Most of the services are provided free of charge. More information: www.visionaustralia.org.au
Independent living and safety at home [Return to Index]	
Independent Living Centre	A service of Yooralla providing information, advice, independence trials and equipment to enhance the quality of life of people with disabilities or age related difficulties. Services are available to all members of the general public. Information is free, but fees apply for some services. More information: www.yooralla.com.au/ilc.php
Aids and Equipment Program	The Victorian Aids and Equipment Program (A&EP) provides subsidised aids, equipment and home modifications to eligible people needing assistance to live safely and independently in their own home. The primary aim is to safely support people with a long-term disability, their families and carers to reduce reliance on carers and prevent premature admission into institutional care or high cost services. To be eligible, clients must have a long-term or permanent disability. Ineligible clients are those who: live in a Commonwealth funded residential aged care facility; are receiving aids and equipment through other government funded programs, such as Workcover, Transport Accident Commission (TAC) or Department of Veteran Affairs (DVA), are able to claim the cost through a private health insurance provider; are an inpatient of a public or private hospital or within thirty days of discharge from a public hospital. More information: www.dhs.vic.gov.au/disability/supports_for_people/living_in_my_home/aids_and_equipment_program Regional areas also have a range of access to advice and equipment through public hospitals and some private providers.
Personal alarms	Personal Alert Victoria (PAV) is a personal monitoring service that responds to calls for assistance and is funded by the Victorian Government through the Department of Health. PAV enhances the confidence of frail, older people and people with disabilities, who are isolated and vulnerable, to live independently in their own home by providing contact 24 hours a day. To be

Need	Service/Program
	eligible for PAV, someone must be assessed by one of the designated PAV assessment organisations. For those who are not eligible, there are numerous private alarms available on the market. Companies providing these can be found in the Yellow Pages. More information: www.health.vic.gov.au/agedcare/services/pav/index.htm
Telecross	Telecross is a service that provides the elderly and housebound with a reassuring daily phone call to ensure that they are safe and well. If this call goes unanswered, an agreed emergency procedure will be activated and help arranged if necessary. More information: www.redcross.org.au/vic/services_communityprograms_telecross.htm
Home modifications	The Office of Housing Home Renovation service provides a free advice service to older people which covers the following health and safety modifications: step less showers, altered bench heights, construction of ramps, wider access doorways, personal safety modifications: safer paths and floor coverings, fencing and gates, smoke detectors, security lighting, internal maintenance: wall and floor tiling, floor coverings to wet areas, painting, heater replacement, general maintenance: electrical rewiring, hot water service replacement, restumping and the renewal of wall or roof cladding. Free home inspections are available to Victorian homeowners or private renters who hold either a current Health Care Card or a Pensioner Concession Card, and: are aged sixty or over, or have a disability, or are permanently caring for someone with a disability. Home inspections are conducted by qualified architects. Home renovation loans are available for eligible home owners. More information: www.housing.vic.gov.au/home-owners-assistance/home-modification
Community safety	The Confident Living for Older Victorians is a program coordinated by Victoria Police and funded by the Department of Justice in conjunction with other emergency services. The program is designed to help older Victorians stay healthy and feel safe in their homes and in the broader community. Basic crime prevention strategies are also covered, including: developing a safety plan for all situations, using public transport, using ATMs, using your car, and fire safety. More information: www.police.vic.gov.au/content.asp?Document_ID=10437 Neighbourhood Watch is a community based crime prevention program which aims to improve the quality of life within a neighbourhood by minimising preventable crime and promoting closer community ties. The objectives are to: minimise the incidence of preventable crime, deter criminal activity by increasing the probability of apprehension, reduce the fear of crime, increase

