Re-ablement of Older People in North Coast NSW

Report to NSW Department of Ageing Disability and Home Care (DADHC)
July 2009
ACKNOWLEDGEMENTS

Funding for the study was provided by the NSW Department of Ageing Disability and Home Care (DADHC) – Northern Region.

The Research Team:

- Chief Investigator: Professor Colleen Cartwright, Director of Aged Services Learning and Research Centre (ASLaRC), Southern Cross University.
- Project Coordinator/Research Officer: Cath Cosgrave.
- DADHC Project Manager: Judith Gooden.
- Administration Officer: Leanne Carpenter.

The Research Team also wishes to acknowledge the advice and support of the service providers who participated in the study.

Disclaimer

This research has been undertaken with assistance from the NSW Department of Ageing, Disability and Home Care. However the information and views contained in this study do not necessarily, or at all, reflect the views or information held by the Department, the NSW Government or the Minister for Ageing, Minister for Disability Services.
# TABLE OF CONTENTS

List of Tables ................................................................................................................. viii
List of Acronyms ............................................................................................................. ix
Executive Summary ......................................................................................................... xi

## CHAPTER 1: INTRODUCTION

1.1. Research Organisation – ASLaRC ................................................................. 1
1.2. Funding Partner – DADHC ........................................................................... 1
1.3. Rationale for the Study .................................................................................. 1
1.4. Aim .................................................................................................................... 2
1.5. Objective ........................................................................................................... 2
1.6. Timeframe ........................................................................................................ 2
1.7. Methodology ..................................................................................................... 2
   - Ethics Approval .................................................................................................. 2
   - Methods ............................................................................................................ 2
   - Phase 1- Literature Review ............................................................................. 2
   - Phase 2 – Focus Groups ............................................................................... 3
1.8. Expected Outcomes ......................................................................................... 3

## CHAPTER 2: BACKGROUND TO RE-ABLEMENT IN AUSTRALIA

2.1. Commonwealth Policy Context ................................................................. 4
   - Social Inclusion Policy Agenda ................................................................. 4
   - Carers ............................................................................................................. 4
   - Primary Health Care Strategy .................................................................... 5
   - The Way Forward .......................................................................................... 6
   - Council of Australian Governments ......................................................... 7
2.2. NSW Policy Context ...................................................................................... 8
   - The State Plan ............................................................................................... 8
   - Towards 2030 ............................................................................................... 8
2.3. Commonwealth and State Home Support Services .............................. 9
   - The Home and Community Care Program ............................................. 9
   - Transition Care ............................................................................................ 10
The Chronic Disease Management Medicare items......................... 10
The ComPacks Program................................................................. 11

2.4. Need for a New Approach to Home and Community Care Services........ 11
   a) Wellness approach............................................................... 11
   b) Increased Demand.............................................................. 12

2.5. Emergence of a Re-ablement Approach in Australia.......................... 12

2.6. Recent Initiatives.................................................................... 14
   2.6.1. National Initiatives.......................................................... 14
      2008 HACC National Forum – Promoting Independence............ 14
   2.6.2. State Initiatives............................................................... 14
      Victoria................................................................................. 14
         Active Service Model......................................................... 14
      Western Australia.............................................................. 15
         Home Independence Approach – Silver Chain...................... 15
         The Wellness Approach to Community Home Care................ 15
      New South Wales............................................................... 15
         IMPACT Services – Supporting HACC Consumers’ Active
         Participation in their Community......................................... 15
         Northern Sydney Wellness and Restorative Care Project.......... 16

2.7. Summary ............................................................................. 17

CHAPTER 3: LITERATURE REVIEW

3.1. Multi-Component Re-Ablement Programs....................................... 18
   3.1.1. Randomised Controlled Trials within Home Care Services.......... 18
      USA – Restorative Models conducted by Home Care Services........ 19
      Australia – Home Independence.............................................. 20
      United Kingdom - The Home Care Re-ablement Team-
      Leicestershire County Council.................................................. 21
   3.1.2. Randomised Controlled Trials not conducted by Home Care Services.. 22
   3.1.3. Other Re-ablement Projects/Activities within Home and Community
      Care Services........................................................................ 25
      Peer-Reviewed Literature........................................................ 25
         Western Australia – Home Independence Project.................... 25
      Non-peer Reviewed Literature.................................................. 27
The United Kingdom – Home Care Re-ablement ................................. 27
New Zealand – Restorative Home Support ........................................ 29
Victoria - Independence Pilot Projects ............................................. 31
Queensland – Supported Independent Living Collaborative ............ 32
Western Australia - Wellness Approach to Community

Home Care .......................................................................................... 33
Organisational .................................................................................... 33
Service Delivery ................................................................................... 34
Key Learning from Projects ............................................................... 34
Organisational .................................................................................... 34
Staff ...................................................................................................... 35
Service Delivery approach ................................................................. 35

3.2. Evidenced-Based Single Component Interventions for Re-Ablement

Programs .............................................................................................. 35

Peer-Reviewed and Grey Literature on Single Component Interventions...

Occupational Therapy ........................................................................ 36
Activities of Daily Living ..................................................................... 36
Task Analysis and Redesign ................................................................. 36
Assistive Technology .......................................................................... 37
Physical Therapy .................................................................................. 38
Mobility and Strength .......................................................................... 38
Social Rehabilitation ............................................................................ 39
Health Education .................................................................................. 40
Chronic disease self-management ....................................................... 40
Falls prevention strategies ................................................................... 40
Medication management ...................................................................... 41
Continence promotion ......................................................................... 41
Nutrition ................................................................................................. 42

3.3. Common Features/Approaches in Re-ablement Programs .............. 43

Goal Setting .......................................................................................... 43
Comprehensive Assessment .................................................................. 45
WA ......................................................................................................... 45
NZ ......................................................................................................... 46
UK ......................................................................................................... 47
The Multi-disciplinary Team ................................................................. 48
WA .................................................................................................. 48
NZ ................................................................................................. 48
UK ................................................................................................. 49
3.4. Key Issues for Implementation of Re-Ablement Programs .......... 50
   Cost Effectiveness ...................................................................... 50
   Funding ....................................................................................... 50
   Staff Training ............................................................................. 51
3.5. Summary .................................................................................... 52

CHAPTER 4: CONSULTATIONS IN THE FAR NORTH COAST
4.1. The NSW Far North Coast – Context ........................................ 53
4.2. Focus Group Process ................................................................. 54
4.3. Focus Group Findings ................................................................. 55
   What do you think about the re-ablement approach? What do you think
   are its best elements? ................................................................. 55
   Do you know of re-ablement type practices that are already occurring
   in your organisation or other local organisations? ...................... 55
   What enablers / barriers do you think your region faces if it were to
   adopt a re-ablement approach? .................................................... 56
   Enablers ..................................................................................... 56
   Barriers ....................................................................................... 56
   What strengths/ weaknesses do you think your organisation faces if
   it were to implement a re-enablement approach? ......................... 58
   Strengths ................................................................................... 58
   Weaknesses ............................................................................. 58
   Costs of participating in a pilot .................................................... 58
   What strategies /activities of re-ablement do you think would
   be worth pursuing? What would it look like? ............................. 58
   Goal Setting .............................................................................. 58
   Security of Tenure .................................................................... 58
   Interventions ............................................................................ 59
   Do you think some service types are more appropriate than others? 59
   Training ..................................................................................... 60
Is there a priority order for these strategies/activities? ....................................... 60
What support would your organisation need to adopt a re-ablement approach? .................................................................................................. 60
Additional Specific Issues Identified: ................................................................. 61
  Selection Criteria ......................................................................................... 61
  Multi-disciplinary Team .............................................................................. 61
  Assessment Tool and Process ..................................................................... 61
  Continued Access to Service ........................................................................ 61
  Training ......................................................................................................... 62
  Reservations ................................................................................................. 62
If a Pilot project is to proceed, where should it be located
and which organisation(s) should be involved in it? ....................................... 62
4.4 Summary .................................................................................................. 62

CHAPTER 5: A RE-ABLEMENT MODEL FOR PILOTING IN THE FAR NORTH COAST
5.1 The Five Key Components of a Re-Ablement Program ............................ 63
5.2 Location of the Trial .................................................................................. 64
  Recommendation 1 ...................................................................................... 65
5.3 Developing a Re-Ablement Model for the Clarence Valley Trial: Key
Components of a Re-Ablement Program ....................................................... 65
  Multi-disciplinary Team .............................................................................. 65
    Recommendation 2 .................................................................................. 66
    Recommendation 3 .................................................................................. 66
    Recommendation 4 .................................................................................. 66
    Recommendation 5 .................................................................................. 66
  Multi-dimensional Assessment Tools .......................................................... 66
    Recommendation 6 .................................................................................. 67
  Goal-orientated Care Planning ..................................................................... 67
    Recommendation 7 .................................................................................. 67
  Targeted Evidence-based Interventions ....................................................... 67
    Recommendation 8 .................................................................................. 68
    Recommendation 9 .................................................................................. 68
5.4 Developing a Re-Abelment Model for the Clarence Valley Trial –
Managing Change ................................................................................................................. 69
Organisational Commitment and Whole of Organisation Involvement ........................................ 69
Recommendation 11 ................................................................................................................. 69
Recommendation 12 ................................................................................................................. 69
Training for all Levels of the Organisation .............................................................................. 69
Recommendation 13 ................................................................................................................ 70
Recommendation 14 ................................................................................................................ 70
Client Commitment to the Program with Support from Families
and Carers ......................................................................................................................... 70
Recommendation 15 ................................................................................................................. 70

5.5 Developing a Re-Abelment Model for the Clarence Valley Trial –
Local Agreements .................................................................................................................. 71
Project Client Group .............................................................................................................. 71
Informed Client Consent and Information Sharing ..................................................................... 71
Referral and Assessment Processes .......................................................................................... 72
Recommendation 16 ................................................................................................................. 72

5.6 Project Management and Structure .................................................................................. 73
Recommendation 17 ................................................................................................................ 73

5.7 Project Phases .................................................................................................................. 74
5.7.1 Planning Phase: Months 1 – 4 ..................................................................................... 74
5.7.2 Development Phase: Months 3 – 6 ............................................................................. 75
5.7.3 The Implementation Phase: Months 6 – 18 .............................................................. 77

5.8 Far North Coast Project: Cost Estimates ............................................................................ 78
Assumptions .......................................................................................................................... 78
Cost Components .................................................................................................................. 78
Client Costs ............................................................................................................................. 78
Training .................................................................................................................................. 79
Evaluation ............................................................................................................................... 79
Project Management ............................................................................................................. 80
Total Project Costs .................................................................................................................. 80
In Summary ............................................................................................................................ 81
LIST OF TABLES

Table 1: The Old and New Service Paradigm Shift....................................................... 13

Table 2: Controlled Trials of Multi-Component Re-ablement Interventions ............... 23

Table 3: Planning Phase Activities ........................................................................... 74

Table 4: Development Phase Activities..................................................................... 76

Table 5: Client Cost Estimates by Individual Client and all Project Clients .............. 79
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACAT</td>
<td>Aged Care Assessment Team</td>
</tr>
<tr>
<td>ACSA</td>
<td>Aged and Community Services Association</td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AIPC</td>
<td>Australian Institute of Primary Care</td>
</tr>
<tr>
<td>ASLaRC</td>
<td>Aged Services Learning and Research Centre</td>
</tr>
<tr>
<td>ASPIRE</td>
<td>Assessment of Services Promoting Independence and Recovery in Elders</td>
</tr>
<tr>
<td>ATRACT</td>
<td>Assessment, Treatment and Rehabilitation Advance Core Training</td>
</tr>
<tr>
<td>CAPS</td>
<td>Client Assessment Protocols</td>
</tr>
<tr>
<td>CASSR</td>
<td>Councils with Adult Social Services Responsibilities</td>
</tr>
<tr>
<td>CDM</td>
<td>Chronic Disease Management</td>
</tr>
<tr>
<td>CHA</td>
<td>Community Health Assessment</td>
</tr>
<tr>
<td>CIARR</td>
<td>Client Information, Assessment and Referral Record</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>COPM</td>
<td>Canadian Occupational Performance Measure</td>
</tr>
<tr>
<td>COSE</td>
<td>Coordination of Services for Elderly</td>
</tr>
<tr>
<td>CSED</td>
<td>Care Services Efficiency Delivery</td>
</tr>
<tr>
<td>CSRP</td>
<td>Clinical Services Redesign Program</td>
</tr>
<tr>
<td>DADHC</td>
<td>Department of Ageing, Disability and Home Care</td>
</tr>
<tr>
<td>DALYs</td>
<td>Disability Adjusted Life Years</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Boards</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>EPC</td>
<td>Enhanced Primary Care</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>FIRST</td>
<td>Flexible Integrated Restorative Support Team</td>
</tr>
<tr>
<td>FITS</td>
<td>Facilitating Independent Training Schedule</td>
</tr>
<tr>
<td>FNC</td>
<td>Far North Coast</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HART</td>
<td>Home Care Assessment and Re-ablement Team</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>HBSS</td>
<td>Home Based Support Service</td>
</tr>
<tr>
<td>HIP</td>
<td>Home Independence Project</td>
</tr>
<tr>
<td>HNI</td>
<td>HACC Need Identification</td>
</tr>
<tr>
<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
</tr>
<tr>
<td>IHS</td>
<td>Intermediate Home Support Service</td>
</tr>
<tr>
<td>MDA</td>
<td>Multi Disciplinary Assessment</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
</tr>
<tr>
<td>NASC</td>
<td>Needs Assessment Service Coordination</td>
</tr>
<tr>
<td>NCAHS</td>
<td>North Coast Area Health Care Service</td>
</tr>
<tr>
<td>NCOSS</td>
<td>NSW Council of Social Services</td>
</tr>
<tr>
<td>NPS</td>
<td>National Prescribing Service</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>PEP</td>
<td>Personal Enablement Program</td>
</tr>
<tr>
<td>PIP</td>
<td>Promoting Independence Programme</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SAP</td>
<td>Single Assessment Process</td>
</tr>
<tr>
<td>SILC</td>
<td>Supported Independent Living Collaborative</td>
</tr>
<tr>
<td>SMART</td>
<td>Service Management in Advanced Restorative Techniques</td>
</tr>
<tr>
<td>START</td>
<td>Short Term Assessment and Re-ablement Team</td>
</tr>
<tr>
<td>START (2)</td>
<td>Standardised Training in Advanced Restorative Techniques</td>
</tr>
<tr>
<td>TACS</td>
<td>Transitional Aged Care Service</td>
</tr>
<tr>
<td>TARGET</td>
<td>Towards Achieving Realistic Goals in Elders</td>
</tr>
<tr>
<td>WEDS</td>
<td>Wirral Enablement Discharge Service</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

1. INTRODUCTION

In May 2008, the Department of Ageing, Disability and Home Care provided funding to the Aged Services Learning and Research Centre at Southern Cross University for a service improvement project to investigate and scope the introduction of active ageing concepts and practices to Home and Community Care Services on the Far North Coast.

Over the last 15 years, a new paradigm for home and community care services has been emerging, which challenges the traditional goals of 'maintenance' and 'support' and instead emphasises a capacity building and restorative approach. Such an approach is known under various terms but for this project the term used is re-ablement.

The main objective of the project was to develop a re-ablement model for future piloting by service providers operating in the Far North Coast of NSW and providing HACC services to older people.

Methodology: Ethics approval was provided by Southern Cross University’s Human Research Ethics Committee and the study used a two phase methodology process, i.e. review of available literature, including government policy documents; and focus group consultations with HACC service providers on the Far North Coast of NSW. The findings of phases 1 and 2 were then used as the basis for the development of a model suitable for implementation in the Far North Coast.

2. BACKGROUND TO RE-ABLEMENT IN AUSTRALIA

Commonwealth Government policies examined included the following:

- Social Inclusion Policy Agenda;
- the Who Cares…? Report on the needs of carers;
- the developing National Primary Health Care Strategy;
- A New Strategy for Community Care – The Way Forward; and
- The Council of Australian Governments (COAG) documents.
**NSW Government policies** examined included:

- *The State Plan: A New Direction for NSW, 2006*; and
- *Towards 2030: Planning for our changing population, 2008*

**Other policy documents** considered in this phase of the study included joint Commonwealth and State programs such as Transition Care, the Chronic Disease Management (CDM) Medicare items under the DoHA’s Enhanced Primary Care (EPC) program and the Com Packs program.

The common theme in the overview of current government policy and programs is the emerging emphasis on early intervention, client focus, restoration of function and reducing pressure on the service system in the face of growing demand.

In the same way, the approach to the delivery of home care and community services is currently being reconsidered for similar reasons, i.e.:

(a) the emerging evidence base of the positive difference a ‘wellness’ approach can make to ageing; and

(b) the expected burden on the home care service system over the next few decades resulting from the significant growth in the number of older people and those living with significant levels of disability.

**Emergence of a Re-Ablement Approach in Australia**

There have been a number of recent initiatives which have progressed the re-ablement approach in Australia. At the national level this included the HACC National Forum, held in Melbourne in February 2008, which brought together over 400 key stakeholders to explore the evidence base and implications for more thoroughly adopting a wellness, capacity-building and restorative care approach to HACC service provision.

State initiatives have included the introduction of the Active Service Model in Victoria; Silver Chain’s Home Independence Approach and the Wellness Approach to Community Home Care in Western Australia; and IMPACT Services - Supporting HACC Consumers’ Active Participation in their Community project, and the Northern Sydney Wellness and Restorative Project in New South Wales.
3. LITERATURE REVIEW

An extensive search of Australian and international peer-reviewed and ‘grey’ literature was conducted which explored:

- multi-component re-ablement programs;
- evidence-based single component interventions for re-ablement programs;
- common features/approaches in re-ablement programs; and
- key issues for implementation of re-ablement programs.

