

Approaching Wellness: National HACC Forum 2008

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NCOSS attended the National HACC Forum alongside three hundred invited delegates in Melbourne on 21 and 22 February 2008. The following is a summary of the highlights of the Forum. Speakers' presentations and workshop findings will be available shortly on the website: www.haccforum08.com.au

It was 2 days of presentations by a range of prominent and international speakers on a new approach to home-based support services. This is the concept described by several definitions: wellness, restorative approach, re-ablement and active service models. In NSW we know this as a strengths based approach.

Essentially this means *doing with*, not *doing for*. In home based support services for frail older people, people with disability and their carers this approach involves working with the person to build on their strengths, not just compensating deficits. HACC services have provided necessary supports at home for people who can no longer manage independently, to avoid inappropriate long term residential care. If the person cannot cook or shop, meals are provided; if the house is unhygienic or dirty, it is cleaned; if the person cannot self-manage personal care eg showering, someone takes care of it. While this is the prevailing service method used in HACC, recent research demonstrates that it can lead to deterioration in some people, hastening their dependence on outside supports and weakening their self-confidence. Ultimately, this can lead to the very thing HACC has been established to avoid.

A strengths based or wellness approach changes all this. It means, where possible, assisting someone to do their own cleaning, enabling the person to do their own personal care, re-learning cooking and facilitating shopping. It means tailoring supports around the person, not slotting the person into services as available. The key is real flexibility, arguably like the original flexibility in service provision encouraged at the inception of the HACC Program in the mid-1980s.

The National HACC Forum aimed to explore evidence for the wellness approach, present projects and programs already in operation and to assess implications for its application within HACC in Australia. The Forum primarily focussed on supports to older people because there was recognition that disability services have a history of operating from independence-promoting and self-efficacy perspectives. This perspective, however, has not translated into HACC service provision.

Wellness or restorative service provision provided extensive benefits to the service user. The person can be involved and active, thereby enhancing independence, maintaining or improving health, confidence and social connectedness; in other words, ensuring the best possible social inclusion.

Benefits to the service provider were also identified. Speakers described impressive rates of improvement in older people, necessitating lower levels of service provision over longer periods, reducing escalation in individual demand for services, allowing more people to be assisted with home based supports. There were, however,

stridently warnings that this approach was designed to focus the person, not to be used as a rationing tool for service provision.

Wellness, the restorative approach, re-ablement and the active service model are all versions of the same concept. Successful restorative or strengths based service provision will depend on several factors, including:

- A recognition that ageing is not a linear decline but is often cyclical, comprising ups and downs, not just downs and more downs.
- The person can determine and work towards their own goals of independence and activity, and participate in service supports
- Allied health will need to play a much bigger role in the provision of home supports, enabling a person to improve or compensate conditions as they arise
- The provision and use of physical aids becomes more prominent in home support services, including improvements to the person's physical environment
- HACC workers prepare to change their way of supporting people, seeing opportunity and possibility, providing encouragement and assistance, not just *doing for*. Training and workforce development will be critical to the success of this new service approach.
- Structural Program supports for this way of working will need to be put into place. Wellness will require changes in contracting and service description schedules, service type guidelines, data collection, new ways of monitoring and quality assurance.

In his introduction to the Forum, Dr Chris Brook, Executive Director of Victorian Rural & Regional Health & Aged Care Services, reminded the Forum of the current negotiations between the Commonwealth and states and territories around Special Purpose Payments, the largest of which is health, but the second largest is HACC. He proposed five principles of care in the community: that the community is the best place to provide treatment; that together we do better; the importance of technology; that the community provides a better experience for people using services; that the community is a better place to work. He stressed the need for flexibility.

Mary Godfrey, of the UK University of Leeds, Institute of Health Sciences, explained what it takes for a "good" old age. Ms Godfrey started with *health*, which she described as not the absence of disease but meaningful activity and social and intimate life with family and friends. *Interdependence and reciprocity* involves the importance of belonging and not being a burden. *Having a purpose and social activity* were critical to a good old age, as were the capacity for comfortable negotiation of the *physical and social environment* and having adequate *material resources*. She cited numerous and various examples of new ways to facilitate processes of compensation and optimisation with the older person.