Need	Service/Program
	the reporting of crime and suspicious behaviour, improve the degree of personal and household security through education, expand the program's involvement in wider community safety and crime prevention initiatives. More information: www.neighbourhoodwatch.com.au Formally known as Seniors Registers (and now including people with disabilities), Community Registers help people to feel secure and give them more confidence to live alone in their own homes. People who are older, have a disability or are isolated for any reason, can put their name on their local register and can, if they choose, be contacted by telephone at agreed times on a regular basis, to check on their well-being. The registers hold people's contact and other information such as emergency contacts and any medical risks. Most of the new Community Registers will be based in police stations. Funded registers can provide important information about local conditions and safety issues to participants through regular telephone calls or newsletters. There is no charge to register and it is voluntary. The registers are mostly run and staffed by volunteers, and are a great way for people to volunteer in the local community. More information: www.seniorscard.vic.gov.au/web19/osv/dvcosv.nsf/headingpagesdisplay/community+register+initiative
Carer support	[Return to Index]
National Respite for Carers Program (NRCP)	Over 600 community-based respite services are delivered to carers and the people they care for in a variety of settings, including homes, day centres, host families and residential overnight cottages. Information about respite services in a local area can be obtained by phoning Commonwealth Respite and Carelink Centre on free call 1800 052 222***** during business hours or, for emergency respite support outside standard business hours, freecall 1800 059 059*****. The Centres can help when friend or family carers need to take a break from caring by arranging respite. They do this by acting as a single contact point for information needed by carers and by organising, purchasing, or managing respite care assistance packages for friend or family carers. Examples of respite care assistance include: in-home respite care; support workers to assist when a carer is taking a break away from home; and residential respite care. The centres also provide information for the general public and health professionals about community and aged care services. More information: www.commcarelink.health.gov.au
Carers Australia	The Network of Carer Associations provides friend or family carers with professional counselling, specialist advice and information. Counselling is provided through qualified counsellors on issues specific to carers needs, such as depression, stress-related issues, grief and loss and coping skills. For contact details of the Network of Carer Associations in each state and territory, visit the Carers Australia website and click on the 'Contact Us' tab. They can also be contacted by calling free call 1800 242 636*.

Need	Service/Program
Access to residential respite in an aged care facility	The Aged Care Assessment Service (ACAS) assess for eligibility for residential respite in a Commonwealth subsidised aged care facility. More information: www.health.gov.au/internet/main/publishing.nsf/content/ageing-acat-acapopgu.htm
Support to friend or family carers of people with dementia	Alzheimer's Australia is the peak body providing support and advocacy for people living with dementia. Services provided in Victoria include: counselling and individual support, Dementia Behaviour Management Advisory Service (DBMAS), education and training, Living with Memory Loss programs, multicultural services, National Dementia Helpline, support groups, telephone outreach program and a telesupport program. More information: www.alzheimers.org.au
Carer Payment/Carer Allowance	There are two separate Commonwealth benefits available for friend or family carers: ◆ Carer Allowance ◆ Carer Payment Many carers using HACC services may qualify for either or both of these benefits. If the carer is not receiving them a referral to Centrelink should be made. More information: www.centrelink.gov.au
Companion Cards	The Companion Card is issued to people with a significant permanent disability, who can demonstrate that they are unable to access most community activities and venues without attendant care support. Participating organisations will issue the cardholder with a second ticket for their companion at no charge. For more information see: www.companioncard.org.au
Carer Cards	The Victorian Carer Card is issued to eligible primary and foster carers in Victoria and entitles them to discounted products, services or venue entry from participating organisations. More information: www.carercard.vic.gov.au
Packaged care and case management	[Return to Index]
Commonwealth funded packaged care (CACPs/EACH/EACHD)	Government subsidised packages of care are available in the community for clients with complex needs. Eligibility is determined by the Aged Care Assessment Service (ACAS). Community Aged Care Packages (CACPs) are individually planned and case managed packages of care tailored to help older people remain living in their own homes, despite being assessed as requiring at least low level residential aged care. The Commonwealth Government provides CACP approved providers with a daily subsidy per package to supply and coordinate care services for frail older people. The

Need	Service/Program
	individual services used by a CACP client may be provided by a variety of organisations in your local area but will be coordinated and planned by the approved aged care service provider. Extended Aged Care at Home (EACH) packages are individually planned and coordinated packages of care, tailored to help older people remain living in their own homes. Generally a person who requires high level residential aged care could be eligible for an EACH package. Extended Aged Care at Home Dementia (EACHD) packages are individually planned and coordinated packages of care tailored to help older people who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia. More information: www.health.gov.au/internet/main/publishing.nsf/content/ageing-publicat-qcoa-03info.htm (CACPs) www.health.gov.au/internet/main/publishing.nsf/content/ageing-publicat-qcoa-04info.htm (EACH) www.health.gov.au/internet/main/publishing.nsf/content/ageing-publicat-qcoa-25info.htm (EACHD)
Linkages	Linkages is a HACC funded case management service with brokerage funds to purchase additional services for people whose needs cannot be met entirely by the usual level of HACC services. This constitutes a package of care for the person. More information: www.health.vic.gov.au/archive/archive2007/hacc/linkages
Case management	Private case management and care coordination can provide an individual with a range of privately contracted user funded care services. These can be utilised either instead of a government funded package, or whilst waiting for one to become available. An internet search can readily identify private agencies providing these services.
Cultural	[Return to Index]
Culturally and linguistically diverse communities	Information about different ethnic and multicultural organisations in Victoria can be accessed via the Victorian Multicultural Commission. The Multicultural Resources Directory can ordered from ECCV or downloaded free from: www.multicultural.vic.gov.au/resources/community-directory The Ethnic Communities' Council of Victoria can be contacted via: www.eccv.org.au
Interpreter services	Department of Health (DH) and Department of Human Services (DHS) funded agencies have access to interpreter services through the Language Services Credit Line ("the credit line"). ONCALL Interpreter and Translator Agency have been contracted to deliver telephone interpreting, on-site interpreting and some translations.