There were very few peer-reviewed and well-evaluated studies of a re-ablement approach in the literature, but a number of relevant studies from the US, the UK, New Zealand and Australia provided a great deal of information of value to this project. In particular, the work of Lewin et al (Silver Chain) from Western Australia and Parsons et al from New Zealand provided the research with examples not only of well-conducted programs that demonstrated the benefits of a re-ablement approach to patients, carers, support workers and funding agencies but also tools and training methods that seemed as if they may be appropriate for incorporating into a model for the Far North Coast of NSW.

The literature review also identified interventions commonly included in re-ablement programs, for example:

- occupational therapy;
- maintaining activities of daily living;
- task analysis and redesign;
- use of assistive technology;
- physical therapy;
- the importance of social rehabilitation; and
- health education.

Common Features/Approaches in Re-Ablement Programs

Most of the re-ablement-type projects/programs reviewed which demonstrated positive outcomes included similar essential components or features, including goal setting; comprehensive assessment; and having multi-disciplinary teams.
Goal setting: An excellent example of goal setting was identified in the New Zealand studies led by Parson et al. This team developed TARGET (Towards Achieving Realistic Goals in Elders Tool), which encouraged older people to set a “distal” goal (i.e., something “achievable” that they would like to be able to do), which was used as an outcome tool, with the intermediate or “proximal” goals (or steps on the ladder) which would help the person reach their goal being defined and set by the service provider.

Comprehensive Assessment: Silver Chain’s HIP program stressed not only the importance of comprehensive assessment but also of sourcing and/or developing appropriate assessment tools.

Multi-disciplinary teams: A multi-disciplinary team which included a physiotherapist, an occupational therapist and a registered nurse, supported by care and therapy aides, was considered essential for the success of most programs.

Key Issues for Implementation of Re-Ablement Programs
Other issues identified which must be considered when undertaking re-ablement programs are:
• cost effectiveness (results to date indicate that such programs will be cost-effective in the long-term but there has been insufficient time to undertake robust, long-term evaluations);
• funding (including finding new, creative approaches to the funding of such programs); and
• staff training, for staff at all levels of the program, including support workers.

4. CONSULTATIONS IN THE FAR NORTH COAST
Three half-day focus groups were conducted in the Far North Coast over March-April 2009, with 52 service provider participants. A 30-minute PowerPoint presentation on the re-ablement approach presented highlights from the literature review; this was followed by a semi-structured discussion, using a set of questions based on the consultation questions developed by the Victorian Department of Human Services (2008).
The discussions reflected a number of the themes previously noted in the review of government policy and the relevant literature but also identified very location-specific issues. There was general agreement amongst service providers that the evidence clearly supports the benefits of adopting a re-ablement approach for the provision of HACC services. It was noted that this requires a philosophical change, from seeing care as being there “for the long haul” to one where the goal is “to support someone to move out of the system”.

Many service providers thought that they were already doing re-ablement but in most cases it appears that these organisations have begun shifting towards a wellness approach in the delivery of their programs, which may have elements of re-ablement but are not full-fledged re-ablement programs.

Factors considered “enabling” for a re-ablement project on the FNC included that the success of Com Packs and TACS programs in the region have laid the ground for the successful adoption of a re-ablement approach, with HACC service providers involved in those programs reporting that: clients will accept short-term interventions provided the terms of the program are clearly spelt out; these short-term intensive programs achieve results; and staff delivering these programs have been able to make the shift from a ‘doing for’ to an independence-promoting approach with clients.

A major barrier for the FNC region identified by participants is the geographic spread of clients requiring care, with the concomitant demand on resources because service providers may have to travel for several hours to provide the services. Other identified regional barriers included a long-standing shortage of occupational therapists and physiotherapists within the public health sector in the FNC and the FNC’s ageing population and disproportionately small population of workforce-aged people means that there are currently shortages of HACC workers, which is expected to continue over the next 30 years.

Other generic barriers which would need to be addressed, no matter where a re-ablement project was introduced, included: the culture of ‘life-long’ entitlement to HACC services amongst older people; and the culture of ‘doing for’ by staff of HACC services, rather than supporting the person to “do for” themselves.
Other issues discussed included goal-setting; selection criteria; assessment; clients’ security of tenure; social isolation/loneliness; capacity of an organisation to undertake a project, including staff training issues; the composition and availability of the multi-disciplinary team (with suggestions that some services may need to be brokered in); and the funding model that would support such a project.

5. A RE-ABLEMENT MODEL FOR PILOTING IN THE FAR NORTH COAST

The review of government policies and the national and international literature, and the local service provider consultations provided a sound understanding of the issues involved in re-ablement generally, and in a model for the Far North Coast specifically. A Far North Coast Re-Ablement model for a Pilot Project was developed, based on the following recommendations:

Recommendations
1. That the Clarence Valley be the selected pilot site.
2. That the Clarence Valley pilot builds a multi-disciplinary team through brokering allied health expertise on a sessional basis from other geographic areas, e.g. Coffs Harbour, other professional situations, e.g. private employment, or other agencies, e.g. Department of Health.
3. That cost estimates include allowance for sessional allied health staff to attend client case conferences, project meetings and training, as well as direct client work.
4. That generic intervention programs be identified and used whenever appropriate.
5. That support workers, re-ablement assistants and aides be trained and supported in the use of generic interventions.
6. That the choice of multi-dimensional assessment tool(s) be made by participating agencies.
7. That the TARGET package (which includes a training component) be adopted for the Clarence Valley trial and that negotiations about this be conducted with the University of Auckland.
8. That interventions in the Clarence trial be evidence-based and cover a range of physical and emotional needs according to client circumstances.

9. That the Clarence trial develop a re-ablement response to socialisation needs in collaboration with local HACC Social Support services.

10. That the duration of Clarence re-ablement intervention programs have an average length of 8 weeks, allowing for shorter or longer programs as needed.

11. That the model be underpinned by service agreements that include a whole-of-organisation commitment to the re-ablement pilot from participating agencies.

12. That information sessions about re-ablement be presented to participating agencies prior to the final approval of service agreements, so that agencies are making an informed choice.

13. That training programs be sourced externally where possible or developed locally as needed.

14. That regular training/support sessions for all staff be timetabled into the project plan.

15. That selection criteria for the program include a positive attitude towards a re-ablement approach by the client, their families and carers and the option that they can withdraw without penalty.

16. That project working groups be established early in the life of the project so that participating agencies, the funding body and other related services can formulate agreement on project protocols which form the basis of formal service agreements.

17. That the Northern Rivers Home Care Branch be the budget holder, lead agency and care coordinator for the Clarence Valley pilot project subject to further investigation of the feasibility of this arrangement and endorsement by Home Care management.

Cost estimates for the project were developed which took account of local constraints and issues. The research team considers that the model could be successfully implemented on the Far North Coast, and that its implementation would contribute significantly to the well-being of older people in this region.
CHAPTER 1: INTRODUCTION

1.1. RESEARCH ORGANISATION - ASLaRC
The Aged Services Learning and Research Centre (ASLaRC) at Southern Cross University aims to improve the health and well-being of older people in the North Coast region of NSW, through scholarship, research, education and training. ASLaRC seeks practical ways to maximise the delivery of services to the expanding ageing population in this region and more broadly, while responding to the expressed needs of service providers and other organisations whose work impacts, or has the potential to impact, on services for older people.

1.2. FUNDING PARTNER - DADHC
The NSW Department of Ageing, Disability and Home Care (DADHC) is one of the largest human services organisations in NSW. DADHC provides support and services to more than 1 million older people, people with disabilities and their carers. DADHC is committed to ensuring that older people, people with disabilities and their carers are valued, lead independent lives and have the opportunity to participate fully in community life.

In May 2008, DADHC granted ASLaRC non-recurrent funding for a service improvement project to be expended during the 2008/09 financial year. The focus of the project was to investigate and scope the introduction of active ageing concepts and practices to Home and Community Care services on the Far North Coast.

1.3. RATIONALE FOR THE STUDY
Over the last 15 years, a new paradigm for home and community care services has been emerging. This paradigm challenges the traditional home and community care goals of 'maintenance' and 'support' and the underlying assumption that services for older people, once begun, will continue indefinitely. Instead the new paradigm emphasises a capacity building and restorative approach. Its principle aim is to maintain and, where possible, restore older people's capacity to live as independently as possible. It is known under various terms including active ageing, successful ageing, wellness, restorative approach, re-ablement, independence approach and active service. For this project the term used is re-ablement.

- 1 -
1.4. AIM
The aim of the project was to investigate and scope the introduction of re-ablement concepts and practices to Home and Community Care (HACC) services on the Far North Coast of NSW.

1.5. OBJECTIVE
The main objective of the project was to develop a re-ablement model for future piloting by service providers operating in the Far North Coast and providing HACC services to older people.

1.6. TIMEFRAME
The project had a 12 month timeframe.

1.7. METHODOLOGY
Ethics Approval
Ethics approval was provided by Southern Cross University’s Human Research Ethics Committee. This included approval of the Information Sheet and Consent Form for service providers (See Appendices 1 and 2).

Methods
The study used a two phase methodology process:
- Phase 1: review of available literature,
- Phase 2: Focus groups with HACC service providers on the Far North Coast of NSW.

Phase 1 - Literature Review
An extensive search was conducted on peer-reviewed literature and ‘grey’ literature both internationally and in Australia. The types of literature reviewed included journal articles, government policy documents and reports, project reports/studies, power-point presentations and pod-casts from forums and conferences, and web pages. Additional information was also gathered from key academics through direct contact with them.
The information gathered in this phase of the work is included in Chapters 2 and 3 of this report; Chapter 2 looks at the environmental context under which re-ablement has emerged and HACC service providers are operating, and Chapter 3 presents the literature on re-ablement.

**Phase 2 – Focus Groups**

To ensure that a good sample of HACC service providers on the Far North Coast had a chance to attend, the focus groups were held in Tweed Heads, Lismore and Grafton. The DADHC Project Manager provided a list of service providers to be invited to the three focus groups and others self nominated. The Information Sheet for prospective group participants (developed for the Ethics Committee – see Appendix 1) was used as the basis for the invitation letter sent to service providers.

The questions for the focus groups were based on those used by the Victorian Department of Human Services for consultations on the development of the Active Service Model in Victoria (Victorian Department of Human Services 2008). A summary of the response data from service providers given in the focus groups is reported in Chapter 4 of this report and a more extensive report of the focus groups’ transcripts is attached at Appendix 3.

**1.8. EXPECTED OUTCOMES**

The project deliverables were:

- a model suitable for piloting a re-ablement approach by HACC service providers on the Far North Coast that takes into account best-practice and regionally-specific issues;
- a project plan for a six month pilot development phase;
- a project implementation plan;
- a clear, user-friendly report to guide future activities in re-ablement.
CHAPTER 2: BACKGROUND TO RE-ABLEMENT IN AUSTRALIA

The ageing of the Australian population, resulting in increased demand for care and services, has required governments at all levels to look for new approaches to service provision that will not only be more resource-efficient but will also have the potential to improve the quality of life of service recipients. This chapter examines recent government policies that support a re-ablement approach.

2.1. COMMONWEALTH POLICY CONTEXT

Social Inclusion Policy Agenda
The Australian government has developed a policy agenda to build social inclusion. To be socially included is defined as giving all Australians the opportunity to: secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crises; and have their voices heard (Australian Government, 2008). The promotion of social inclusion has required the Government to take a new approach in developing and implementing its policy and programs. The principles of the approach include:

- building on individual and community strengths;
- building partnerships with key stakeholders;
- developing tailored services;
- giving a high priority to early intervention and prevention;
- building joined-up services and whole-of-government(s) solutions;
- using evidence and integrated data to inform policy;
- using locational approaches; and
- planning for sustainability;
(Australian Government, 2008:2-4)

Carers
In May 2009, the House of Representatives’ Family, Community, Housing and Youth Standing Committee launched its report on better support for carers entitled ‘Who Cares ...?’ The Committee made 50 recommendations, with the highest priorities
being: increased financial support for carers; an increase in respite and in-home assistance for carers; and better coordination of services, including nationally consistent and more streamlined support systems (Parliament of Commonwealth of Australia, 2009).

**Primary Health Care Strategy**

The Rudd Government, as part of its commitment to improving the Australian health care system, has initiated an extensive program of health care reform looking at the interconnection between preventative care, primary health care and acute care. As part of this reform, the Department of Health and Ageing (DoHA) is currently developing Australia’s first National Primary Health Care Strategy. The need for the Strategy has come about because of the increasing challenges that the primary care system is facing due to: the growing burden of chronic disease; Australia’s rapidly ageing population; pressures on the health workforce; and the increasing complexity and volume of care required to be delivered in the community.

In 2008, the Government released a Discussion Paper ‘Towards a National Primary Health Care Strategy’ which proposed ten key elements that could underpin Australia’s future primary health care system; these focussed on access (1-4), service delivery (5-7), workforce (8-9) and sustainability (10). Of particular interest to this project are the elements that emphasise prevention, client focus and self-managed care.

---

1 Other key reform processes include:
- The Council of Australian Governments (COAG) Health and Ageing Working Group;
- National Health and Hospitals Reform Commission;
- The Preventative Health Taskforce; and
- A review of Maternity Services.

2 Primary health care services involve a range of health care providers including: general practitioners, nurses (including general practice nurses, community nurses and nurse practitioners), midwives, allied health professionals, pharmacists and dentists.

3 In 2003, DoHA undertook a review of the Divisions of General Practice which endorsed the role the network of divisions plays in the provision of primary health care in Australia and recommended that it be supported by the development of a national primary care framework. In 2004, the Howard Government agreed with most of the recommendations made in the review but stopped short of agreeing to develop a national primary health care policy.

4 This has emerged as a result of factors such as: changes in hospital services (through reductions in length of stay and increased day surgery); increased focus on ageing at home; increased care being provided to people in their homes that was previously provided in hospital; ongoing impacts of de-institutionalisation; new technologies which support alternative models of community-based care; and better knowledge and expectations of best practice by both health providers and patients (Commonwealth of Australia, 2008:11).
care. The need for fiscally sustainable, efficient and cost effective programs is also highlighted (Commonwealth of Australia, 2008:13).

The Way Forward
In 2004, *A New Strategy for Community Care – The Way Forward* was released by the Australian Government which aimed to streamline administrative arrangements and create a nationally consistent and fairer community care system for older people. The Strategy outlines the research and actions required to strengthen community care and identified a number of key areas for improvement in community care programs (including the Home and Community Care Program [HACC]). These include:

- addressing gaps and overlaps in service delivery;
- providing easier access to services;
- enhancing service management;
- streamlining Australian Government programs;
- adopting a partnership approach.


The implementation of these community care reforms has been occurring in the States and Territories through the adoption of consistent approaches (known as common arrangements) concerning matters such as:

- improving access to services;
- assessing eligibility, client and carers’ needs;
- user fees;
- financial reporting;
- standards and quality assurance;
- information management and data collection.

As part of the development of common arrangements a number of projects have been undertaken including: Access Point Demonstration Projects; Carers’ Eligibility and Needs Assessment; National Consumer Fees Framework; National Framework for Quality, Financial and Planning Reporting; Electronic Continuous Client Records; and Community Care Data Dictionaries. NSW is currently participating in an Access Point Demonstration Project⁵.

**Council of Australian Governments**

The Council of Australian Governments (COAG) seeks to improve coordination and policy development and implementation across the Commonwealth and State/Territory Governments. In December 2007, COAG agreed to establish a new model of cooperation underpinned by more effective working arrangements, including the establishment of working groups focused on issues such as ageing and the productivity agenda. The establishment in March 2008 of a Ministerial Council on Ageing, reporting to COAG, is expected to facilitate this process.

Further, in October 2008, COAG agreed to progress reforms relating to the roles and responsibilities between the Commonwealth and states/territories for community and residential care services for older people, people with disabilities and people with mental illness (COAG, Communiqué, 2⁶nd October 2008). These reforms aim to help with the building of a seamless service system that better meets the needs of the above-mentioned population groups and their carers. A Working Group has been established to develop a reform package for consideration by COAG and this process will include consultation with local government. The reform package will focus on the intersection of aged care and disability services and clarifying the roles and responsibilities of all levels of governments.

---

⁵ The NSW Access Point Demonstration Project commenced as a business unit of NSW Health in March 2008. The Project focuses on HACC services and uses a central intake model. The project is promoted as *Community Care Access Centre*. Clients access the services by calling 1300 731 556 and speaking with trained staff who make assessments using the ‘ONI-N’ assessment tool. The project is servicing nine local government areas of the Hunter Region.
2.2. NSW POLICY CONTEXT

The State Plan

In November 2006, *The State Plan: A New Direction for NSW* was released, which set out the priorities for action for the NSW Government over the next 10 years. In relation to community care and older people, the State Plan recognised the pressures of an ageing population on Government services, especially hospitals, and the potential benefits of better involving older people in the community. The plan focuses on five areas of activity; of particular relevance to older people are the activities ‘Delivering Better Services’ and ‘Fairness and Opportunity’\(^6\). In these activity areas the Plan commits to considering the following new directions:

- Encouraging healthy ageing – targeted initiatives and projects to promote healthy ageing amongst the population, including an emphasis on dementia and falls prevention (NSW Government, 2006, State Plan- Delivering Better Services - Priority S3, p. 49);
- Development of a whole-of-government strategy on ageing to set the direction for future service delivery with a focus on areas of illness and disability prevention, early intervention, community care and support and improved health care (NSW Government, 2006, State Plan - Fairness and Opportunity -Priority F4, p. 77).