Dr Dianne Gibson, from the Australian Institute of Health and Welfare, presented statistics on ageing in Australia into 2036 and described the changes in profiles and characteristics of the older population, including older people of culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander older people.

Professor Anne Harding, Director of the National Centre for Social and Economic Modelling (NATSEM), provided economic comparisons of the impact of ageing on Australian economy now and into the future, but warned that economic inequity among older people is set to increase. She projected that 25% of the older population will be wealthier retirees able to pay for their needs but that 25% of older people will have relatively low resources to sustain their old age.

Dr Gill Lewin, Research Manager at Silver Chain in Western Australia, proposed a different paradigm for HACC called "home independence". She said that Silver Chain had found that 60-70% of their clients were suitable for the new service approach and there was a significant success rate. Dr Lewin described three "doing" strategies by Silver Chain for the new approach: establishing independence promoting or enablement programs; changing the culture of home care organisations to ensure that we do not inadvertently contribute to further disablement; striving to assist the community to have different expectations about HACC and home care ie using services episodically as you need them rather than permanently. Dr Lewin recommended casemix funding in community care with classifications of funding at different levels ie packages in HACC.

Michael Fine, Associate Professor in Sociology and Director of the Centre for Research on Social Inclusion at Macquarie University NSW, reviewed the previous presentations, observing that traditional notions of care involved one person doing for or to another whereas a new relationship of care is now proposed where both are active participants.

Gerald Pilkington has been working on the Homecare Re-Ablement Programme with the Health Department and local councils in the United Kingdom. England spends £16 billion on adult social care annually, with 150 councils providing social service. The Homecare Re-ablement Programme uses the proposition of trying to move people to lower tiers of support or off support entirely. Re-ablement is not rehabilitation. He defines re-ablement as helping to accommodate a person's illness through learning. Its common features include helping people *to do* rather than *doing for* them; it is outcomes focussed with goals set for a defined maximum duration; assessments for ongoing care packages require observations over a defined period rather than on one occasion. The objective of re-ablement is to maximise a person's independence while minimising their need for continuing daily support. The Programme's significant results have meant 133 of the 150 local councils in England have established re-ablement programmes. For the individual, re-ablement packages have no upper limit or maximum level. There is additional funding available for the purchase of equipment and aids to daily living as well as separate additional funding available for adaptations to houses.

Hilary O'Connell works for CommunityWest Inc in Western Australia and her role, in partnership with the WA Home & Community Care program, has been to manage the development and implementation Wellness Approach to Community HomeCare (WATCH). WATCH assesses for need not want and encompasses the following features:

1. it is ability focussed, needing to regain or retain abilities
2. it uses ability based documentation
3. strives for the right balance of support

4. supports “to do” not “do for” tasks
5. uses the person’s expectations and involves them in goal setting
6. has an awareness that support might create dependence
7. minimises the impact of ageism
8. works to reconnect the client with the local community

WATCH recognised the role of volunteers and emphasised the importance of constantly “messaging wellness to staff”. Under this new service approach, direct support staff reported they “no longer feel just like cleaners.”

Avril Fahey is responsible for the Independence Programs portfolio at Silver Chain in Western Australia. Key components of their two independence programs are:

- multi-disciplinary teams
- multi-dimensional assessments
- clients set goals
- targetted evidence based approaches
- time limited

The Home Independence Program HIP is for people aged 65+ years for up to 12 weeks with referrals from the community or GP or hospital. The Personal Enablement Program PEP is for people of all ages providing support for up to 8 weeks with referral from public hospitals. The same independence team provides both programs and people must be HACC eligible and not using other programs. HIP and PEP provide aids and equipment, task analysis and simplification and re-design, exercises for strength and balance and medication management. These are not programs for people not able to learn or understand, but there have been good results in people with early stage dementia. Ms Fahey listed the operational challenges for HIP and PEP:

- referrals: getting appropriate clients who are medically stable
- clients: enabling clients to set goals and to understand re-ablement
- staffing: shortage of allied health professionals, need for a generic role
- Service Development: direct care staff understand re-ablement and flexibility

Meg Henderson, Department of Human Services Victoria, presented on the early stages of the Active Service Model. The key components of this Model include:

- Restorative and adaptive approach
- Strengthen capacity
- Holistic and person centred assessments and supports
- More timely, flexible and targetted supports
- Increase and maintain independence
- Long term quality improvement strategy

The Active Service Model also uses the term *capacity building* as part of its description. The nine pilot projects under this Model will address a variety of topics including: home care, continence, assessment practices, gardens, physical activity, nutrition, partnerships. Ms Henderson said that the reporting of results of the Active Service Model had not yet been reconciled with the HACC MDS requirements, it was still a challenge.

Corrienne Nichols, Aged and Disability Unit at Murrindindi Shire Council Victoria, presented on the Well for Life Project. Ms Nichols listed the enablers for a successful wellness program approach as: staff enthusiasm, assessment staff with

knowledge of the client base, volunteer resource centre support and participation of volunteers, cooperation from providers and project staff. She described the learnings from the Project as the need for: available allied health staff; open and honest discussions about what is possible; formal Memorandum of Understanding with Allied Health; role clarification and orientation for volunteers.

Dr Matthew Parsons is senior Lecturer in Gerontology at The University of Auckland, and Shereen Moloney is Senior Manager, Health of Older People, for Capital and Coast District Health Board, New Zealand. Their presentations described the establishment and development and findings of restorative home support in New Zealand. Shereen said their integrated continuum of care is provided to anyone aged 16+ years with chronic care issues. The key principles of the Restorative HACC Packages, which began in 2003, include:

- Systemic problems require systemic solutions
 - For care to be integrated, funding must be integrated
 - People with the best information make the best resource allocation decisions
- This approach introduced goal ladders where a person is supported to move from one achievement to the next over a defined period of up to 10 months. These goals are set by the person and integrated into the care plan by the assessment agency and the service provider. It works best if the service provider has “lots” of responsibility. These were major staff and organisational changes that were implemented within existing budgets.

Associate Professor Gerry Naughtin from La Trobe University in Victoria, in discussing Workforce issues, said “HACC is a victim of its own success”, in that consumer and staff expectations have been established over a period of 20 years. In 2004/05, HACC had a national workforce of over 40,000 people. Allied Health comprises only 3% of the HACC service mix but a restorative approach will need more. He listed the workforce implications of the new approach as

- Training programs for assessment and allied health staff
- Recruitment of more staff
- Engineering of the skill base of the HACC workforce

Forward planning for restorative interventions must occur five years prior to the service request.

While most speakers in the final session enthusiastically supported the wellness, restorative, re-ablement, active service model, strengths based approach, many raised issues and concerns:

- The role and needs of carers should not be lost within this new approach. There was no focus on carers during the Forum.
- There will always be a need for some people to receive ongoing support services, beware losing sight of supporting people in this category.
- Beware imposing this new approach on older people, they must be active partners
- The use of language matters within this approach, beware modelling ageism
- The new approach should incorporate what HACC does best especially its social supports.
- Wellness should not be used as a rationing tool and should be supported by funding frameworks, staff management and contracting.

- Implications for people of non-English speaking backgrounds had not been explored at the Forum
- There were concerns that Aboriginal and Torres Strait Islander older people could require even more flexibility in implementation of any new service approach. Again this was not explored at the Forum.
- Data collection should respond to the new approach and regular reports should be released.

NCOSS is very supportive of the wellness approach within HACC. NCOSS is very concerned, however, that no NSW HACC Development Officers were invited to attend the National HACC Forum as these workers will be critical to the establishment of new approaches at the local and regional level in NSW. It is disappointing that NSW had no profile on the Forum agenda. NCOSS believes that NSW has significant examples of leading practice, including some with strong strengths based approaches.

The next steps will entail further discussions amongst the NSW delegates, hopefully in April, to engage the broader HACC sector in NSW in responding to this nation-wide movement. Let's explore the possibilities.