Need	Service/Program
	More information: www.dhs.vic.gov.au/multicultural/html/langservices.htm
Aboriginal community controlled organisations	Information about Aboriginal people and Aboriginal community controlled organisations (ACCOs) can be accessed via: www.vaccho.com.au
Social and recreational	[Return to Index]
Planned Activity Groups (PAG)	HACC Planned Activity Groups (PAG) maintain an individual's ability to live at home and in the community, by providing a planned program of activities directed at enhancing the skills required for daily living and providing physical, intellectual, emotional and social stimulation. They also provide respite and support for friend or family carers. The group may meet at a local venue, such as a HACC building (senior citizens centre) or community health service, or go on outings. For more information about individual PAG programs contact local service directories or the local council: www.localgovernment.vic.gov.au For information about ethno-specific PAGs see the Multicultural Resources Directory, which can be downloaded free from: www.multicultural.vic.gov.au/resources/community-directory
Telelink	Telelink is funded by the Victorian Department of Health (DH) through the HACC program to assist people overcome social and geographical isolation. Telelink allows up to ten people in different locations to join a group discussion on the telephone. Using their home telephone, each person can hear and speak to the other people in the group. The service is provided free to participants. More information: www.cbchs.org.au/telelink.php
Friendly visiting	Wesley Do Care support socially isolated, frail older people and people with disabilities by organising volunteers to visit on a weekly basis, establishing continuing relationships based on mutual trust and respect. Wesley can also provide assistance to link people into community activities of their choice. It is mainly available in metropolitan Melbourne. More information: www.wesley.org.au/agedcare/addressingsocialisolation.html Numerous other friendly visiting programs exist, particularly those provided by local churches, and ethno-specific and multicultural organisations for specific CALD communities. For more information see the Multicultural Aged Care Directory 2009 – order form available from: www.eccv.org.au

Need	Service/Program
U3A	University of the Third Age (U3A) members organise their own activities by drawing on the skills of one another. Like-minded members from all walks of life are encouraged to form study groups and share their knowledge with fellow members, all on a voluntary basis. U3As all over Victoria share the same philosophy but each is autonomous and develops its own character. Each U3A's program of educational and recreational activities develops from the interest of its members and the resources of its community. More information: www.vicnet.net.au/~u3avic/ Many social activities for older adults can be found in local service directories eg. senior citizen centres, libraries, neighbourhood centres, leisure centres, activity based groups (bowls, bocce, walking groups, tai chi, dancing etc) More information: www.seniors.gov.au
Active Ageing - Go for your life	Website detailing Active Ageing programs for older adults including: Well for Life, Pryme Movers, Preventing Falls, Living Longer- Living Stronger. More information: www.goforyourlife.vic.gov.au/hav/site.nsf/PresentPracArticles?open&s=al_older_adults+all#programs
Neighbourhood houses	Neighbourhood houses are local not-for-profit centres, funded by the Victorian DHS, where people of all abilities, backgrounds and ages can come to: ◆ meet, talk and make friends ◆ develop new skills ◆ transition to work and further study ◆ volunteer ◆ become involved in community events ◆ find out about other services or activities in the area ◆ join a class or support group ◆ take up an activity for fun and enjoyment There are over 350 Neighbourhood houses in Victoria. For further information on where they are located see: www.anhlc.asn.au/
Veterans	[Return to Index]
	Through the Department of Veterans Affairs, a range of support is available to help eligible veterans and widows live independently in their homes. These include: home maintenance line, home modifications, household assistance, nursing, home and garden, low cost internet, personal care, respite care, Veterans' Home Care (VHC). More information: www.dva.gov.au/benefitsAndServices/home_services/Pages/index.aspx