Other priorities relevant for frail older people include:

- Improving access to quality and timely health care in hospitals;
- Improving survival and quality of life for people with potential fatal or chronic illnesses through improvements in health care;
- increasing community participation for people with disabilities; and
- reducing avoidable hospital admissions.

Towards 2030

In 2008, the NSW Government released *Towards 2030: Planning for our changing population*, a whole-of-government strategy to actively plan for the ageing of the population. The 2030 horizon for the strategy was selected because, by that time, the proportion of people living in NSW who are 65 years and over will have almost doubled (from 14% to 22%) and people will be living longer than ever before (the

\(^6\) Other priority activity areas are Rights, Respect and Responsibility; Growing Prosperity Across NSW and Environment for Living.
The number of centenarians will have increased eight-fold). This will present two significant planning challenges: to the health system to ensure that it continues to be able to support increased longevity of the population and improve quality of life, by drawing on new techniques and medications; and ensuring adequate and appropriate housing and services for older people, placing a premium on independence and mobility (NSW Government, 2008).

The strategy was informed by the report of the 2007 roundtable event on ageing, ‘Ageing 2030’, hosted by the NSW government, which focused on the changes that population ageing will bring to NSW and the development of long-term responses. The vision of Towards 2030 is that people, communities and businesses in NSW will be focused on planning and adapting for the changing population. The strategy has five strategic outcomes:

- getting in early and planning for change;
- improving prevention and early intervention;
- supporting the development of a productive, skilled and adaptable workforce;
- facilitating participation in all areas of society;
- providing quality care and support.

(NSW Government, 2008:13).

2.3. COMMONWEALTH AND STATE HOME SUPPORT SERVICES

The Home and Community Care Program

The Home and Community Care (HACC) Program is a joint Commonwealth, State and Territory Governments initiative for the provision of community care services auspiced under the Commonwealth Home and Community Care Act (1985). The HACC target population, as defined under the Act, is older and frail persons and younger persons who have moderate, severe or profound disabilities, plus the unpaid carers of these people. Eligibility for services is based on the level of functional disability which makes it difficult for the person to perform the tasks of daily living.

The Program aims to deliver high quality, affordable and accessible services in the community to assist HACC clients to be more independent at home and in the community and to reduce the potential or inappropriate need for admission to residential care.
Transition Care

The Transition Care Program was established in 2004-05 as a jointly-funded initiative between the Commonwealth and states/territories. The Program provides short-term support and assistance for older people after a hospital stay. As set out in the Program’s guidelines, Transition Care targets older people who require more time and support in a non-hospital environment to complete their restorative processes, optimise their functional capacity and finalise their longer-term care arrangements. The program’s focus is people who would otherwise be eligible for residential care.

An older person may only enter Transition Care upon discharge from hospital and following assessment by an Aged Care Assessment Team (ACAT), which is organised through the hospital. Eight weeks is the expected average duration of Transition Care, although in certain circumstances the care period may be extended, up to a maximum duration of 12 weeks.

The program provides goal-oriented, time-limited, therapy-focused care for older people at the end of a hospital stay and can be delivered either in clients’ homes or in a home-like environment in a bed-based residential setting. It provides a package of services that includes case management, low intensity therapy (such as physiotherapy, occupational therapy and social work) and nursing support and/or personal care. Services are able to be used flexibly and support is usually intensive in the first few weeks and then service usage declines as the person’s condition improves.

The Chronic Disease Management Medicare items

The Chronic Disease Management (CDM) Medicare items under the DoHA’s Enhanced Primary Care (EPC) program were introduced to provide more preventive care for older Australians and improve coordination of care for people with chronic conditions and complex care needs. The program provides a framework for a multidisciplinary approach to health. Patients who have a chronic condition\(^7\) and have complex care needs\(^8\) can be managed by their GP under an EPC plan. The CDM items

\(^7\) A chronic medical condition is one that has been (or is likely to be) present for six months or longer and includes conditions such as asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke.

\(^8\) Patients have complex care needs if they need ongoing care from a multidisciplinary team consisting of their GP and at least two (2) other health care providers.
significantly increase care planning options for GPs, as well as expanding patient eligibility and increasing the assistance that practice nurses and others can provide. They also provide more flexibility in who can provide review services. The CDM items include: preparation and review of a GP Management Plan; Coordination and Review of team care arrangements; GP’s contribution to a multidisciplinary care plan being prepared by another health or care provider and access to services of allied health professionals.

The Com Packs Program
Com Packs was designed to assist patients to leave hospital and return to functionality in a timely manner. The focus is on maximising patient independence and capacity in line with their preferences and goals while helping to manage demand across the health system. A six week package of care is provided following discharge from hospital.

2.4 NEED FOR A NEW APPROACH TO HOME AND COMMUNITY CARE SERVICES
The common theme in this overview of current government policy and programs is the emerging emphasis on early intervention, client focus, restoration of function and reducing pressure on the service system in the face of growing demand.

In the same way, the approach to the delivery of home care and community services is currently being reconsidered for similar reasons, i.e.:

(a) the emerging evidence base of the positive difference a ‘wellness’ approach can make to ageing; and

(b) the expected burden on the home care service system over the next few decades resulting from the significant growth in the number of older people and those living with significant levels of disability.

a) Wellness approach: ‘Wellness’ refers to a state of optimal physical and mental health, especially when maintained by proper diet, exercise and social engagement, and reflects a shift from treatment to prevention that has gradually occurred in health provision over the last 50 years. The importance of promoting wellness, even in the context of chronic illness, is consistent with a
growing body of evidence demonstrating that continuing to undertake domestic activities and exercise is very important for overall fitness (Stuck et al., 1999; Seeman & Crimmins 2001) and for the psychological and social well-being of older people (Gill et al., 2002; van der Bij, 2002). Alongside these developments in understanding of ‘wellness’ has been a growing emphasis on ‘successful ageing’ which focuses on promoting physical activity and active participation in the community to maximise physical and mental well-being (Browning & Kendig 2003; 2004). In 2002, in response to criticisms of earlier models of ageing, the World Health Organisation developed an ‘active ageing’ framework, defining ‘active ageing’ as “the process of optimizing opportunities for health participation in order to enhance quality of life as people age” (WHO, 2002:12).

b) **Increased Demand:** Demand for home and community care throughout Australia currently outstrips service availability (Victorian Department of Human Services, 2008). This situation, together with the expected increase in the number of older people and people with disabilities in Australia over the next 20 years, is a major impetus on governments and service providers to rethink the model of service provision.

Both of these factors demand a new approach to the provision of HACC services for older people.

### 2.5 **EMERGENCE OF A RE-ABLEMENT APPROACH IN AUSTRALIA**

Re-ablement is based on the principles of active/successful ageing and wellness and includes the following key components:

- an emphasis on capacity building or restorative care to maintain or promote a client’s capacity to live as independently as possible, with an aim of improving functional independence, quality of life and social participation;
- an emphasis on an holistic, person-centred approach to care, which promotes clients’ wellness and active participation in decisions about care;
- an attempt to provide more timely, flexible and targeted services that are capable of maximising clients’ independence.
It contrasts with more traditional models of service delivery which have been focussed on service priorities such as tasks, routines and time-frames and has had workers orientated towards ‘doing for’ the client. Person-centred care is flexible, responsive and based on the specific goals of each client and their carer/s, with workers orientated towards a ‘doing with’ approach (National Ageing Research Institute, 2006).

The Northern Sydney Wellness and Restorative project (see NSW projects, below) developed a table summarising the main focus of this paradigm shift in home care and community care (Table 1).

**Table 1: The Old and New Service Paradigm Shift**

<table>
<thead>
<tr>
<th>Old Paradigm</th>
<th>New Paradigm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older person as service user</td>
<td>Older person as citizen</td>
</tr>
<tr>
<td>Supporting carers in their caring role</td>
<td>Supporting positive family &amp; friends relationships</td>
</tr>
<tr>
<td>Support carer to maintain caring role</td>
<td>Support the well being of a person who has a caring role</td>
</tr>
<tr>
<td>Prioritising on high need</td>
<td>Early intervention &amp; prevention</td>
</tr>
<tr>
<td>Service type specific focus</td>
<td>Holistic perspective with education and health promotion focus</td>
</tr>
<tr>
<td>‘Deficit’ or problem based assessment</td>
<td>Strength-based assessment</td>
</tr>
<tr>
<td>Maintenance support</td>
<td>Capacity-building/ resilience support</td>
</tr>
<tr>
<td>Eligibility screening and service level assessment</td>
<td>Professional allied health assessment when indicated</td>
</tr>
<tr>
<td>Service provision to substitute for loss of function</td>
<td>Goal oriented care planning</td>
</tr>
<tr>
<td>Assumption of ongoing service on entry</td>
<td>Potential for episodic support</td>
</tr>
<tr>
<td>‘Doing for’/ care</td>
<td>‘Doing with’/ enabling and mentoring</td>
</tr>
<tr>
<td>Service provision focus</td>
<td>Person-centred</td>
</tr>
<tr>
<td>Standard service provision</td>
<td>Individually tailored</td>
</tr>
<tr>
<td>Collaboration with other services</td>
<td>Co-ordination with other services</td>
</tr>
<tr>
<td>Care and service plans per program</td>
<td>Integrated care plan per person across programs/ services</td>
</tr>
<tr>
<td>Exit when person’s care needs exceeds program provision and targeting</td>
<td>Future planning options supported and ‘warm transfer’ to other service support when required.</td>
</tr>
</tbody>
</table>

*Source: UnitingCare Ageing NSW.ACT, 2008.*
2.6. RECENT INITIATIVES:
There have been a number of recent initiatives which have progressed the re-ablement approach in Australia:

2.6.1. National Initiatives

2008 HACC National Forum – Promoting Independence
Held in February 2008 in Melbourne, the HACC National Forum brought together over 400 key stakeholders including academics and researchers, service providers, peak bodies and governments, to explore the evidence base and implications for more thoroughly adopting a wellness, capacity-building and restorative care approach to HACC service provision.

2.6.2. State Initiatives

Victoria
Active Service Model
As part of a policy shift outlined in 2005, ‘A Fairer Victoria’, and detailed in 2006 ‘A Fairer Victoria: progress and next steps’, the Victorian government committed to helping older Victorians stay in their homes by supporting them to maintain independent living. Related to this has been a policy shift in home care services delivered through the Victorian Department of Human Services (DHS), emphasising a restorative or re-abling approach known as ‘the active service model’. Since this time the DHS has undertaken considerable work and consultation with HACC service providers to develop objectives and define the parameters of the active service model. This includes:

- funding four pilot projects;
- commissioning a literature review by the Australian Institute of Primary Care at Latrobe University (as at 14th July 2009 the DHS website still showed this report as unavailable [http://www.health.vic.gov.au/hacc/projects/asm_project.htm]);
- hosting the HACC National Forum on promoting independence – February 2008;
- consulting with HACC funded service providers during May & June 2008; and
- producing a discussion paper on the active service model in May 2008.
The DHS is currently developing an implementation plan for the active service model which was expected by December 2008 (as at 14th July 2009, the DHS website as above gives no further updates on this). Directions that emerged from the consultation process were:

- strengthen practice within current structures and policy through developing resources and training, strengthening assessment and further developing partnerships;
- undertaking one or more demonstration projects
- further exploration, research and development (DHS, 2008).

**Western Australia**

*Home Independence Approach, Silver Chain* - See Chapter 3.

*The Wellness Approach to Community Home Care* - See Chapter 3.

**New South Wales**

*IMPACT Services - Supporting HACC Consumers’ Active Participation in their Community*

Following the HACC National Forum on Promoting Independence held in Melbourne in February 2008, a NSW working group was convened by the Aged and Community Services Association (ACSA) NSW/ACT and the Council of Social Service NSW (NCOSS). Members of the working group include representatives of the peak organisations for aged and community care services and consumers in NSW, community care providers and relevant Federal and State Government departments (DoHA, DADHC & NSW Health). The working group’s aim has been to refocus the NSW HACC program towards a more empowering, client-centred approach in relation to how it identifies and supports clients’ needs. This work has been branded IMPACT Services and the working group has developed a set of five key principles which describe its philosophical approach to the delivery of HACC services:

- person-centred to enable each consumer to explore individual strengths and goals and work towards achieving the outcomes they desire, with security of support for those who need it;
• culturally-appropriate, socially inclusive, sensitive to individual circumstances, social context, relationships and enabling the consumer to continue with what is important to them;
• flexible and responsive to the range of changing needs, interests and choice of consumers;
• supportive and enabling of the positive relationship between consumers and carers;
• recognised as a fundamental and valued part of society that grows and develops to meet the changing expectations of consumers, carers, funders and the workforce.

Although the Working Group has not prescribed a service delivery model it has identified three key development factors which it believes will be required for successful implementation of IMPACT services in NSW. These are:
• adoption of a goal-setting approach with clients;
• use of assistive technology to assist clients to remain in their home environment and to maximise their abilities to do for themselves;
• increased access to the expertise of allied health professionals to provide targeted interventions with clients and build resilience and capacity in clients with chronic conditions.

Northern Sydney Wellness and Restorative Care Project
Also following the 2008 HACC National Forum, the Metro North Region of DADHC commissioned the Northern Sydney Wellness and Restorative Project. The project’s aim is to establish where wellness, capacity building or restorative care approaches could be adopted within existing HACC service types, with particular focus on centre-based day care and social support, and to identify options to pilot and implement the new approach. In July 2008, UnitingCare Ageing NSW.ACT was contracted to undertake the project, which has two phases:

1. the development of a new service paradigm taking a person-centred, strengths-based approach\(^9\) based on a literature review and recommendations arising from consultations and surveys with key regional stakeholders.

\(^9\) versus service orientation, deficit approach
2. piloting the new paradigm in centre-based day care programs operating in the metro north region of Sydney. This phase will conclude with the production of a Final Report with recommendations based on the two phases of the project. Phase one was completed in December 2008.

2.7. SUMMARY
This chapter has identified Commonwealth and State government policies that promote a re-ablement approach to care provision for older people, as well as programs and projects currently being implemented and/developed throughout Australia. Chapter 3 will examine the available national and international literature on a re-ablement approach to care provision for older people.
CHAPTER 3: LITERATURE REVIEW

An extensive search was conducted of peer-reviewed literature and ‘grey’ literature both internationally and in Australia. In addition to government policy documents, reports and projects (reported in Chapter 2), journal articles, conference presentations and web pages were accessed with additional information gathered through direct contact with key academics working in this area. This chapter reports the findings of the review in relation to:

- multi-component re-ablement programs;
- evidence-based single component interventions for re-ablement programs;
- common features/approaches in re-ablement programs; and
- key issues for implementation of re-ablement programs.

3.1. MULTI-COMPONENT RE-ABLEMENT PROGRAMS

3.1.1. Randomised Controlled Trials within Home Care Services

A search for peer-reviewed literature of randomised controlled trials of re-ablement programs, undertaken and administered ‘in-house’ by home care services, produced only one study report (Tinetti et al, 2002). In addition, two other controlled trials undertaken by home care services (but not yet reported in peer-reviewed literature) were identified. These were the Western Australian Silver Chain 2002-04 two-group controlled trial of its Home Independence Program; and, in the United Kingdom, an evaluation of a small scale re-ablement intervention with a control group undertaken by DeMontfort University (Kent et al, 2000). These three programs have had the most robust evaluations and have received the most attention in the development of other re-ablement models (Victorian Department of Human Services, 2008).

All three programs were undertaken within home and community care services and:

- involved multidisciplinary teams;
- included delivery of multi-component interventions; and
- were time-limited interventions.
USA – Restorative Model conducted by Home Care Services

The large trial conducted by Tinetti et al (2002) compared two groups (691 matched pairs) who were eligible for Medicare, which covered home care following an acute illness and a period of hospitalisation. This is considered the most comprehensive and robust study done to date on restorative interventions and is the only peer-reviewed study to be delivered by home care staff. Criteria for the study participants were those at risk of functional decline, but without severe cognitive impairment or requiring total assistance with their care. The trial group of clients received home care through a home care service that had changed its approach to a more restorative model of care and the control group received ‘usual’ home care services from six other services. The restorative care model provided therapy and home health support and was based on principles of geriatric medicine, nursing rehabilitation and goal attainment.

Key characteristics of this restorative care approach included:

- training staff in issues relevant to the above-mentioned principles;
- re-organisation of staff from individual care providers into an integrated coordinated interdisciplinary team;
- reorientation of focus from treatment of disease and ‘caring for’ to maximising function and comfort;
- establishment of goals with input from patient, family and staff; and
- development of a self-care progress report as the principal communication tool which included: establishing a baseline; clarifying the individual’s goals; standardising assessment; documenting responsibilities across staff; and monitoring patients’ progress towards achievements.

This restorative care model was associated with a greater likelihood of remaining at home and a reduced likelihood of visiting an emergency department. Patients in the restorative group had significantly shorter care duration than usual care patients. The restorative care patients also had significantly higher, albeit modest, mean scores than the ‘usual’ care patients in self-care, home management and mobility (Tinetti et al, 2002:2101).
**Australia – Home Independence**

In 1999, in response to an extended period where demand exceeded supply in HACC-funded home care services, Silver Chain, the largest provider of home care services in Western Australia, began developing a home care model promoting independence. Over a six-year period, Silver Chain trialled two new home care re-ablement-focussed programs aimed at persons aged 65 years and over:

i) **HIP (Home Independence Project)**—which targeted Silver Chain’s clients with low to medium needs at two points: either when they were first referred to home care or when they were being re-referred for increased home care services; and

ii) **PEP (Personal Enablement Program)** which targeted clients following discharge from hospital.