Need	Service/Program
Disability	[Return to Index]
Support services	Supports and services are available from a range of government and non-government organisations for people with disabilities. These include services to support someone living at home, and in the community, such as: ◆ Individual Support Packages, which provide flexible funding to suit the person's particular needs. ◆ Aids and Equipment Program, which provides aids and equipment for maintaining safety and independence in the home and getting around in the community. ◆ Outreach Support provides short-term support to assist someone to live in the community. ◆ A range of allied health programs (such as physiotherapy, occupational therapy) to assist someone to live as independently as possible in the community. Futures for Young Adults provides information, advice and support for young people with disabilities leaving school. ◆ Day Supports provide the opportunity to learn new skills and enjoy the benefits of living in the local community. ◆ Recreation to provide things for someone to do in their free time. ◆ Specialist disability supports that assist people with a disability, their families, carers and support providers in matters relating to behaviour intervention or the criminal justice system. More information: www.dhs.vic.gov.au/disability/supports_for_people
Accommodation	Disability Services accommodation programs include: Disability Housing Trust, Shared Support Accommodation and *my future my choice*. (to reduce the number of younger people with a disability living in residential aged care (RAC) facilities). More information: www.dhs.vic.gov.au/disability/supports_for_people Local services can be accessed via the Department Better Health Channel health services directory website at www.betterhealth.vic.gov.au
Companion Card	The Companion Card is issued to people with a significant permanent disability, who can demonstrate that they are unable to access most community activities and venues without attendant care support. Participating organisations will issue the cardholder with a second ticket for their companion at no charge. More information: www.companioncard.org.au
Mental Health	[Return to Index]
Aged persons' mental health services	Aged persons' mental health services are primarily for people with a long-standing mental illness who are now over 65 years of age, or who have developed functional illnesses such as depression and psychosis in later life. They also provide services for people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

Need	Service/Program
Assessment and treatment	Aged persons' assessment and treatment services provide community-based assessment, treatment, rehabilitation and case management for older people. The service is delivered through multidisciplinary teams. They provide specialist expertise in medical assessment and treatment, psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions. The teams also provide education for clients and friend or family carers as well as consultation to other service providers.
Aged persons' mental health (APMH) nursing homes and hostels	APMH nursing homes and hostels provide a range of specialist bed-based services to clients who cannot be managed in mainstream aged care residential services due to their level of persistent cognitive, emotional or behavioural disturbance. APMH nursing homes and hostels specialise in caring for older persons with a mental illness and provide longer-term accommodation, ongoing assessment, treatment and rehabilitation. They are designed to have a familiar, homelike atmosphere, and residents are encouraged to participate in a range of quality of life activities. Clients may remain in these units for lengthy periods but opportunities are sought where possible to achieve discharge to a less restrictive environment such as a generic nursing home.
Acute inpatient	Acute inpatient services provide short-term inpatient management and treatment during an acute phase of mental illness until sufficient recovery allows the person to be treated effectively in the community. These services are located with other aged care facilities and/or general hospitals. In some rural services, aged acute inpatient beds are co-located with an adult inpatient unit.
Adult services (16-64 years)	Adult specialist mental health services (16-64 years) are aimed primarily at people with serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder. Commonly these will be people with a diagnosis of a major mental illness, such as schizophrenia or bipolar disorder, but will also include some people with other conditions such as severe personality disorder, severe anxiety disorder, or those who present in situational crisis that may lead to self-harm or inappropriate behaviour towards others. The distinguishing factor is the level of severity of the disturbance and impairment. Increasingly, adult mental health service clients have more than one disorder, with drug and alcohol related disorders (dual diagnosis) being most prevalent.
Crisis Assessment and Treatment (CAT) teams	Crisis Assessment and Treatment Teams operate 24 hours a day and provide urgent community-based assessment and short-term treatment interventions to people in psychiatric crisis. CAT services have a key role in deciding the most appropriate treatment option and in screening all potential inpatient admissions. CAT services provide intensive community treatment and support, often in the person's own home, during the acute phase of illness as an alternative to hospitalisation. CAT services also provide a service to designated hospital emergency departments through an onsite presence.

Need	Service/Program
Mobile Support and Treatment teams (MSTS)	Mobile Support and Treatment Teams provide intensive long-term support to people with prolonged and severe mental illness and associated high-level disability. They utilise an assertive outreach approach and operate extended hours seven days a week. MSTS's differ from continuing care services in the frequency and intensity of intervention offered and work more closely with psychiatric disability rehabilitation and support services. More information and local services: www.health.vic.gov.au/mentalhealth/services/index.htm
Transport	[Return to Index]
Multi-purpose taxis	The Multi Purpose Taxi Program is a State Government subsidy program administered by the Victorian Taxi Directorate (VTD), Department of Infrastructure. A 50 per cent discount on taxi fares (up to a maximum of $60 per trip) is provided for eligible people. The program aims to improve the accessibility of transport services for Victorians with a severe and permanent disability that significantly restricts their mobility and prevents them from independently accessing public transport. More information: www.taxi.vic.gov.au
Disabled parking permits	Disabled parking permits are issued by councils and typically require the endorsement of the client's general practitioner. For information about disabled parking permits contact the local council: www.localgovernment.vic.gov.au
Community transport	Community transport is provided in many local areas, either by councils or community organisations. Check your local government service directory for details.
Victorian Patient Transport Scheme	For information about the Victorian Patient Transport Scheme see: www.health.vic.gov.au/ruralhealth/vptas/index.htm
Red Cross patient transport	In a number of areas in the state Australian Red Cross provides a free transport service to and from hospital or a medical appointment for people who cannot use public transport or afford a taxi. More information: www.redcross.org.au
Housing	[Return to Index]
Public rental housing	The Department of Human Services – Division of Housing and Community Building provides public and social housing and support for those most in need. More information: www.housing.vic.gov.au/home

Need	Service/Program
Housing Support for the Aged Program (HSAP)	Housing Support for the Aged Program (HSAP) supports people 50 years and over with complex needs and a history of homelessness to maintain long-term State public housing and improve their health and wellbeing. Ongoing case management and support is provided to these people as they enter public housing through the priority segments of the Segmented Waiting List or into community managed housing, or those already in public housing where their tenancy is at risk. Members of the client population typically: have complex support needs associated with combinations of conditions such as psychiatric disability, alcohol or drug dependence, acquired brain injury, sensory disability, age-related frailty, and chronic health issues; have a history of homelessness and social marginalisation; lack support from friends and family and are not well linked into services. Support includes low-level monitoring, case management to coordinate client access to services, and practical assistance such as helping clients to get to appointments or linking them into social and recreational activities. Workers have access to a flexible pool of funds to overcome crises (including evictions) or respond to a pressing need that cannot be readily met by existing services. HSAP clients are usually identified and referred by the Community Connection Program. More information: www.health.vic.gov.au/agedcare/services/lowcost/housing.htm
Community Connection Program	The Community Connection Program recognises that people with multiple or complex needs who are homeless or living in insecure or low-cost accommodation are often very isolated and not well connected into health, housing or community services. These people tend to have difficulty negotiating their way around services and often “slip through the gaps” in service systems. The program uses an assertive outreach model to proactively find, engage, assess, and link these people into the services they need. Each CCP service has a pool of flexible care funds to assist clients to overcome a pressing need or crisis. The program also works with local services to assist them to become more accessible and responsive to the needs of this client group. Additionally, the CCP provides proactive and immediate support to people in the client group who need assistance to relocate following closure of their accommodation. More information: www.health.vic.gov.au/agedcare/downloads/ccp_flexcare
Older Persons High Rise Support Program (OPHR)	The Older Persons High Rise Support Program (OPHR) was developed to assist tenants residing in high rise estates. The OPHR support program was designed to: ensure isolated and vulnerable tenants have access to support and services, support tenants to problem solve issues so that they maximise their independence and safety, involve tenants in social and community activities. Services and assistance offered by OPHR workers include: information and referral to other services including Office of Housing and Tenant Support Services; assisting tenants with day to day issues including letter reading and writing, filling in forms, organising home care help, assisting with medical and health needs, helping organise medical appointments, and referral to other health services such as podiatry and physiotherapy. Workers may also run recreational and social groups as well