The programs were designed as a short-term intervention (up to 3 months) directed at “optimising functioning, preventing or delaying further functional decline, promoting healthy ageing and encouraging self-management of chronic diseases” (Lewin et al, 2008:15). Some key features of the programs were:

- interdisciplinary team;
- comprehensive multi-dimensional assessment;
- goal-orientated care planning in partnership with client;
- targeted evidenced-based interventions (see below);
- minimised face-to-face contact, including telephone support and follow-up;
- use of participatory language with clients and families;
- recognition of importance of social support aspect of home care services and supporting clients to develop other avenues to gain this support; and
- use of local resources (Silver Chain, 2007)

Areas of functioning and types of targeted, evidence-based interventions included:

- promotion of active engagement in activities of daily living (ADLs)\(^\text{10}\) and instrumental activities of daily living (IADLs)\(^\text{11}\);
• strength, balance and endurance programs for mobility;
• chronic disease self-management;
• falls prevention strategies;
• improvements or maintenance of skin integrity; and
• medications, continence and nutrition management.

As part of its research, in 2002-04 Silver Chain conducted a randomised controlled trial of HIP, funded by the WA Lotteries Commission, comparing the outcomes of 100 individuals receiving HIP in one metropolitan region of WA with 100 other clients receiving usual home care services. Some key findings of the HIP intervention group were that:
• the HIP group demonstrated better ADLs, better mobility, reduced falls and higher morale;
• receiving HIP made it 15 times more likely that a client at three months would no longer be receiving assistance, and at 12 months, seven times more likely not to be needing ongoing services.(Lewin and Vandermeulen, 2006b).

United Kingdom - The Home Care Re-ablement Team - Leicestershire County Council
The Centre for Group Care and Community Care Studies at De Montford University in the UK was engaged to undertake three evaluations of Promoting Independence Pilot projects\textsuperscript{12} for the Leicestershire County Council. The report produced by Kent et al in 2000 concerned the first of the three projects, the home care re-ablement team (‘Re-ablement Team’) in Melton. The aim of the service delivery approach of the Re-ablement Team project was to help service users do more for themselves (Kent et al: 2000:25). The Re-ablement Team consisted of six home carers, one programmer, one senior home care assistant, a half-time home care manager and a commissioning officer. Some of its distinctive features were:
• short-term – time limited involvement – 6 weeks;
• clear goal-setting and monitoring;

\textsuperscript{11} IADL’S (Instrumental Activities of Daily Living) are driving, preparing meals, doing housework, shopping, managing finances, managing medication, using the telephone.

\textsuperscript{12} Also includes the Specialist Home team in Coalville and two residential Rehabilitation projects at Hadrian House Older People’s Home.
high standards of case recording;
• a dedicated Commissioning Officer who reviewed cases;
• regular team meetings to review service users’ progress and to adjust goals; and
• specific training for all team members on goal setting and rehabilitation techniques.

The aim of the research was to evaluate the extent to which the Re-ablement Team enabled project participants to achieve their maximum level of independence and therefore remain in their own homes. A statistical analysis was conducted of service users who were provided with a service from the Re-ablement Team Project (42 service users) compared with a matched group of service users (n=38) who did not participate.

Key results included:
• packages of home care were initially larger for service users of the re-ablement project;
• packages provided by the re-ablement team were far more likely to be discontinued at first review compared to the matched group (62% versus 5%);
• packages provided by the re-ablement team were far more likely to be reduced at first review compared to the matched group (26% versus 13%).

3.1.2. Randomised Controlled Trials not conducted by Home Care Services

Four peer-reviewed controlled trials that investigated multi-component re-ablement programs but were not conducted by Home Care Services were identified (Gitlin et al [2006], Gill et al [2002], Tinetti et al [1999] and Siu et al [1996]. Of particular relevance to this project is the study by Gitlin et al.

Gitlin et al (2006) conducted a two-group randomised trial to test the efficacy of a multi-component home intervention aimed at reducing functional difficulties and enhancing self-efficacy and adaptive strategies. The target group were older adults aged 70 and over (n=319) who reported having some difficulties with ADLs but were not eligible for home care support. The intervention group received five therapy sessions: occupational therapy (4) and physical therapy (1). These sessions involved:
• home modifications and training in their use;
• instruction in problem-solving strategies;
• energy conservation;
• safe performance and fall recovery techniques; and
• balance and muscle strength training.

At six and twelve months post-intervention, the intervention group had less difficulty with IADLs and ADLS, with the largest reductions in difficulty occurring in bathing and toileting. They also had greater self-efficacy, less fear of falling, fewer home hazards and greater use of adaptive strategies. Benefits were also found to be sustained 12 months after the intervention for most outcomes.

Table 2 presents a summary of the above trials.

Table 2: Controlled Trials of Multi-Component Re-ablement Interventions

<table>
<thead>
<tr>
<th>Authors</th>
<th>Study Design and Date</th>
<th>Participants</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tinetti et al., (2002)</td>
<td>USA</td>
<td>Older persons 65+</td>
<td>Restorative care provided by home care agency – providing therapy and home health support – based on principles of geriatric medicine, nursing rehab and goal attainment.</td>
<td>Restorative care associated with:</td>
</tr>
</tbody>
</table>
|                        | Prospective two group, individual matching: home care agencies – 5 providing usual care and 1 restorative care. Study conducted between 1 Nov 1998 – 30 April 2000. |• had experienced an acute illness or hospitalisation;  
• were at risk of functional decline;  
• in receipt of Medicare-covered home care;  
• had an absence of severe cognitive impairment  
• were not requiring total assistance with care.  
691 matched pairs with 6 home care agency offices in Connecticut. | Key characteristics of restorative care approach:  
• training staff in issues relevant to above principles;  
• re-org of staff from individ care providers into integrated coordinated interdisciplinary team;  
• reorientation of focus – from treatment of disease and ‘taking care of’ to maximising function and comfort;  
• establishment of goals with input from patient, family, staff. A self-care progress report. |  
• greater likelihood of remaining at home;  
• reduced likelihood of visiting ER;  
• shorter home care episodes;  
• better scores in self care; home management; and mobility. |
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study Design and Date</th>
<th>Participants</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Lewin et al., (2008) Australia | Two group controlled trial in WA conducted by Silver Chain (largest community care provider in WA) – developed a Home independence Program (HIP) operational trial in 1 metro region. Pilot study conducted 2001-2003 | Targeted older individuals 65+  
- first referred for home care services; or  
- existing Silver Chain home care client requesting increase in level or amount of service.  
100 HIP clients and 100 other clients receiving usual home care services. | 12 week program – key components:  
- interdisciplinary team;  
- comprehensive multi-dimensional assessment;  
- goal-orientated care planning in partnership with client;  
- targeted evidence based interventions to optimise ADLs;  
- minimised face-to face contact;  
- education and principles of self management, healthy ageing;  
- participatory language;  
- recognition of importance of social support;  
- use of local resources. | Personal outcomes: HIP group demonstrated better ADLs, better mobility, reduced falls and higher morale.  
Service outcomes: Receiving HIP made it 15 times more likely that client at 3 months no longer receiving assistance; and at 12mths – HIP recipients 7 times more likely not to be needing ongoing services.  
Cost of providing services – no significant difference between direct care cost of HIP and standard home care – but as 57% of HIP group no longer receiving services and 81% control group were, reasonable to assume cost saving of HIP in longer term. |
| Kent et al., (2000) UK | Prospective, two group, home care re-ablement group vs home care standard. Study was conducted in 1999-2000 | Services available to range of individual with disability and difficulties with ADLs; 80 participants, average age 78-83yrs, 42 service users using home care re-ablement team compared with 38 receiving home care but not re-ablement. | Single team – providing intensive packages (4-6 weeks) of support and rehabilitation to re-learn ADLs or gain new ones. Team: Manager, social worker, occupational therapist, 2 half-time physiotherapist, therapy assistant and 6 re-ablement assistants. | In re-ablement group, home care packages far more likely to be discontinued after first review (62% vs. 5%);  
Home care packages twice as likely to be decreased (26% vs. 13%) and far less likely to be increased (2% vs. 11%).  
Home care packages far less likely to be maintained (10% vs. 71%) in re-ablement group. |
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study Design and Date</th>
<th>Participants</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gitlin et al.,</td>
<td>(2006) USA Two group randomised trial – treatment group,</td>
<td>Study included 319, 70+ adults reporting difficulties with one or more ADLs and</td>
<td>6 month intervention: Occupational therapy (4 x 90 mins face-to-face +1x20 min telephone) and physical therapy (1x90 mins) sessions involving home modifications and training, strategies for problem-solving; energy conservation, safe performance and fall recovery and muscle strength training.</td>
<td>At 6mths post-intervention participants had fewer difficulties than controls with ADLs. Also higher self-efficacy; lower fear of falling; fewer home hazards; and greater use of adaptive strategies. These benefits were sustained at 12 months for most outcomes. Lower mortality rates were also observed.</td>
</tr>
<tr>
<td>(2006) USA</td>
<td>non treatment group. Study conducted between 2000 and 2003.</td>
<td>not receiving home care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.1.3. Other Re-ablement Projects/Activities within Home and Community Care Services

*Peer-Reviewed Literature*

*Western Australia – Home Independence Project*

In 2008, Lewin et al produced a peer-reviewed paper in Geriacton outlining the findings from a pilot and an operational trial of HIP (these were in addition to the controlled trial discussed above).

Initially the HIP was undertaken as a pilot study with 56 Silver Chain clients. The purpose of the pilot was to test the program’s effectiveness in increasing participants’ independence (i.e. increased functionality and reduced need for services) and identifying any refinements required to the program. The program was found to be effective in both areas, with demonstrated gains in functioning of 41 clients who completed the program: 71% had less difficulty performing IADLs, 33% no longer needed ongoing services and 39% needed a lower level of service. Some other key findings of the HIP pilot were:
• the Assessment tool (RAI-Home Care.v2.0)\textsuperscript{13} did not work well as a care planning tool (see the Assessment section of this Chapter for further discussion);
• there were sufficient similarities between clients and their goals to be able to develop ‘standardised’ interventions;
• for those clients with difficulties in multiple domains, several home visits by various allied health professionals was confusing for the client, difficult to coordinate and costly for the service provider.

As a result of these findings the Team agreed on ‘generic’ inter-disciplinary interventions and documented the knowledge and skills required to support these. Also, for those clients not progressing as well as expected, if their needs were assessed as being outside those of the ‘generic’ interventions and if the expertise existed with one of the Team members, that person was asked to provide a clinical consultation.

Following the success of the pilot study, the Western Australian (WA) Department of Health funded Silver Chain to undertake a two year operational trial. The trial involved 418 participants\textsuperscript{14} and was again implemented by the same multi-disciplinary team of allied health professionals that implemented the pilot. The key outcome measure for the trial was whether clients required ongoing home care services immediately after completing the program, and when assessed again after one year. At service end, 70% of clients no longer needed ongoing home care services and 7% of clients needed a lower level of service than at referral. One year later, 62% of those clients who had ceased services were still not using any home support services (Lewin et al, 2008).

A key finding of the HIP trial was that clients needing a lower level of service decreased from 39% in the pilot to 7% in the operational trial. Lewin et al attributed this decline to different proportions of client types from the pilot and trial; the research team observed that 87% of clients in the operational trial were referred

\textsuperscript{13} InterRAI is an international collaboration of gerontologists and clinicians who develop a range of assessment tools for older people, the InterRAI Home Care (HC) v2.0. is one of these tools. In New Zealand’s restorative home support program a later version of this assessment tool is currently being used.

\textsuperscript{14} 23% of clients who commenced HIP did not complete the program, mostly (85%) due to illness.
because they were experiencing difficulties with personal care, whereas in the pilot this only accounted for 27% of clients. Lewin at al observed that it appeared easier to assist people to become completely independent with personal care tasks than with household tasks. They argued that this was probably because people had a stronger motivation for independence in personal care tasks than household tasks and also because of common physical limitations that prevented clients from undertaking heavier aspects of household work (Lewin et al, 2008).

As a consequence of these results, Silver Chain, in agreement with WA’s Department of Health, is now offering HIP across the metropolitan areas of Western Australia and has established independence teams in all of its service centres in Perth and in two regional centres as well. Silver Chain is also targeting the HIP program to clients who have been first referred for personal care. In 2007, Silver Chain commenced a four-year randomised controlled trial funded by the Australian Health Ministry’s Advisory Council Priority Driven Research Program. The study has been designed as a randomised controlled trial in which 1,250 individuals referred for HACC-funded personal care in the metropolitan area, and who meet the study inclusion criteria, will be randomly assigned to receive either ‘standard’ HACC services or HIP (for 3 months maximum, after which they will receive ongoing HACC services, if they need them) (Silver Chain, 2009). The trial examines individual and group outcomes, including use of other health and aged care services for two years after intervention (Lewin et al, 2008).

**Non-peer Reviewed Literature**

*The United Kingdom – Home Care Re-ablement*

In the United Kingdom (UK) there have been no peer-reviewed research publications but there is a large body of grey-literature, primarily produced by the Department of Health’s Care Services Efficiency Delivery (CSED) Unit, which produces reports that describe and evaluate re-ablement home care services being provided by local Councils in the UK ([http://www.dhcarenetworks.org.uk/csed/](http://www.dhcarenetworks.org.uk/csed/)).

---

15 It is also still available for clients with just IADL needs if they are keen to participate.
Home care re-enablement programs in the UK are primarily provided by local Councils and are fairly common. Pilkington et al’s research (CSED, 2006) included surveying 150 Councils with Adult Social Services Responsibilities (CASSR) to identify the prevalence of home care re-ablement schemes operating in the UK; the study showed that 60 CASSRs had a home care re-ablement service of some kind. There are two main types of re-ablement services in the UK:

i) intake re-ablement, which targets people assessed as needing or being eligible for home care services; and

ii) discharge support, which accepts referrals from people leaving hospital.

In both cases clients are then further assessed for whether they are likely to benefit from a re-enablement approach (Newbronner et al, 2007).

Case studies of re-ablement services operating across UK undertaken by CSED reveal that whilst they vary widely in structure, they share common objectives, i.e. maximising long-term independence of older people and minimising ongoing support (Pilkington et al in CSED, 2006). They also have some common features:

- having a helping ‘to do’ rather than ‘to do for’ approach;
- outcome focussed;
- comprehensive multidisciplinary assessments;
- time-limited services – usually six weeks (up to three months); and
- multi-disciplinary teams that include: homecare agency staff, occupational therapists, social workers and, in some teams, physiotherapists (Pilkington et al in CSED, 2006 and Kent et al, 2000).

The studies undertaken by Kent et al (2000) and Pilkington et al (CSED, 2006) clearly established that by undertaking a phase of re-ablement, frail older people could make significant improvements in their levels of independence. For Councils, this re-enablement approach also resulted in a reduction in the number of hours of commissioned care required; however whether these reductions were maintained in the longer term was unknown. The CSED therefore commissioned a further study to address this gap in evidence (Newbronner et al, 2007). Newbronner et al’s study
evaluated four re-ablement service sites – two intake\textsuperscript{16} and two discharge support services\textsuperscript{17}. The results in home care usage two years after re-ablement services were ceased were positive in three out four services; 53\%-68\% left re-ablement requiring no immediate home care packages; two years later 36\%-48\% of this group still continued to need no care. Of those requiring home care within two years of a re-ablement intervention, 34\%-54\% had maintained or reduced their package two years after the re-ablement intervention.

\textit{New Zealand – Restorative Home Support}

Since early 2000, New Zealand has been pursuing an ageing-in-place strategy which is now well integrated into several government policy areas; it refers to people making choices in later life about continuing to live in the community and in receiving support services to enable them to do so (Parsons & Parsons, 2005). District Health Boards (DHB) and the Ministry of Health supported the development of various ageing-in place initiatives; in 2006 an assessment of three of the more significant projects (Promoting Independence Programme [PIP] – Lower Hutt; Community FIRST – [Flexible integrated Restorative Support Team] – Hamilton; and Coordination of Services for Elderly [COSE] – Christchurch) were undertaken by the University of Auckland. The study is known as ASPIRE (Assessment of Services Promoting Independence and Recovery in Elders) (Auckland UniServices, 2007). All three programs were found to be effective at:

- reducing mortality (FIRST 28\%, PIP 14\%, COSE 10\%); and
- reducing risk of entry into residential care (COSE- 43\%, FIRST 33\%, PIP-16\%).

Some other key findings of the ASPIRE assessment were that:

- older people with high care and complex needs, who would otherwise be admitted to residential care, could remain living at home with no apparent increased risk of harm;

\textsuperscript{16} Service accepts referrals for all people assessed as needing or being eligible for homecare and then screened out if considered unlikely to benefit from a re-ablement approach.

\textsuperscript{17} Service that accepts referrals from people leaving hospital; usually highly selective, accepting only those people who are likely to most benefit from a re-ablement approach.
• caregiver stress levels did not appear to increase in the intervention groups in comparison to the usual care group, despite the higher numbers of older people with high and complex needs remaining living at home; and

• clients of the Community FIRST program, which provided intensive, restorative home-based services, also showed an improvement in independence levels (using ADL measures and comparing them with those in usual care).

The report recommended using the Community FIRST approach for a nation-wide roll out of a restorative home support approach (Auckland UniServices, 2007).

Key features of the ‘restorative home support model’ include:

• comprehensive assessment, using various assessment tools to ensure assessment is tailored to best suit the complexity of needs of the client;

• as part of assessment, a goal facilitation process that follows an holistic person-centred approach and uses a standardised tool (‘TARGET’ - Towards Achieving Realistic Goals in Elders);

• a strong focus on functional exercises and repetitive ADLs primarily concerned with working on muscle groups used in every day activities;

• a change in the role of support workers from providing care to older people to supporting older people to maximise their independence. This is a substantial philosophical shift and requires initial and ongoing training for support workers; and

• a change in the role of the Coordinator, compared to usual home services (in New Zealand this role is usually held by an RN) in terms of role and competencies required, with increased clinical and academic expectations (thus post-graduate education is recommended) (Parsons & Parsons, 2006).