Need	Service/Program
	as health programs. More information: www.health.vic.gov.au/agedcare/services/lowcost/highrise.htm
Retirement Villages	In many areas, private companies or community organisations have built retirement villages – clusters of independent housing units for people, generally retired or over 50 years, with some communal amenities and support services. Units may be purchased, or leased and a weekly maintenance fee is charged. There are over 400 such villages in Victoria. They are governed by the *Retirement Villages Act 1986*. More information: www.consumer.vic.gov.au/CA256EB5000644CE/page/Retirement+villages?OpenDocument&1=910-Retirement+villages~&2=~&3=~
Legal	[Return to Index]
Seniors' Rights and elder abuse	Seniors Rights Victoria (SRV) is an education and legal service to help prevent and respond to incidents of abuse, mistreatment or neglect of older people. Seniors Rights Victoria operates a confidential help line to provide support, advice or information to seniors, their family, friends or professional carers. Call 1300 368 821 or visit the Seniors Rights Victoria website. More information: www.seniors.vic.gov.au For more information about elder abuse see: *'With respect to age – 2009. Victorian government practice guidelines for health services and community agencies for the prevention of elder abuse'* www.health.vic.gov.au/agedcare/publications/respect/index.htm
Powers of Attorney	Information about power of attorney and guardianship can be found at: www.publicadvocate.vic.gov.au Finding a Lawyer - you can get information about how to choose a lawyer and find details of lawyers through the Law Institute of Victoria, including online in the 'find a lawyer' section of their website.
Legal Aid	Victoria Legal Aid (VLA) is an independent statutory body, jointly funded by the State and Commonwealth Governments, that provides legal aid services to the Victorian community. VLA provides legal information, advice and assistance in relation to criminal issues, family breakdown, family violence, immigration, social security, mental health, debt and traffic offences. Community Legal Centres (CLCs) are independent, non-profit organisations which provide referral, advice and assistance on a variety of legal matters. Details of your nearest Community Legal Centre can be found on the Community Legal Centres Section of the Law Institute of Victoria website, or on the the Federation of Community Legal Centres (Vic) Inc website.

Need	Service/Program
	More information: www.justice.vic.gov.au/wps/wcm/connect/justlib/DOJ+Internet/Home/The+Justice+System/Legal+Assistance/
Financial	[Return to Index]
Income support	Centrelink provides information about eligibility for income support or the option to pay bills by having amounts deducted from Centrelink payments (Centrepay): www.centrelink.gov.au/internet/internet.nsf/individuals/index.htm
Financial counselling	The Commonwealth Financial Counselling (CFC) Directory lists organisations funded by the Commonwealth Government to provide CFC financial counselling services in each state and territory. The webpage also provides links to the Victorian-based services. More information: www.fahcsia.gov.au/sa/families/progserv/pages/cfcp-cfcp_directory.aspx#vic
Concessions on energy, water, rates & properties, hardship and other assistance	For information about concessions provided directly by Department of Human Services see: www.dhs.vic.gov.au/concessions/
Consumer Affairs Victoria	Consumer Affairs Victoria provides free advice on debt problems, referrals to a financial counsellor and information on avoiding scams including travelling con men. More information: www.consumer.vic.gov.au

Table 6.1: Programs and services in detail

6.3 Other services/programs

Some medical, inpatient and ambulatory services that your clients may need to access, or will already be using, are listed below. These health services may also refer their clients for HACC services. It is therefore useful for HACC assessors to have a working knowledge of these services and what they can provide.

6.3.1 Sub-Acute inpatient services

Sub-acute inpatient care is provided through two streams of care funded by the Department of Health. These are:

Geriatric Evaluation and Management (GEM)

GEM is sub-acute care of chronic or complex conditions associated with ageing, cognitive dysfunction, chronic illness or disability. These conditions require inpatient admission for review, treatment and management by a geriatrician and multidisciplinary team for a defined episode of care. The GEM client group is predominately, but not limited to, older people with complex, chronic or multiple health care conditions requiring treatment and stabilisation of those conditions and / or medical review for future treatment options or service planning.

Rehabilitation

Rehabilitation is an integral part of a sub-acute service, and is a specialist area of health that aims to:

- maximise independence and quality of life for people with a disabling medical condition, and maximise the likelihood that they will remain or become active and productive members of the community; and
- minimise the long-term care needs and community support needs of these people and so bring about considerable cost savings both in acute health care and in long-term social security, community care and supported accommodation.

Rehabilitation is proactive and goal-orientated. It targets people with loss of function or ability from any cause, either congenital or acquired, and its aim is to improve function and/or prevent deterioration of function to bring about the highest possible level of independence, physically, psychologically, socially and economically.

6.3.2 Services to people following discharge from hospital

Post Acute Care (PAC) Program

- Provides community-based services to assist people to recuperate after leaving hospital
- Aims to prevent hospital readmission.

The PAC program is for people being discharged from a public hospital (acute or sub-acute) including Department of Veterans Affairs and Transport Accident Commission clients or people who have presented at a public hospital emergency department. A range of community-based services are provided based on the person's individually assessed needs. The most common services provided are: community nursing, personal care and home care. Services arranged by PAC are provided for the duration of the recuperative period and are generally of a short-term nature. PAC works in conjunction with, but does not replace the services provided by other programs, such as HACC, and Sub-acute ambulatory care services (SACS).

More information: www.health.vic.gov.au/pac

Transition Care

The Transition Care Program provides goal oriented, time limited and therapy focussed care to help older people at the conclusion of a hospital stay. The program operates via either bed based or home based places for a maximum of twelve weeks. Clients have a case manager who purchases home care/personal care/meals and nursing services as required.

More information: www.health.gov.au/ageing-transition-care

6.3.3 Sub-Acute ambulatory care services (SACS)

Sub-acute ambulatory care services are available to people of all ages and may follow a hospital stay, hospital day attendance, or may be accessed directly from the community. The aim of SACS are to help people who have a physical disability, are frail, chronically ill or recovering from traumatic injury or illness to regain and/or maintain optimal function, and to allow people to maximise their independence and return to, or remain in, their usual place of residence. Also, SACS aim to help people with newly emerging and chronic symptoms or concerns that require assessment, diagnosis and treatment, through a range of specialist clinics. SACS extend and complement inpatient services. SACS can be delivered in a client's home or at an ambulatory care centre. The features of SACS are:

- a flow of care, where therapy in a community setting follows an inpatient hospital stay to assist people in achieving the maximum level of reintegration into their community

- individualised, time-limited, goal-centred episodes of care that aim to improve health outcomes
- the ability to reduce inpatient length of stay and prevent admissions and readmissions to inpatient services by providing people with home-based or centre-based therapeutic interventions, which prevent the deterioration of an existing condition and/or improve a client's functioning
- an interdisciplinary approach in which team members from different disciplines collectively set goals and share resources and responsibilities.

6.3.4 Community rehabilitation: centre-based and home-based

Community rehabilitation services are time-limited and delivered according to a care plan that is based on goals negotiated with the client and their carer(s). The services should form part of an integrated team, working with clients where it best suits their need and preference for treatment and recovery.
To maximise the opportunity for care continuity, community rehabilitation services are delivered in a number of settings including a client's home (home-based) or at a centre (centre-based).

More information: www.health.vic.gov.au/subacute/overview.htm#crc

6.3.5 Aged residential care

There are two broad types of permanent aged care that are funded and regulated by the Commonwealth Government – low level and high level care.

Low level care (previously known as hostels)

These facilities provide accommodation and personal care, such as help with dressing and showering, together with occasional nursing care.

High level Care (previously known as nursing homes)

These facilities provide care for people with a greater degree of frailty, disability or complex medical conditions and care needs, who often need continuous nursing care.

Ageing in place

Many facilities provide both low level and high level care, so that residents who enter at a low level can 'age in place'.

Residential care can be offered as either permanent or short-term care. Short-term care is called respite care. Eligibility for either permanent or short-term care in a government subsidised facility is determined by the Aged Care Assessment Service.

Government subsidies and fees in residential aged care are calculated based on income and assets.

More information:
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-costs.htm
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-secure-guidelines.htm
www.ocs.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-aged-care-australia.htm

Supported Residential Services (SRS)

SRSs cater for people who can no longer live independently at home. These people are generally mobile but need assistance with daily tasks.

- older, frail people
- people with a physical, psychiatric, intellectual, acquired brain injury or other disability

- people with particular needs, for example dementia.

Some SRSs cater for a particular group only, for example, older frail people.

SRSs are private businesses that provide accommodation and personal care. This care usually includes assistance with showering, personal hygiene, toileting, dressing, meals and medication, as well as physical and emotional support. Some SRSs also provide nursing or allied health services.

SRS residents are not eligible for Home and Community Care services that are already provided by the SRS, such as delivered meals, home care, home maintenance and personal care. Residents are eligible for other services such as assessment, home nursing, social support and allied health.

SRSs vary in the services they provide, the people they accommodate and the fees they charge. They are regulated by the State Government.

More information: www.health.vic.gov.au/srs/

6.3.6 Palliative Care Program

The Department of Health (DH) provides funds for specialist palliative care services to operate throughout Victoria. While general health care services are often involved in the care of people with a terminal illness, the Palliative Care Program provides specialist services that address specific issues such as the management of pain and other symptoms associated with a terminal illness and to provide psychological, social and spiritual support where required or if requested. Services include:

Inpatient care

Clients may be admitted to a hospital or specialised unit for the relief of pain or other distressing symptoms or may need care for a period of time to provide a break for families or friends. See website below for hospitals that receive funding for specialist palliative care services.