Wellington was the first District Health Board to develop an across-the-whole-region restorative home care support approach and to develop the community services to support it.
It is important that (the home restorative support approach) does not just live in home based support services but it is as important to integrate the service within allied health, primary care and NASCs\(^\text{18}\) and this was able to happen in Wellington for the first time (Parsons, 2008, podcast 8).

The learnings from the Wellington DHB approach have since been used by Parson’s team at Auckland University to develop an eight-week training package called SMART (Service Management in Advanced Restorative Techniques), to assist other DHBs to implement the same model. Twelve DHBs are currently implementing the Wellington model at varying levels, limited now only by how quickly it can be rolled out (Parsons, podcast 8, 2008). With across-the-country implementation now occurring, the Auckland University Team is currently exploring benchmarking: this new study is called IN-TOUCH.

**Victoria - Independence Pilot Projects**

In 2005, the Victorian Government’s Department of Human Services funded four pilot programs that focussed on the provision of preventative services to clients eligible for HACC services but assessed as low priority and on a waiting list. Three of the four pilots were for time-limited (twelve weeks) independence projects similar to Silver Chain’s HIP. These projects were: Moreland City Council – Independent Living Program (146 participants); Alpine Shire – Home Independence Program (5 participants) and Murrindindi Shire – ‘Look Good, Feel Good, Eat Well’ project (21 participants). The fourth project, implemented by the Baw Baw Council, focussed on increasing independence of older people through enabling them to look after their own gardens, in a project called ‘Low Maintenance Gardens’ (21 participants).

The evaluation report of the four projects (HDG Consulting Group, 2007) concluded that the small number of participants in three out of the four pilots (the exception being the Moreland City Council project) meant that there was insufficient data to provide clear evidence on objective functional measures i.e. whether the interventions impacted positively on functionality and independence in ADLs. However, subjective measures suggested a high level of satisfaction with an independence approach. Other

\(^{18}\) Needs Assessment Service Coordination (NASC) is an organisation contracted by the Ministry of Health to determine a person's eligibility and need for funded disability support services, they are equivalent to Australia’s Aged Care Assessment Teams.
key findings were that detailed assessment is the keystone of this approach and a re-ablement approach must focus on strengths, abilities, problem solving, restoration and independence-enhancing strategies using inter-disciplinary expertise and knowledge. Saxon et al (HDG Consulting Group, 2007) also observed that a key future challenge for the roll out of a re-ablement approach is how HACC providers can influence perceptions of the community and the workforce to reflect and accept the active service model approach.

Queensland – Supported Independent Living Collaborative

The Supported Independent Living Collaborative (SILC) was a project funded by Queensland’s HACC program in 2001 to explore the use of a re-ablement approach for HACC services. An action research pilot program was undertaken by the HACC network with service providers operating in the Brisbane South area. The project’s aim was to investigate whether older people assessed as eligible for HACC services but with low needs (therefore not receiving services) would benefit from pro-active early interventions that support independent living. Over an 18 month period (2003-2004), 252 clients, with an average age of 70 years, were provided with time-limited (three months) low-level interventions including: allied health; domestic assistance; industrial cleaning; socialisation; and living skills. A questionnaire was given to service providers regarding their perceptions of the outcomes of this program. Service providers reported positive results for their clients such as:

- remaining independent at home;
- reduced risk of falls;
- increased ability to travel independently to appointments;
- reduced anxiety; and
- increased access to social support.

A post-intervention measure of quality of life\(^{19}\) was undertaken with clients and their carers who, in the main, responded positively in relation to their quality of life, reporting a decrease in illness, an increase in psychological wellbeing and the ability to continue to live independently (Mathews, 2004). However, given the absence of a

\(^{19}\) The Australian Quality of Life Instrument
baseline or comparison group it is difficult to assess whether these effects are an impact of the intervention or selection criteria.

**Western Australia - The Wellness Approach to Community Home Care**

In March 2006, WA HACC, which is administered through the Western Australian Department of Health, adopted a wellness approach as its policy position. From 2008/09 all future growth applications from HACC-funded agencies need to reflect a wellness approach in their service delivery models. It is important to note that ‘wellness’ is **not** re-ablement, i.e. it is not a specific time-limited targeted program led by an allied health team but is a new organisational approach to HACC service delivery and requires organisational and attitudinal change (O’Connell, 2008, podcast 6).

To support this process of change, WA HACC and CommunityWest Inc., a not-for-profit organisation, began a partnership initiative in 2006 to develop a model and resources. As a result of this partnership, CommunityWest has:

- developed an Information Booklet – *Wellness Approach to Community Home Care*;
- developed documentation for assessment and care planning;
- made various presentations on the wellness approach; and
- conducted training workshops for HACC agencies to assist them to adopt this new approach.

Through this work CommunityWest identified some key features/strategies that have assisted agencies to implement a wellness approach. They can be categorised into two broad areas, organisational and service delivery, which have the following features:

**Organisational**

- changing the mind set of all stakeholders, i.e. management, staff, volunteers, clients and their families, about the views they hold in relation to the capacity of older people to improve in their functioning;

---

20 Wellness is the foundation stone of implementing a re-ablement program and whilst it is possible to take a wellness approach and not implement a re-ablement program it would be very difficult to implement a re-ablement program without also undertaking the accompanying organisational change towards a ‘wellness’ approach. The learnings from WA in implementing a wellness approach are therefore considered highly relevant to re-ablement and have thus been included in this literature review.
• building staff awareness, skills and confidence to promote the wellness approach;
• undertaking staff training in the principles of the wellness approach and how to undertake assessments and develop client support plans using the approach. “Time spent at beginning, working with staff to gain confidence in new skills is well spent” (CommunityWest, 2008).

Service Delivery
• looking at the reason behind the request for assistance or change in support instead of just providing services or increasing services;
• undertaking ability-based assessments and support plans;
• undertaking goal planning in partnership with client;
• undertaking time-limited interventions and services;
• client and carer education in principles of optimising function and well-being;
• regular reviews and changes to support plans to accommodate progress, including looking at the appropriateness of continuing service;
• an emphasis on social networks and community connections to link clients back to their communities; and
• at the end of service, looking at the appropriateness of connecting clients with mainstream community programs/services.

Key Learnings from Projects
Key learnings from HACC agencies that have begun implementing a wellness approach, in relation to the factors that support change (other than those mentioned above) can be categorised under organisational, staff and clients:

Organisational
• wellness is a philosophical change and needs to be part of an agency’s overall vision and approach to service delivery;
• the receptive context is important, it needs senior management to be key drivers; there needs to be a ‘can do’ organisational culture; and a history of successful change;
• good communication is critical; there must be both early and ongoing consistent messaging and dissemination of information to all stakeholders;
• there should be a steering group, led by a Senior Manager and including a cross-section of staff, which has decision-making powers and oversees implementation;
• policies and procedures need to support this new way of working; and
• a strategy for staff education and training in the approach and how to implement it needs to be developed.

Staff
• having the support of home care coordinators/supervisors is critical in persuading support workers of the merits of the approach.

Service Delivery approach
• staged implementation is important to allow for development and testing;
• mapping the processes and having action items helps the implementation process; and
• it is easier to implement a wellness approach with new HACC clients but it is also possible to implement with existing HACC clients but the changes need to be implemented more slowly. (CommunityWest, 2008).

3.2. EVIDENCE-BASED SINGLE COMPONENT INTERVENTIONS FOR RE-ABLEMENT PROGRAMS

Re-ablement programs commonly include a range of interventions that focus on optimising functioning, promoting healthy ageing and encouraging self-management. This section looks at interventions commonly included in re-ablement programs and the research relating to their effectiveness, drawing from a range of sources including Silver Chain’s Home Independence Program User Manual, 2007; the AIPC’s Literature Review, 2007 and Ryburn et al ‘s 2009 ‘Enabling Independence’.
Peer-Reviewed and Grey Literature on Single Component Interventions

**Occupational Therapy**

Occupational therapy interventions focus on maximising functional independence and are a common and important component of a re-ablement approach. Most re-ablement teams include an occupational therapist (OT). OTs are responsible for developing treatment programs to improve peoples’ capacity to undertake ADLs and IADLs and include the use of assistive technologies.

Clark et al (2001) undertook a randomised clinical trial, “The Well Elderly Study”, of older people living independently, to evaluate the efficacy of preventative occupational therapy. The focus of Clark et al’s study was the promotion of health and independence by maximising functional abilities, minimising hazards in the home environment and education on the importance of meaningful and appropriate activities to achieve a healthy lifestyle. These researchers concluded that maintaining the ability to perform key activities helps older people to continue to experience meaning in their lives, and is an important component for healthy ageing.

**Activities of Daily Living**

Rantanen et al’s 1997 study also supported the importance of maintaining activities of daily living; it looked at the performance of everyday key activities such as personal care and household maintenance by older people and found that such activities had a training effect on higher functioning. Specific interventions found to improve older people’s functioning in the performance of ADLs were: task analysis and redesign, the use of assistive technology and physical therapy.

**Task Analysis and Redesign**

Tinetti et al (1997) undertook a demonstration study of a physical and functional home-based therapy program for older persons after hip fracture. The functional therapy component focussed on identifying and modifying unsafe and/or inefficient performance of ADLs. The study produced positive results and concluded that the “systematic assessment and intervention protocol, targeting impairments and ADL, was feasible, safe and effective” (p.1237).
**Assistive Technology**

‘Assistive Technology’ is increasingly the generally accepted term for the devices (aids and equipment such as canes, walkers and bath benches) and systems (environmental modifications such as addition of ramps, lowering cabinets, and removal of rugs) that support independent functioning. Assistive technology is used to make a functional activity or task easier to perform and safer to manage (Silver Chain, 2007).

Studies have shown that the provision of devices has beneficial effects for older people in terms of independence and for home care service providers in terms of reduced costs. Verbrugge et al (1997) undertook a study looking at two common strategies used to reduce disability in older people: personal assistance and equipment assistance. The study looked at twelve everyday tasks that predominately involved upper extremities (dressing, reaching, bending); lower extremities (standing, walking) or both (getting in/out of bed, bath, car; or on/off toilet) and found that the use of ‘equipment only’ was the most efficacious strategy for reducing limitations. (However, see Packham, 1999 and Heywood, 2001 [below] who advocate caution in provision of equipment). Mann et al (1999) undertook an 18-month randomised trial on the use of assistive technology devices and interventions by frail older people to assess effectiveness in increasing independence and reducing costs in home care. The study results indicated that while all participants declined in functional status over time, the decline could be slowed and home care costs reduced through a systematic approach to providing assistive technologies.

In terms of environmental modification it is generally accepted that housing adaptations can promote functional abilities for people with disabilities and improve their quality of life (Iwarsson et al, 1998; Heywood, 2001). However, there has been little research done on the clinical effectiveness of environmental modifications with most of the research conducted focussing on acceptance and use of environmental modifications. Gosselin et al’s 1993 study showed that individuals were more motivated (four times more likely) to modify their home environment if they thought it would improve their performance of ADLs. A study on the utilisation of bathroom safety devices for older adults living in the community (Aminazadeh et al, 2000) demonstrated that the fear and actuality of falling can be reduced by simple
environmental modifications (in Silver Chain, 2007). There is also some evidence to support the proposal that home modifications are cost effective (Smith & Widiatmoko, 1998). However the positive benefits of home modifications need to be considered alongside evidence that incidence of incorrectly installed and unsafe equipment is high (Packham, 1999) and that poor adaptions can have very negative effects (Heywood, 2001).

**Physical Therapy**

Physical therapy is a key component of a re-ablement model and most re-ablement team members will be involved, to some degree, in the promotion of exercise and physical activity with clients. Most re-ablement teams include a physiotherapist who has particular expertise in developing programs to maintain or restore maximum movement and associated functional ability/in older people.

**Mobility and Strength**

Ageing is strongly associated with impaired mobility and decreased physical functional performance (de Vreede et al, 2004). Available evidence suggests that the main interventions for promoting mobility and delaying functional decline in older people is the promotion of walking and regular physical activity including mobility and strength exercises.

Declining mobility can significantly affect an older person’s ability to remain living independently in the community. Difficulty in walking, weight transferring and standing are strong indicators of a person’s ability to perform ADLs and it is ADL disability that strongly predicts the use of home care services by older persons (Wang et al, 1999). Research has shown that regular walking can provide protection for older people from decline in mobility. Clarke (1996) found an association between increased walking frequency and better functional outcomes in older people.

Regular exercise is important in developing strength and improving musco-skeletal function (Silver Chain, 2007). Exercise programs that focus on working on muscle groups used in everyday activities have also been proven to be more effective in improving functional performance than other exercise programs such as resistance or aerobic; e.g. for an older person having difficulty standing from a chair, a functional
approach would be to have them undertake repeated sit-to-stand exercises from their chair. Parsons’ work in this area also found that more abstract exercises required an allied health professional to oversee, whilst functional exercises could safely be delivered by support workers (Parsons, 2008, podcast 8).

**Social Rehabilitation**

Social rehabilitation is about assisting older adults to increase their social networks and connections to their local community and is a common component of re-ablement programs. Social contact with friends outside the home is known to decline significantly with age, e.g. only 41% of people aged over 85 years went out with or visited friends in the previous three months as compared with 72% of people aged 55-64 (AIHW, 2007 in SPC, 2009). The Australian Longitudinal Study of Ageing showed that being part of a social network is a significant determinant of longevity (Giles et al, 2005). Research also shows a close association between social isolation and loneliness and increased physical and emotional health risks (AIPC, 2007).

A UK Study (Cattan et al, 2005) looking at interventions for assisting older people to combat loneliness and social isolation found that effective programs had some common characteristics, including:

- group activities with an educational or support input;
- long-term;
- targeted towards a particular group of older people;
- participants had some control over the program; and
- the program offered a wide range of activities.

However, for socially isolated people to be able to engage in such programs they first may need to re-build their socialisation skills; there is some evidence of effective social enablement programs being provided by home care services. In the UK a social rehabilitation program for older people that provided a time-limited program of support was piloted by Age Concern\(^{21}\). The program was based on a comprehensive assessment of an individual’s needs and aspirations and used volunteers as peer-mentors to work with clients to achieve their specific goals. An evaluation of the

\(^{21}\) a large charity organisation
program, undertaken by Le Mesurier from the University of Birmingham, found that service users had greater confidence, enhanced opportunities for social contact and to take up old or find new relationships/activities and regained personal confidence and a sense of social identity (Le Mesurier, 2000 in AIPC 2007). This program is now also being piloted by Silver Chain; the trial began in 2006 and preliminary results after 12 months indicated that the program was achieving positive client outcomes in terms of reduced depression and loneliness and increased well-being but there were issues with how the program was being implemented. To address these issues Silver Chain has funded an extension of the trial for another two years (Silver Chain, http://www.silverchain.org.au/Research-Projects/Social-Rehabilitation-Pilot/ [accessed June 2009]).

**Health Education**

**Chronic disease self-management**
In Australia, chronic diseases\(^{22}\) in terms of disability-adjusted-life-years (DALYs) account for an estimated 80% of the total burden of disease (AIHW, 2001). Many chronic diseases can be prevented with early intervention or can be effectively self-managed to prevent further complications. Chronic disease self-management programs provide people with the skills and knowledge necessary to maintain and control their own condition (Silver Chain, 2007:12). Effective programs of home-based self-managed care are multi-faceted and include: chronic disease and healthy life-style education; collaboratively developed personalised care plans; and regular monitoring (Flinders Human Behaviour & Health Research Unit, 2005 in Silver Chain, 2007).

**Falls prevention strategies**
Older people are at significant risk of falls, with one in three people over the age of 65 living in the community likely to experience one or more falls in a year (Lord et al 2003). As well as falls having a deleterious effect on the health of older people, the fear of falling can contribute to functional decline due to individuals avoiding physical activity, which can result in increased physical dependence and de-conditioning (Tinetti & Powell, 1993). Tinetti et al’s 1988 study that looked at the risk

---

\(^{22}\) In Australia the most prevalent chronic conditions include: asthma, hay-fever, arthritis, high blood pressure, diabetes; depression and chronic obstructive pulmonary disease.
factors for falls among elderly persons living in the community estimated that between 10-25% of falls are associated with poor balance and gait abnormalities. Current research for falls prevention intervention supports a ‘multi-factorial’ approach that includes individual tailored strength and balance exercises (Clemson et al, 2003, Campbell et al, 1997; Tinetti et al, 1994).

Medication management

Poly-pharmacy (the use of multiple medications) is common in older people in Australia; for persons over 65 years using medications, 37% are using four or more medications (ABS, 1996). Using multiple medications places older people at increased risk of falling and/or experiencing an adverse drug reaction (due to dosage issues, interactions between medications and/or mismanagement of medications). Reasons for mismanagement of medications by older people include:

- complex medication regimes;
- seeing a number of different doctors;
- poor communication between health professionals and clients;
- keeping out-of-date medication;
- dexterity problems;
- cognitive deficits; and
- impaired eye-sight (Lim & Woodward, 1999).

The most common intervention for medication management is the ‘Home Medication Review’ which is usually conducted by a GP, pharmacist or community nurse, who assesses appropriateness, needs and drug interactions between medications and identifies potential problems with taking medications (Silver Chain, 2007). The ‘Home Medication Review’ has been found to be able to provide early identification of risk; prevent unnecessary adverse drug reactions, improve older people’s quality of life and reduce health care costs (NPS, June 2004 in Silver Chain, 2007:14).

Continence promotion

Incontinence is commonly experienced by older people, with an estimated 35% of Australian women and 17% of men over 65 years experiencing urinary incontinence (Chiarelli et al, 2005). The effects of incontinence can significantly impact on an older
person’s quality of life with many people restricting their out-of-home activities, which can contribute to social isolation (Silver Chain, 2007). Studies show that older people are reluctant to discuss urinary incontinence with their GP but, if left untreated, the chronicity and severity of the problem can increase. There is strong evidence to support the effectiveness of behavioural interventions for managing incontinence and these are generally better accepted by people as they are less confronting, allowing older people to self-manage their incontinence in their home environment. Behavioural interventions include: education about what is required for a healthy bladder; bladder training; and pelvic floor exercises. Such interventions have been shown to reduce symptom severity.

**Nutrition**

*Good nutrition is essential to health, independence and quality life of older people and one of the major determinants of successful ageing (Silver Chain, 2007:15).*

Under-nutrition in older people is associated with fractures, pressure ulcers, impaired immune response, longer hospital stays and high mortality and morbidity (Silver Chain, 2007). Australian studies indicate that a significant proportion of older Australians are under-nourished. Corbiac and Syrette’s 1995 study that used a nutritional screening tool, found that 30% of those people over 70 years who were screened were at high risk of malnutrition and another 20% were at moderate risk. A study undertaken in 1999 at Senior Citizen Centres showed similar findings, with 27% at high risk and another 30% at moderate risk (Burge & Gazibarich, 1999 in Silver Chain, 2007). There are a number of interventions that have proven successful in improving nutrition in older people; these include:

- providing professional dietary advice to correct dietary deficiencies or excesses;
- providing social support including transport and access to shopping;
- providing Meals-on-Wheels to house-bound people;
- referral for people with dental problems; and
- physical activities and exercise programs (Silver Chain, 2007).
3.3. COMMON FEATURES / APPROACHES IN RE-ABLEMENT PROGRAMS

Most of the re-ablement-type projects/programs discussed above that have demonstrated positive outcomes for their clients include similar essential components or features. The most of important of these are: goal setting; comprehensive assessment; and multi-disciplinary teams.

Goal Setting

Parsons work in the re-ablement area recognised very early on that goals were extremely important in re-ablement programs but that it was very difficult to engage older people in them. Generally, goals were set up by the health professional because they were important to the health professional but not necessarily to the older person. Goal setting originally came out of management, then moved into mental health (Recovery Model) and more recently has been used in the physical health area. Locke and Latham’s study (2002) looked at 35 years of empirical research on goal setting and concluded that goals affect performance through four mechanisms, these being:

- direct function - giving direct attention and effort, both cognitive and behavioural, towards goal-relevant activities;
- energising function - i.e., goals lead to greater effort;
- persistence affect - either leading to increased intensity of work effort or increased time spent on working towards the goal; and
- functionality affect - actions taken are indirectly affected by arousal of old, or discovery of new, goal-relevant knowledge and strategies.

Research has shown that psychological well-being and life satisfaction in ageing are related to the expression in behaviour of goals that are important to the individual. Findings from the Berlin Longitudinal Aging Study showed that older people did identify with goals, although they did not see it as ‘goal setting’, that language being fairly alien to them (Parsons, HACC Forum, podcast 16, 2008). Goal setting appears to be an intrinsic part of being human and the study showed that older people continued to have dynamic, multifaceted, and future-oriented goals right up until they died (Parsons, Podcast 16, 2008).
Bandura and Schunk’s 1981 study showed that an individual's performance in achieving a complex distal goal (long-term goal) is enhanced when the person has an interest in the goal, and that setting proximal goals (short-term goals) is instrumental to achieving long term goals.

Self-motivation relies on the intervening processes of goal setting and self-evaluative reactions to one's own behaviour. This form of self-motivation, which operates largely through internal comparison processes, requires personal standards against which to evaluate ongoing performance. By making self-satisfaction conditional on a certain level of performance, individuals create self-inducements to persist in their efforts until their performances match internal standards.

Personal goals or standards do not automatically activate the evaluative processes that affect the level and course of one's behavior. Certain properties of goals, such as their specificity and level, help to provide clear standards of adequacy. Hence, explicit goals are more likely than vague intentions to engage self-reactive influences in any given activity (Bandura and Schunk, 1981).

Godfrey’s experience with a re-ablement approach with older people also supports the importance of proximal goals.

When talking about goal setting what we are also talking about is the ‘direction of travel’. The goal is not necessarily the outcome. What is important are the elements/steps/process whereby people can take little steps to do what they want and in the course of that, perhaps, develop the skills and confidence to go further than they anticipated at the outset (Godfrey, 2008 Podcast 16).

Drawing on goal-setting research and their experience in developing home restorative programs, the Parsons-led team at the University of Auckland developed TARGET (Towards Achieving Realistic Goals in Elders Tool). TARGET used various formal assessment tools\textsuperscript{23} to identify what people are currently unable to do\textsuperscript{24} and any other concerns they have (e.g. feeling that they are a burden to their care-giver or family); the client then ranks these issues (1, 2 or 3 scale) in terms of importance to them and whether they want to change it, and this information is then used to develop the distal goal i.e where the clients wants to be. In TARGET, the distal goal is individualised for each client; this goal is then used as the outcome tool. In order to achieve the client’s distal goal, a goal ladder is established with the distal goal placed at the top of

\textsuperscript{23} Nottingham Extended ADL Scale- IADL scale; Inter-RAI- MDS-HC -scale for ADLs; EuroQoL- Health related quality of life scale.- gives a picture of where the client currently perceives themselves as being at functionally which may different from where they actually are.

\textsuperscript{24} Strength-based goal setting tools were explored but older people found them inappropriate.
the ladder (this goal is always owned by the client) and then steps to the ladder are
developed. The ladder’s steps are proximal goals (which are set by the health
professionals to help clients’ achieve their goals) and all the goals need to be
SMART. Parson’s sees the setting of the proximal goals as the most challenging
part of the goal-setting process, and the health professionals setting these need to have
at their finger tips knowledge of the most effective intervention approaches, which
requires a high level of expertise and experience. Currently, in New Zealand, goal
setting for non-complex clients is initially done over the phone and then face-to-face
at three months.

TARGET is probably the single most significant event for us around
restorative home support, it completely revolutionized the way we were
delivering services because for the first time goal facilitation was
possible with older people (Parsons, 2008, podcast 8).

Comprehensive Assessment

Comprehensive multidisciplinary assessment is a key feature of re-ablement
programs. This section focuses on the assessment tools used and the person(s)/agency
who/that undertakes assessment in the three key models (WA, NZ, and UK).

WA: The comprehensive multi-disciplinary assessment (MDA) tool used by Silver
Chain for its home independence program was specifically developed by the HIP
team after the initial pilot study revealed that the RAI-HC v2.0 did not work well as
both an assessment and care planning tool. The RAI-HC v2.0 was replaced by the
MDA which was developed based on an assessment tool that was already being used
within Silver Chain, the HACC Needs Identification (HNI). The HNI was used to
determine eligibility for HACC services and to provide a basis for care planning for
clients with low care needs. The HNI included HACC MDS items, ADLs and IADLS
and was further developed by the HIP team to include prompts and guidance
questions to assist assessors to understand the clients’ level of functioning and other
factors (Silver Chain, 2007). As discussed above, it is the Care Manager who
undertakes the assessment of clients for HIP and this role is held by one of the three
HIP allied health team members.

SMART- Specific, Measurable, Attainable, Repeatable, Time-orientated
NZ: In New Zealand, assessment of older people needing support services is undertaken by a Needs Assessment and Service Coordination agency (NASC). These agencies have regionally-based multi-disciplinary teams that complete all aged care assessments.

In the ASPIRE study of three independence projects, a standardised data collection tool, the InterRAI Minimum Data Set – Home Care (MDS-HC) was used. InterRAI is an international collaboration that has developed a suite of clinical tools to assess the needs of older people with a view to developing an effective care plan. The information is recorded in a standardised format (minimum data set) and as information is collected it triggers more in-depth assessments of selected domains. In 2006, five DHBs in New Zealand trialled a standardised approach to assessment using an electronic version of InterRAI’s Minimum Data Set - Home Care (MDS-HC) Assessment Tool. A key output of the MDS-HC is Client Assessment Protocols (CAPS), the MDS-HC has 30 CAPS embedded within the assessment data and, when triggered, CAPS automatically generate a warning signal of risk e.g. ‘this person is at risk of falls’. A key finding from the trial was that the CAPS can support the development of an individualised restorative home support package for clients (University Of Auckland, 2006 and Parsons, HACC forum-podcast 8, 2008).

In the roll out of the restorative home support approach across New Zealand, NASCs have continued to be responsible for the assessment component and either undertake phone based or face-to-face assessments. Assessment is undertaken by the NASCs at the beginning and end of a package. For non-complex or community-based clients, phone-based assessments are undertaken and TARGET is used as the assessment tool (see Goal Setting section in this Chapter for more information). For more complex clients, face-to-face assessment is undertaken and the assessment tool used, in addition to TARGET, is either the InterRAI-MDS-HC or the less in-depth InterRAI MDS-Community Health Assessment (CHA) or the Support Needs Assessment Form. From this assessment the NASCs develop a service plan for the client (including distal goal, ladder and action list) and determine package length and composition (i.e. inputs

---

26 Includes such things as ADL/Rehab Potential, Urinary Incontinence, Cognition, Falls, Nutrition, Elder Abuse
from allied health professionals and support workers). After this initial assessment the
NASC then refers the client to a home-based support service.

**UK**: In August 2007, the CSED produced a summary of functional assessment tools,
outcome measures and standardised assessment tools being used by seven CASSRs
pursuing a home care re-ablement approach. In all but one Council, the home care re-
ablement services operated through mixed or multi-disciplinary teams. The Councils
that participated used a range of assessment and monitoring tools or documentation
and many of these tools were agency-grown. Assessment documents and tools used
by the seven Councils generally fell into one of three categories:
i) relies on the single assessment process (SAP\(^{27}\)) documentation;
ii) receives the SAP but then supplements with additional assessments or
documentation;
iii) utilises its own assessment tools.

Specifically in relation to functional assessment tools that measured activities of daily
living, Councils tended to differentiate between two levels of activity, ADLs and
IADLs, and the differences in each Council’s tool were generally because of
differences in areas of activity that the Council was seeking to support. In terms of the
use of other formal functional assessment tools, there were various types used by the
Councils and some used different versions to provide greater sensitivity to specific
impairments or conditions. The summary Report made specific mention of the
Canadian Occupational Performance Measure (COPM)\(^{28}\), which the CSED had been
told was a useful tool when there was assessment and re-assessment stages, as it
enabled comparisons to be drawn. An outline of 23 various outcome measures/
standardised assessments most frequently used within social care settings was included as
an Appendix to the report.

\(^{27}\) The UK’s Department of Health since 2002 has required all NHS bodies and Councils with social
services responsibilities to use its standardised assessment tool, the ‘single assessment process’ (SAP)
when assessing older people.

\(^{28}\) The COPM is a client-centred assessment, designed for use by occupational therapists, to identify
problems in the areas of self-care, productivity and leisure, using a semi-structured interview. Problems
are then rated by the client for importance, performance and satisfaction. The assessment is used for
collaborative goal setting with the client, and can therefore provide a measure of outcomes.
The Multi-disciplinary Team

**WA**: Silver Chain’s HIP was designed and implemented by a multi-disciplinary team which included a physiotherapist, an occupational therapist and a registered nurse. Inter-disciplinary working was seen as an important element of the HIP and in recognition of this, the approach aimed to recognise the importance of each professional’s discipline and specific knowledge as well as, and at the same time, seeking to blur these boundaries. From the outset, training and ongoing support was provided to HIP’s team members to assist them to be able to undertake assessments and deliver the generic interventions of the HIP program. In Silver Chain, a Care Manager is appointed for each client from any of the three HIP team members and the Care Manager then undertakes the assessment. The multi-disciplinary team meets weekly to discuss clients and their progress.

After assessment, the delivery of care and support for Silver Chain’s HIP clients is primarily undertaken by its care and therapy aides (care providers). These care providers are taught to stand back and allow clients to do for themselves whilst also encouraging clients and helping clients make progress to achieving their goals. As previously discussed, HIP uses standard interventions and the care providers are trained in these. If a client requires a non-standard intervention, the Care Manager and care provider would both attend, so that the Care Manager can demonstrate any special techniques required. The care providers are encouraged to provide feedback and have a responsibility to provide a weekly verbal or written report to the client’s Care Manager as well as completing client’s progress notes whilst in the home.

**NZ**: The restorative home support model is implemented by home-based support services (HBSS) which come in after the NASCs have assessed clients and developed clients’ service plans. The HBSS service role is to develop a functionally-orientated support plan which is usually developed by a multi-disciplinary team (comprising a registered nurse (RN), physiotherapist and occupational therapist); this is done after a face-to-face visit from the HBSS Coordinator (and this role is usually held by the multi-disciplinary team’s RN). It is then delivered by trained support workers/therapy aides under the close supervision of the Team. Client contact can be up to four times a

---

29 It also included Lewin whose role was as the principal project designer.
day by the support workers, a minimum of once every two weeks with the RN and with the physio or OT as/if prescribed by the NASC-determined Package. The support plan is then reviewed by the HBSS Coordinator after three months (by phone for less complex clients and face-to-face for complex clients); this includes repeating the TARGET tool, assessing progress against goals, facilitating new proximal and/or distal goals (where needed) and developing from this a new functionally-orientated support plan.

**UK:** In Newbronner et al’s 2007 retrospective longitudinal study on home care re-ablement, four CSSRs providing a home care re-ablement service, i.e. Wirral, Leicestershire, London Borough of Sutton and Salford City, were examined. The team structure for each of these programs differed and is outlined below to highlight the variety of team structures that are possible:

- **Wirral:** Wirral Enablement Discharge Service (WEDS) was a discharge support enablement service. There were four groups of staff working in WEDS: home care organisers, home care enablers, OT team leader (Senior II OT) and OT assistants. Initial client assessment was undertaken by the OT Team Leader and an enablement plan was drawn up from this.

- **Leicestershire:** Home Care Assessment and Re-ablement Team (HART). This program operated across the County and the home care team consisted of 16 managers, 30 senior carers and 422 care workers. The client’s initial care plan was received from the Commissioning Team and progress was monitored on a weekly basis by a senior carer and care workers.

- **Sutton:** Short Term Assessment and Re-ablement Team (START). START was one strand of Sutton’s overall Home Care Service which included a service manager, team managers, access to a nursing provider team and an in-house OT and equipment service. The START team of carers included 21 home carers and 7 senior carers (with moving/handling qualifications). Clients initial care plans were received from the referring agencies. At the first home visit the senior home carer would undertake a further assessment. The START team could, without referring back to the Home Care Service team, increase or decrease a client’s service level according to the client’s changing needs.
Salford: Intermediate Home Support Services (IHS). IHS had 5 Home Support Managers, 3 Assessment Officers (AO), 11 senior support workers and 138 home support workers. The AO would undertake all assessments. If the referral involved a hospital discharge the AO would visit the hospital, otherwise they would visit clients in their homes.

3.4. KEY ISSUES FOR IMPLEMENTATION OF RE-ABLEMENT PROGRAMS

Cost Effectiveness
While the peer-reviewed randomised controlled trial undertaken by Tinetti et al (2002) did not include cost effectiveness analysis, the research team argued that given the fact that restorative care recipients had shorter and less intensive home care episodes, and had comparable or lower utilisation rates in other areas than usual care recipients, it strongly suggested that the restorative care model was cost-effective.

In Lewin et al’s (2007) controlled HIP trial in 2002-2004 there was found to be no significant difference between the direct care cost of HIP and standard home care services but as 57% of the HIP group were no longer receiving services, and 81% of the control group were, the Research Team argued it was reasonable to assume there would be cost savings in using HIP over the long term. In addition, during the pilot HIP was also found to reduce the number of home visits required by clients, compared with the provision of usual HACC services; thus the research team concluded that HIP was more cost-effective than the current HACC model. This evidence, along with the better outcomes achieved for clients, was the argument that Silver Chain presented to the WA Department of Health, which resulted in it funding the HIP operational trial.

Funding
The NZ Ministry of Health is working with a number of District Health Boards to explore different ways of funding the home restorative approach. One method currently being trialled is gain-sharing, where the providers are incentivised, e.g. if a client is discharged earlier than before their funding package is used, the funds are split between the relevant DHB and the service provider. Preliminary results are
showing varying levels of success, with the scheme working well in smaller DHBs but less so in larger DHBs where there are multiple providers and more clients.

**Staff Training**

In New Zealand an early precursor to the current country-wide role out of restorative home support programs was the Quality and Safety Project, a national project looking at the disability sector, which included an evaluation of the New Zealand support workers workforce (estimated at 47,000). The evaluation revealed that:

- support workers had very poor morale;
- experienced very low satisfaction with their role;
- the staff turnover rate was very high (about 39% for home-based workers);
- support workers were commonly not paid for travel costs incurred as part of their home-visiting work;
- support workers were paid very poorly (about one-third earning less than the minimum wage); and
- support workers were reluctant to attend training.

A key finding was that the main thing that support workers wanted was to be made part of the team (as they believed they were making a difference to their clients’ lives but that no-one else recognised it) and they also wanted there to be a career structure.

The Parsons team, recognising that there were likely to be significant training issues in rolling out the restorative home support across New Zealand, developed a range of training programs with a functional orientation for different groups:

- FITS (Facilitating Independent Training Schedule) for support workers;
- START (Standardised Training in Advanced Restorative Techniques) for coordinators (working in the Ministry of Health’s HBSS Unit); and
- ATRACT (Assessment, Treatment and Rehabilitation Advanced Core Training)\(^{30}\) for health and allied health professionals.