Community based palliative care

These services include medical support, nursing care, equipment loan, counselling, bereavement services and volunteer support. In addition, community based palliative care will help people to access other community services such as home help, meals on wheels, home maintenance etc. . See website below for list of community based providers.

Special needs services

These statewide services provide education and support to palliative care service providers and the community in regard to specific issues such as HIV/AIDS, Motor Neurone Disease and children's needs. See website below for list of special needs services.

Bereavement services

The Palliative Care Program provides funding to the Australian Centre for Grief and Bereavement to operate the Specialist Statewide Bereavement Service (SSBS). Community health services provide counselling to bereaved people. Information about grief and bereavement is available from the Better Health Channel Website. Bereavement services are also available through all community palliative care services. See website below for list of community palliative care services.

More information: www.health.vic.gov.au/palliativecare/what.htm

6.4 Other service systems

- Alcohol and other drugs services
  www.health.vic.gov.au/drugs/links.htm
- Problem gambling
  www.problemgambling.vic.gov.au
- Family and children's services
  www.cyf.vic.gov.au/
- Child protection services
  www.cyf.vic.gov.au/child-protection-family-services/home
- Education
  www.education.vic.gov.au/parents/default.htm

6.5 Recapping

The service system for the HACC target group is large and complex. As a HACC assessor you will be asked to conduct broad, holistic needs based assessments. If you have concerns about your client's medical condition their GP should be contacted (except in an emergency when an ambulance should be sought). If your frail aged client has complex care needs and you are unsure how to proceed, the Aged Care Assessment Service can be contacted for advice. If you have concerns about a younger person with a disability (under 65 years) you should contact your local Department of Human Services office. As a new assessor you may want to discuss potential referrals with your manager/mentor and/or check eligibility with the service prior to making the referral.

6.6 Learning activities

Learning activities #1

1. Check with your manager what local service directories and referral resource files are used by assessment staff in your organisation.

   Gather copies of brochures about local services for your own resource file.
   How are they shared and updated?
   Choose some examples and check by:

   Looking up the Department of Health website – www.health.vic.gov.au
   Going into the Aged Care page
   Investigate 'Services'
   Click on 'Publications and Resources'
   Find the 'Living at Home, your choices. A guide for older Victorians.'

   Go into the Human Services Directory using your agency login – www.humanservicesdirectory.vic.gov.au
   and note down service contacts for your local area

2. If you were allocated a client who required an interpreter how would you go about organising this?

3. Choose a service type you are least familiar with and find out: which agency is responsible for delivering this service to residents in your municipality, the details of how it operates, referral processes, key contacts and the frequency of referrals from your organisation.

4. Find out who is the Linkages provider in your area.

6.7 Checklist – Have you read the following documents?

- ☐ *Victorian HACC Program Manual, February 2003* (including updates/amendments)
- ☐ Community Care Common Standards - check DH website for updates: www.health.vic.gov.au/hacc/quality_frmwrk/index.htm
- ☐ *Who gets HACC? A Statistical Overview of the Home and Community Care Program in Victoria in 2004–06*
- ☐ *Framework for Assessment in the Home & Community Care Program in Victoria 2007*
- ☐ *'Strengthening assessment and care planning: A Guide for HACC Assessment Services in Victoria'.2010.*
- ☐ *Active Service Model Project documents - on DH website: www.health.vic.gov.au/hacc/projects/asm_project.htm*
- ☐ *ASM Prepare, February 2010*
- ☐ *Victorian Service Coordination Practice Manual, August 2009.*
- ☐ *Strengthening Home and Community Care (HACC) in Aboriginal Communities Strategy*

(all available on: www.health.vic.gov.au/hacc/)

Self-Evaluation

When you have read through this document and completed the learning activities and checklists, you may want to ask yourself the following questions, and consider the responses as part of finalising your induction program and discussing your ongoing professional development with your manager:

- Is there anything that I don't fully understand?
- If yes - how can I best clarify my understanding of this area?
- Which areas do I need to continue to work on?
- Besides my manager, are there other peers or mentors I can work with?
- What can I do to consolidate and deepen my understanding of the HACC program and the HACC service system?
- Do I have a sound knowledge base to start making good professional relationships with relevant organisations in the local service system?