As part of the roll out of the restorative home support approach across New Zealand, the Parsons group explored with HBSS extending the program to a broader client

---

\(^{30}\) Career Force a National organisation funded by the Ministry of Health purchased these programs and is currently implementing them throughout New Zealand.
group\textsuperscript{31}. In 2007, a trial of the approach with lower-needs clients was undertaken with Presbyterian Support Northern in three DHBs. Preliminary results from a randomised controlled evaluation trial of one of these programs indicates that staff turnover of support workers reduced from 50% to 20% and job satisfaction increased amongst support workers and coordinators (Parsons, 2008, podcast 8).

3.5. SUMMARY

This Chapter reviewed the Australian and International literature on single-and multi-component studies of a new re-ablement or wellness approach to care and service provision. In particular, literature relating to the delivery of service in the community was examined and the key components of successful models were identified, as well as issues to be considered in relation to implementation. Chapter 4 will present the findings from the Community Consultation component of the project.

\textsuperscript{31} Community First’s client group had predominately been complex high-end clients
CHAPTER 4: CONSULTATIONS IN THE FAR NORTH COAST

A review of government policy and programs and an exploration of national and international literature provided the context from which identified issues could be explored with HACC service providers on the Far North Coast of NSW. This chapter reports the processes and outcomes of that consultation.

4.1 THE NSW FAR NORTH COAST - CONTEXT

The FNC geography is dominated by three major river systems forming the Tweed, Richmond and Clarence Valleys. These rivers are prone to flooding and cause major disruption when they do. The area is a mix of large regional centres, smaller towns and villages, coastal and hinterland, and rural areas including rurally isolated areas. Transport infrastructure is very limited and movement around the area is generally by car.

The total population of the FNC is approximately 270,000. The number of people aged 65 and over is 53,027, 19% of the total population. This compares to the Australian average of 13.3%. Of particular note is Tweed LGA with 14,686 people (24.7%) aged 65 and over. The FNC has a correspondingly smaller proportion of people aged 25-54 years, 37.9% (107,990 people) compared with the Australian average of 42.2%.

There is a high population of Aboriginal and Torres Strait Islander people on the FNC, approximately 4% of the total population compared to a national average of less than 2.3%.

The FNC is also characterised by very low scores on the SEIFA scale, which is scale of relative socio-economic disadvantage. All areas of the FNC are below the state average, with areas in the Clarence Valley and Kyogle LGAs amongst the lowest in the State.
4.2 FOCUS GROUP PROCESS

Three focus groups were conducted in the Far North Coast (FNC) over March-April 2009. The focus groups targeted agencies providing HACC-funded services to older people. Invitations were made either directly through an emailed letter to CEOs, General Managers and HACC Managers of these services or through promotion by DADHC’s Program Manager at local inter-agency meetings. A total of 52 service provider participants attended three focus groups held in Lismore, Tweed Heads and Grafton.

The focus groups were half-day events and started with a 30-minute PowerPoint presentation on the re-ablement approach, which presented highlights from the literature review. The presentation was followed by a semi-structured discussion, using a set of questions based on the consultation questions developed by the Victorian Department of Human Services (2008); supplementary questions were asked whenever relevant. Recordings of the focus groups proceedings were taken with the consent of participants and transcripts were made.

The questions used to lead the focus group discussions were:

1. What do you think about the re-ablement approach? What do you think are its best elements?
2. Do you know of re-ablement type practices that are already occurring in your organisation or other local organisations?
3. What enablers / barriers do you think your region faces if it were to adopt a re-ablement approach?
4. What strengths/weaknesses do you think your organisation faces if it were to implement a re-enablement approach?
5. What strategies/activities of re-ablement do you think would be worth pursuing?
   What would it look like?
6. Do you think some service types are more appropriate than others?
7. Is there a priority order for these strategies/activities?
8. What support would your organisation need to adopt a re-ablement approach?
4.3 FOCUS GROUP FINDINGS

Discussion of the above questions during the focus groups identified a number of issues which have important implications for a FNC pilot project. A summary of that discussion is reported below, under Question headings: dot points denote general discussion or issues raised by a number of participants; comments in italics are direct quotes. Not all comments could be included here but because of the richness of discussion, a more extensive list of comments is included at Appendix 1.

What do you think about the re-ablement approach? What do you think are its best elements?

- There was general agreement amongst service providers that the evidence clearly supports the benefits of adopting a re-ablement approach for the provision of HACC services.

- It was also noted that it requires a philosophical change, from seeing care as being there “for the long haul” to one where the goal is “to support someone to move out of the system”.

  Re-ablement gives service providers a model to run by. Its something you can give the whole family to look at beforehand, not just a set of processes which can often be very confusing to a family in crisis.

  It identifies clients’ real needs by taking a case-management approach and looking at what people really need rather than just throwing everything at them.

Do you know of re-ablement type practices that are already occurring in your organisation or other local organisations?

- Many service providers think they are already doing re-ablement but in most cases what appears to be happening is that these organisations have begun shifting towards a wellness approach in the delivery of their programs to older people and while these programs may have elements of re-ablement, they are not full-fledged re-ablement programs.
We do set goals with our clients but often they are those huge ones like wanting to remain independent and at home. We realise these may be too broad and that clients actually want to set smaller goals, something that is achievable like walking to the post box and then building from there. They may not reach that big goal.

What enablers / barriers do you think your region faces if it were to adopt a re-ablement approach?

Enablers:

- The success of Com Packs and TACS programs in the FNC have laid the ground for the successful adoption of a re-ablement approach; those HACC service providers that have been involved in delivery of in-home services for these two programs have seen, first hand, that:
  - clients will accept short-term interventions provided the terms of the program are clearly spelt out;
  - these short-term intensive programs achieve results; and
  - staff delivering these programs have been able to make the shift from a ‘doing for’ to an independence-promoting approach with clients. 

  *With Com Packs there was an initial reluctance from staff but after 10 months it gained impetus and momentum and now staff find the program invigorating and energising.*

- In the FNC there is a history and culture of services working collaboratively together with successful results.

  *Council has already started the process of training around this approach, trying to focus on what people can do rather than what they want. And we are already working as a multidisciplinary team on two of our NCAHS-funded programs.*

Barriers:

- The geographic spread of clients requiring care was a major issue.

  *This area is quite large in terms of geographical distance and a lot of villages are isolated in terms of lack of services on the ground … Often there is no home care service and there is a lack of transport too.*

  *Invariably those most in need tend to live out in the bush and for services this is very cost prohibitive.*
In the rural setting the time taken by travel can be quite significant. In the current model there is an allocation of two hours but this is just not feasible when providing assistance to clients who live in remote rural areas. Part of the cost structure for re-ablement would need to address these travel/transport issues in rural areas.

- The culture of ‘life-long’ entitlement to HACC services amongst older people is a significant barrier to the successful adoption of a re-ablement approach.

- The culture of ‘doing for’ by the staff of HACC services could be a potential and significant impediment to adoption of a re-ablement approach and will need to be addressed.

  People think by doing and giving they are being loving and caring. In our work if you actually put your hands behind your back you help more.

  Reality of funding and time constraints is that staff tend ‘to do for’ clients because it’s quicker.

- There is a long-standing shortage of occupational therapists and physiotherapists within the public health sector in the FNC. Given this shortage, several suggestions were made by service providers to train-up either OT- or physio-aides, or RNs, coordinators and/or support workers, to better recognise physiotherapy and occupational therapy needs, to enable those groups to undertake assessment; however, there was also fairly strong opposition voiced to taking this approach.

- The FNC’s ageing population and disproportionately small population of workforce-aged people means that there are currently shortages of HACC workers and this will continue to be the case over the next 30 years.

- Unmet demand for HACC services operating in the FNC may effect the introduction of the re-ablement approach and this appears to be especially so in the Tweed Heads area.

- For the re-ablement model to be really relevant for the FNC it will need to include those clients who live in remote areas and address the cost of providing services to them.
What strengths/ weaknesses do you think your organisation faces if it were to implement a re-enablement approach?

Strengths:

• Aboriginal service providers generally felt that the model could work for the communities and families they supported.

  We’ll need to go out to the community and do community education.
  Think this model would suit our people, along with equipment.

Weaknesses:

• Costs of participating in a pilot: Some providers expressed reservations about participating in the pilot because of the additional burden of paperwork and data collection, usually to satisfy evaluation requirements.

  In our dementia rehabilitation pilot, which was quite a big project, we had a designated person to gather all the information and check that the data was collected in an appropriate way.

What strategies/activities of re-ablement do you think would be worth pursuing?
What would it look like?

• Goal Setting: Focus group participants understood and were enthusiastic about goal setting as a basis for service provision and appreciated the difference between broad and somewhat vague goals and those goals which are recognisable and achievable.

• Security of Tenure: It is important that a re-ablement program addresses security of tenure for HACC services.

  They tend to hold on to services because they fear that when they really need the service it won’t be available- so often there are people getting home care who don’t really need it.

• This could be supported by having selection criteria that allows clients, their carers or other family members to elect not to participate in the re-ablement program and to be directly referred on to ‘standard’ home care services.

  We need to look at those points in people’s lives when life circumstances change, e.g. when people are widowed and men may need to be taught how to cook, women may need to learn how to budget and do the banking. Also people who have been caring for many years and suddenly their life focus has gone: “All I did was care
about this person for the last five years and I didn’t think about my own socialisation needs”. These people need to be re-introduced/re-integrated back into the socialisation components of their lives. These life-changing events need to be the focus.

- **Interventions:** Loneliness was seen by several HACC services as often being the underlying reason for a client’s ongoing need for services and they noted that a more appropriate response to that issue would see a reduction in the need for higher level services such as personal care and a more positive outcome for the person concerned. It was therefore thought important that the FNC re-ablement model included access to these types of services.

  *Loneliness often underlies service need, people are desperate for contact. If this need could be met directly then I think we would see a reduction in demand on other HACC services.*

  *We found that increasing numbers of people are accessing our social programs and once they establish a connection with peers, they begin to take a lot of control in the things they do. First they begin to support each other, then they form networks outside the group, their moods lift and carers feel better, so there is less residential respite needed.*

Do you think some service types are more appropriate than others?

- Most commonly HACC service providers saw all services as needing to be involved in a FNC re-ablement pilot, perhaps with a lead agency being allocated for each client (as is done with Com Packs). Part of the rationale for this approach appears to be based on the experience of services across the FNC of already working closely together to provide services to older people. It was, however, also recognised that having lots of different services involved would probably be less manageable, although it would really assist services to be able to provide highly ‘individualised’ care programs for clients.

- Using a consortium model was also suggested by several agencies and there had been some experience and success with this approach in the FNC. The consortium approach was also seen as an effective way to bring management into the pilot and would assist services to be able to work better together.

---

32 This has probably arisen through necessity: in the Clarence Valley because of geographic isolation and its small number of services and in the Tweed because of the very high demand for services.
Training: The larger the HACC service provider’s workforce, the more able they appear to be to accommodate staff taking time-out for training.

We currently shut down one day a month and on that day we have a staff meeting, review clients and do training – we deal with all the important issues that needs everyone together and if there is any specific external training on that I think staff should go to, that’s the day we program it in.

Is there a priority order for these strategies/activities?

Identifying the relevant cohort of service recipients, finding or developing the right assessment tools and ensuring that the training of the Coordinator and other staff is adequate were considered high priorities for a number of participants.

Firstly we need to identify the cohort we want to work with

Will need trained support workers to make the shift.

It’s about making sure the Coordinators are trained because that’s where your strength comes from – so they can support the staff working underneath and everyone knows the outcomes expected.

What support would your organisation need to adopt a re-ablement approach?

The appropriateness of the current HACC funding model and reporting structures for a re-ablement approach will need to be considered. A funding model and reporting structure that can measure client outcomes as well as outputs and allow for more up-front funding may be needed.

Re-ablement sounds like an outcome-driven approach and outcomes are not able to be measured as easily as outputs. How will the funding model deal with this?

As noted above, most participants were service coordinators with few from management participating in the focus groups. However, it was generally agreed that the introduction of re-ablement would only work with strong management support. Those services who had successfully implemented change were very clear about the role of management.

It needs senior executive strength, good mentoring and the selection of the right staff.
Additional Specific Issues Identified:

Selection Criteria

To determine someone’s suitability for a re-ablement approach, at assessment you would need to have certain crucial criteria and one of these would be the person’s commitment to re-ablement – not someone who says “I just want help, I just want you to do it for me.”

- Given TACS and ComPacks is operating across the FNC, the target group for the model should probably not extend to include the cohort of older people leaving hospital following an acute episode.

Multi-disciplinary Team

- Service providers generally agreed that the multi-disciplinary team was an important component of the re-ablement model. However the shortage of allied health professionals on the FNC was a concern and it was thought for re-ablement to work on the FNC it would need the model to find ‘innovative’ ways to provide the required physiotherapy and occupational therapy inputs into the program that do not compromise the standards of these professions.

  So if you have a limited resource like OTs, are you saying that maybe that OT could train RNs with some of the required expertise that is specific to the needs identified in the assessment? Then the allied professional could be a reference point for those people to go back to? Yes, I think that would work.

  We have a physiotherapy aid with TACS and a therapy aid with the OT department in MacLean and there are things that they can do that really take the load off the professionals.

Assessment Tool and Process

- While there was general agreement amongst service providers that the assessment tool was a critical component of a re-ablement approach, there was no clear consensus, just ideas suggested for more research e.g. ONI, Can Do.

Continued Access to Service

- A cautionary note was sounded by a number of participants about the need for access to ongoing services and this is consistent with the research literature. It
cannot be expected that every client will want re-ablement and those who do may still need on-going services, albeit hopefully at a reduced level.

While lots of people go through the (ComPacks) program in 6-8 weeks and show improved functionality and have a reduced need for services there are also many people who still require an old-style home care service.

Training
• The involvement of the allied health professionals was seen as crucial at all stages of the project and its development, and particularly through the training process.

If you are going to take a multi-disciplinary approach then that team needs to be involved from the start in the training of the supervisors and coordinators. They need to all be hearing the same message, all be on the same wave length, and then that will filter down to the staff and out to clients.

Reservations
• Despite the positive and enthusiastic support from many participants, some service providers clearly had reservations about the proposed pilot project, summed up by the following comment -

I am sceptical; I think re-ablement could be just another way to for government to justify cut backs.

If a Pilot project is to proceed, where should it be located and which organisation(s) should be involved in it?
• All three areas where the focus groups were run expressed interest in being involved in the pilot and many agencies indicated their readiness to begin a pilot.

We could start (Implementing a re-ablement approach) with one Coordinator and ten support workers now.

4.4 SUMMARY
The three focus groups held on the Far North Coast with HACC service providers reflected a number of the themes previously noted in the review of government policy and the relevant literature but also identified very location-specific issues. The findings from these three sources were used in the development of a model, presented in Chapter 5.
CHAPTER 5: A RE-ABLEMENT MODEL FOR PILOTING IN THE FAR NORTH COAST

5.1 THE FIVE KEY COMPONENTS OF A RE-ABLEMENT PROGRAM

Drawing from the literature, five key components of successful re-ablement programs emerge:

- multi-disciplinary team;
- multi-dimensional assessment;
- goal-orientated care planning;
- targeted evidence-based interventions; and
- time-limited program.

Each of these components should be present in the FNC pilot for it to be considered re-ablement and for it to have the best chance of success.

There are also a number of features which can be challenging in any change management process and these are borne out in the re-ablement literature. They include the main contextual aspects of re-ablement:

- organisational commitment and whole of organisation involvement;
- training for all levels of the organisation; and
- client commitment to the program with carer and family support.

In addition, there are a number of aspects which have been dealt with in different ways in various re-ablement programs, usually impacted by local circumstances, and therefore able to be negotiated by participating agencies on the FNC. These include

- definition of the client group and selection criteria;
- assessment and referral processes;
- informed client consent, client confidentiality and information sharing; and
- agreements between participating agencies.
Finally there are a number of aspects which are unique to the FNC such as the size of the over 65 population and its rurality and geographic spread, the shortage of trained staff, in particular allied health professionals, and the high Aboriginal population.

The management of such a large and important project is also a major consideration. For the project to progress smoothly it will require an independent project leader or facilitator to work alongside the participating agencies on all matters of project planning, development and implementation. The project facilitator’s role is more clearly defined in the project plan below but will include convening project working groups, organising and possibly delivering training programs and problem solving as the need arises.

Each of the project aspects will be discussed separately and recommendations made. However the primary decision for the FNC pilot is its location.

5.2 LOCATION OF THE TRIAL

While interest in the re-ablement model was high across the FNC, it was clear from the focus groups that implementation of the trial would be more straightforward in some areas than others. It was also clear that in some areas there are complicating factors, e.g. cross-border issues that could make it more difficult to replicate the positive results achieved in previous trials.

Of the three areas where focus groups were held, the site that appears most suited for a trial is the Clarence Valley, given that:

- it is reasonably self-contained in terms of geography and service provision;
- during the focus groups, substantial interest was expressed in the trial by participants in this area, with some providers saying that they were already using a version of re-ablement;
- the area has a high population of Aboriginal people and it is crucial that the trial encompasses their needs.

In addition, the Clarence Valley can be seen as representative of the FNC with large regional centres and small villages, coastal and hinterland areas, pockets of significant
rural isolation and a diverse population. These characteristics are typical of the FNC but not every possible pilot site has all of these characteristics.

The disadvantages of locating the trial in the Clarence Valley include:

- a shortage of allied health personnel
- existing demand pressures on services
- its large geographic area which can be seen as both an advantage and a disadvantage. The disadvantage is the time and cost of travelling long distances for home visits but the advantage – and it is a significant one – is the opportunity to test the effectiveness of a re-ablement model for rurally isolated clients.

**Recommendation 1**: That the Clarence Valley be the selected pilot site.

### 5.3 DEVELOPING A RE-ABLEMENT MODEL FOR THE CLARENCE VALLEY TRIAL: KEY COMPONENTS OF A RE-ABLEMENT PROGRAM

**Multi-disciplinary Team**

The re-ablement literature emphasises the importance of a multi-disciplinary team comprising:

- allied health professionals including a Physiotherapist, an Occupational Therapist and a Registered Nurse;
- care coordinator; and
- re-ablement assistants or support workers.

In many of the successful re-ablement programs, allied health staff were employed by the program and played a pivotal role in the multidisciplinary approach. In the Clarence Valley there is a long-standing shortage of allied health staff and this presents challenges for the project. Rather than expecting to employ allied health staff in the project, it may be preferable to broker them on a sessional basis for their expertise in specific areas. Previous experience in other unrelated pilot projects on the FNC shows that this has been a practical solution to this issue in the past.
It is also feasible for the RN and Care Coordinator roles to be held by one person, which would result in cost savings. It is suggested that the RN have community nursing and aged care experience and be engaged full-time for the duration of the project. The RN will have responsibility for undertaking all client assessments (and reviews), the development of care plans, goal setting with clients, referrals and coordination of services delivered.

**Recommendation 2:** That the Clarence Valley pilot builds a multi-disciplinary team through brokering allied health expertise on a sessional basis from other geographic areas, e.g. Coffs Harbour, other professional situations, e.g. private employment, or other agencies, e.g. Department of Health.

**Recommendation 3:** That cost estimates include allowance for sessional allied health staff to attend client case conferences, project meetings and training, as well as undertake direct client work.

A number of successful re-ablement programs have identified that there are sufficient similarities between clients and their goals to be able to develop some common interventions and that once developed, generic programs can be implemented by support workers, re-ablement assistants or aides who are trained in their use, thus reducing demand on the allied health staff.

**Recommendation 4:** That generic intervention programs be identified and used whenever appropriate

**Recommendation 5:** That support workers, re-ablement assistants and aides be trained and supported in the use of generic interventions.

**Multi-dimensional Assessment Tools**
The literature does not provide any ‘stand-out’ multi-dimensional assessment tool for the model. This is partly because the tools corresponded with the interventions in each re-ablement trial and partly because there are such a large number of internationally recognised standardised assessment tools available. The experience of Silver Chain in its HIP pilot, of first using the interRAI-HC and then deciding to develop a project-
specific assessment tool, based on the tool that was already being used within Silver Chain for HACC clients, is an important learning. The selection of a comprehensive assessment tool for the Clarence Valley model will need more investigation, including:

- having a closer examination of Silver Chain’s HIP Assessment Tool and New Zealand’s Home Restorative Support InterRAI-HC;
- surveying participating agencies about assessment tools they are currently using and prefer;
- negotiating with other local service providers such as Aged Care Assessment Teams that currently use multi-dimensional assessment tools; and
- drawing on a range of assessment tools to ensure that assessment is best suited to the complexity of needs of each client.

**Recommendation 6:** That the choice of multi-dimensional assessment tool(s) be made by participating agencies.

**Goal-orientated Care Planning**

Goal orientated planning is the feature of re-ablement essential in creating a person-centred approach that builds on the hopes and needs of each individual. Given the extremely strong evidence presented by Parsons et al, the use of the TARGET tool may be the best option for goal orientated care planning.

**Recommendation 7:** That the TARGET package (which includes a training component) be adopted for the Clarence Valley trial and that negotiations about this be conducted with the University of Auckland.

**Targeted Evidence-based Interventions**

There is sufficient evidence from previous re-ablement trials to point to effective interventions. They should definitely include:

- a strong focus on functional exercises and repetitive ADLs primarily working on muscle groups used in everyday activities;
- social rehabilitation;
• assistive technologies; and
• home modifications.

Interventions will be agreed to as a result of the initial assessment. Generic interventions will be possible for a proportion of clients. These will be carried out by re-ablement assistants. A mechanism for discussing support plans with other HACC agencies will be agreed to by participating agencies. The recently-increased regional capability in relation to assistive technologies will enhance their use in the trial.

There is also good evidence to support health education and nutrition programs. The evidence for social inclusion programs is not always directly linked to re-ablement. Nevertheless, programs that support social networking should be part of the Clarence trial as there is both research and anecdotal evidence of the negative impact on older people of loneliness and social isolation and the resulting increased demand for services.

**Recommendation 8:** That interventions in the Clarence trial be evidence-based and cover a range of physical and emotional needs according to client circumstances.

**Recommendation 9:** That the Clarence trial develop a re-ablement response to socialisation needs in collaboration with local HACC Social Support services.

**Time Limited Program**
The evidence supports the duration of a re-ablement program of between 6-12 weeks, with stronger results for clients tending towards the longer end, i.e. 8-12 weeks. This compares with Compacs – 6 weeks, and Transition Care - 8 weeks with an option for extending to 12 weeks. Interventions are likely to last an average of 8 weeks and clients will be reviewed and an exit plan agreed to by all parties prior to the person leaving the project.

---

33 Southern Cross University has recently appointed a Professor of Information Technology with a specific interest in assistive technology for older people; he is based at the Coffs Harbour campus.
Recommendation 10: That the duration of Clarence re-ablement intervention programs have an average length of 8 weeks, allowing for shorter or longer programs as needed.

5.4 DEVELOPING A RE-ABLEMENT MODEL FOR THE CLARENCE VALLEY TRIAL – MANAGING CHANGE

Organisational Commitment and Whole of Organisation Involvement
The research demonstrates that changing to a re-ablement model is most likely to succeed where the whole organisation (including Board, managers, care coordinators, support workers and volunteers) is involved and receives training and support to understand and implement the new approach. While attendance at the FNC consultations was high and participants were positive about re-ablement, it was generally only management who were represented; support workers, volunteers, and Board members did not attend.

Recommendation 11: That the model be underpinned by service agreements that include a whole-of-organisation commitment to the re-ablement pilot from participating agencies.

Recommendation 12: That information sessions about re-ablement be presented to participating agencies prior to the final approval of service agreements, so that agencies are making an informed choice.

Training for all Levels of the Organisation
One feature that emerges strongly from the re-ablement literature is the importance of adequate training and support for all involved in the shift to a re-ablement approach. There is compelling evidence as to the importance in re-ablement programs of ensuring support workers understand the re-ablement philosophy and feel confident to deliver the interventions. It is generally agreed that this shift takes time and may be challenging for some staff, and that there may be staff turnover as a consequence. However, the final outcome appears to include higher staff morale and better staff retention rates. While there are some training packages that can be purchased (e.g. University of Auckland), other training will require local development so that local
agreements and arrangements can be incorporated with the more conceptual re-
ablement thinking. In addition, regular reinforcement of the reablement change through training or support sessions will improve the outcomes for staff and clients.

The development of a training program needs more investigation, including:

- looking more closely at the range of training programs that have been developed by Parsons’ et al;
- discussing with Lewin et al at Silver Chain how training was approached for HIP; and
- surveying those FNC HACC service provider(s) that will participate in the pilot, to ascertain what training approaches have previously worked well for their staff.

**Recommendation 13:** That training programs be sourced externally where possible or developed locally as needed.

**Recommendation 14:** That regular training/support sessions for all staff be timetabled into the project plan.

**Client Commitment to the Program with Support from Families and Carers**

While it appears that the involvement of families and carers is crucial to the success of re-ablement, there is also potential for increased carer stress if clients are remaining at home for longer and/or their use of services is decreasing. The well-being of families and carers should be closely monitored and options for withdrawing from re-ablement without penalty should exist.

**Recommendation 15:** That selection criteria for the program include a positive attitude towards a re-ablement approach by the client, their families and carers and the option to withdraw without penalty.
5.5 DEVELOPING A RE-ABLEMENT MODEL FOR THE CLARENCE VALLEY TRIAL – LOCAL AGREEMENTS

A number of agreements between providers will need to be in place to ensure smooth operation for HACC and related service providers undertaking this project. To recruit clients to the project, exchange information about them and then to exit them from the project, agreements will be needed on the following:

**Project Client Group**
The evidence supports the key client group as being older people when they are first referred for a HACC service or when requesting an increase in services.

A positive attitude towards re-ablement by the client and their carer and his/her family is a critical element. If a potential client and/or their carer or family are not supportive, they may choose not to participate in the project. The selection criteria should also include:

- HACC special needs groups including Aboriginal people, people who live in rurally isolated areas, financially disadvantaged people and CALD people, and quotas for these sub-groups should be set;
- existing HACC clients (of the service providers participating in the pilot) whose services are reviewed because of a significant life event such as significant illness, death of a partner or carer;
- HACC-eligible older people who are not eligible for Com Packs or TACS

Exclusion criteria may include HACC-eligible older people whose family and/or carers are not supportive of the older person’s participation in the re-ablement program. Other client groups who will be excluded from the project include people with advanced dementia and/or neuro-muscular disorders and those needing total assistance with their care.

**Informed Client Consent and Information Sharing**
HACC National Standards, with which all HACC services should comply, emphasise the importance of fully informed client consent and ability to withdraw that consent.
without penalty. The project will need to develop a form of words that explains re-ablement in plain English, that this is a trial project and how access to services may be affected. Only on the basis of fully informed consent should people agree to participate in the project.

**Referral and Assessment Processes**
The evidence emphasises that assessment for re-ablement requires a level of clinical expertise and extensive experience. However there is also evidence to support phone-based assessments for less complex clients, possibly supported in some cases by use of appropriate Information Technology applications.

Client assessment will occur using the tool agreed to by participating agencies. The scale and depth of assessment will be determined for each individual. Multi-disciplinary and goal-oriented assessment will form the basis of support and will reflect the preferences and needs of each client and their family.

It is likely that existing referral arrangements within the Clarence Valley will be used with agreed protocols for identifying re-ablement clients.

Agreement between service providers about administrative arrangements will also be required and should cover such matters as:
- payment for services
- data collection and recording

It is suggested that examples of de-identified service level agreements from other DADHC funded trials and demonstration projects are sourced as a guide.

**Recommendation 16**: That project working groups be established early in the life of the project so that participating agencies, the funding body and other related services can formulate agreement on project protocols which form the basis of formal service agreements.
It is anticipated that because services in the Clarence already have close cooperative arrangements, the service agreements will build on and strengthen these while adding specific detail about the reablement project.

5.6 PROJECT MANAGEMENT AND STRUCTURE

Management of the project will have a number of facets. Overall project management should be the responsibility of DADHC, who are also the project funding body and the major stakeholder. A number of DADHC personnel will be involved including representatives of the central Community Care Reform Unit and the regional office. The regional DADHC officer will play a significant role in the project and will work closely with all other stakeholders, especially the project facilitator.

Facilitation of the project will be led by an independent project facilitator.

Management of client service provision could be disbursed in a number of ways but one option emerges, both from the literature and from the focus groups, as a workable choice. Most of the evidence for re-ablement is from services that provide domestic assistance and personal care and the Northern Rivers Branch of the Home Care Service of NSW expressed strong interest and readiness to implement re-ablement. Therefore the Northern Rivers Home Care Branch could become the budget holder and lead agency for client services.

**Recommendation 17:** That the Northern Rivers Home Care Branch be the budget holder, lead agency and care coordinator for the Clarence Valley pilot project subject to further investigation of the feasibility of this arrangement and endorsement by Home Care management.

Other HACC agencies will participate in the pilot by accepting referrals and providing services within the re-ablement framework. To support these agencies to be able to take on these clients, training and support will be provided in order to develop a ‘service-specific’ re-ablement approach. Depending on the service approach developed, these agencies may or may not have ‘designated’ re-ablement staff.
5.7 PROJECT PHASES

The project will require three phases as follows:

- **Planning Phase** (finalisation of pilot site and lead agency, selection of independent project facilitator, development of training packages, setting up project working groups);
- **Development Phase** (service agreements, selection of assessment tools, staff training, development of targeted interventions, other project protocols); and
- **Implementation Phase** (identification and recruitment of client participants, using the selection inclusion and exclusion criteria; assessment, goal setting and program implementation and evaluation).

(Note: evaluation of the project is not part of this paper’s scope. However, a carefully designed evaluation process is essential and should commence from the beginning of the trial project).

Project plans for each of the project’s phases are presented below.

5.7.1 Planning Phase: Months 1 – 4

It is estimated Project Planning would take approximately four months (with some overlap of time with the Development Phase). Table 3 outlines the activities that need to be undertaken in the Planning Phase, the expected outcomes and the agency responsible.

**Table 3: Planning Phase Activities**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Expected outcomes</th>
<th>Responsible Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project model finalised including</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• pilot site selected;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• lead agency selected;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• participating agencies identified;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• target client group(s) identified;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• selection/inclusion/exclusion criteria established;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• program duration agreed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Model</td>
<td></td>
<td>DADHC</td>
</tr>
<tr>
<td>Budget for selected project model finalised.</td>
<td>Budget in place</td>
<td>DADHC</td>
</tr>
<tr>
<td>Activities</td>
<td>Expected outcomes</td>
<td>Responsible Agency</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Process for selecting Project Facilitator determined.</td>
<td>TOR and /or tender selection process</td>
<td>DADHC</td>
</tr>
<tr>
<td>Contract negotiations with selected Project Facilitator.</td>
<td>Contract in place</td>
<td>DADHC/ Project Facilitator</td>
</tr>
<tr>
<td>Contract negotiations with HACC Lead agency finalised.</td>
<td>Contract in place</td>
<td>DADHC/ Lead Agency</td>
</tr>
<tr>
<td>Ethics (client info sharing and consent) addressed.</td>
<td>Ethics approval obtained</td>
<td>DADHC/ Project Facilitator</td>
</tr>
<tr>
<td>Lead agency reablement staff recruited</td>
<td>Job Descriptions developed; Contracts signed</td>
<td>DADHC/ Project Facilitator</td>
</tr>
<tr>
<td>Negotiations with University of Auckland re: training in / purchasing TARGET commenced</td>
<td>Contract in place</td>
<td>DADHC/ Project Facilitator</td>
</tr>
<tr>
<td>Project Working Group convened.</td>
<td>Project structure supports expert inputs and direction</td>
<td>DADHC &amp; Project facilitator</td>
</tr>
</tbody>
</table>

### 5.7.2 Development Phase: Months 3 – 6

A Development Phase of three to six months (with some overlap with the Planning Phase) is recommended to allow for the following activities:

- identify and recruit or broker in all members of the multi-disciplinary team;
- develop service agreements and processes for matters such as project coordination, assessment and referral mechanisms, client confidentiality and information sharing;
- agree on the choice of a multi dimensional assessment tool;
- develop generic interventions and undertake training in their use;
- undertake training in goal setting (TARGET) before the pilot commences;
- staff of the HACC agencies that will participate in the pilot undertake re-ablement training;
- organise a training program for the support staff which will include:
  - explaining the FNC re-ablement project and its aims and objectives;
  - building an understanding of the re-ablement approach generally and the FNC model in particular;
• teaching the support staff how to deliver the generic targeted interventions to clients;
• understanding the role of HACC agencies and referral processes;
• work with agencies to develop an agency-specific re-ablement approach and/or program for each;
• select or develop a comprehensive assessment tool(s) and develop the paperwork for its use in the pilot;
• develop the criteria for undertaking phone-based or home-based client assessments and the circumstances under which each will occur;
• develop paperwork for Home Care support staff to be able to easily report on clients’ progress.

Table 4 outlines activities that need to be undertaken in the Development Phase, the expected outcomes and the agency responsible.

**Table 4: Development Phase Activities:**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Expected outcomes</th>
<th>Responsible Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Working Group meets monthly.</td>
<td>Project is well managed.</td>
<td>DADHC/Project facilitator/ HACC agencies</td>
</tr>
<tr>
<td>Training in TARGET.</td>
<td>Workers are sufficiently skilled to implement goal-setting approach.</td>
<td>Project Facilitator</td>
</tr>
<tr>
<td>Targeted interventions are developed into generic training packages for the support workers</td>
<td>Re-ablement Program’s interventions selected and developed into training packages.</td>
<td>Project Facilitator</td>
</tr>
<tr>
<td>Training for all agencies and staff</td>
<td>Staff understand the re-ablement approach and are confident and capable of implementing the re-ablement interventions with clients.</td>
<td>Project Facilitator</td>
</tr>
<tr>
<td>Comprehensive assessment tool(s) selected and developed with paperwork for use in the pilot. <em>(NOTE: The tools selected are checked to see they meet the needs of the external evaluation.)</em></td>
<td>Most appropriate assessment tool(s) has been selected.</td>
<td>Project Facilitator/ HACC agencies</td>
</tr>
</tbody>
</table>
The Terms of Reference for an external evaluation are developed. The evaluation will look at the pilot’s effectiveness and replicability and, if found viable, develop a costed HACC service model.

The effectiveness & replicability of the program can be assessed and a costed model developed.

**The Implementation Phase: Months 6 – 18**

An Implementation Phase of minimum 12 months duration is recommended, although stronger results could be expected to be demonstrated with a project of 18 months.

Activities in the Implementation Phase would include, but not be limited to:

- identification and recruitment of client participants, using the selection inclusion and exclusion criteria;
- assessment of clients using agreed assessment tool(s);

For each client:

- distal goal(s) identified with client;
- proximal goals established by multi-disciplinary team in line with client’s distal goal(s);
- referrals made as required to participating agencies;
- program implementation;
- overall program monitoring and evaluation.
5.8 FAR NORTH COAST PROJECT: COST ESTIMATES

(This section was developed in collaboration with the DADHC Project Manager based on the recommendations made by ASLaRC in this report).

Assumptions

- The project will run for 12 months and will involve 50 clients receiving intensive intervention for an average of eight weeks.
- There will be a Planning Phase and a Development Phase prior to implementation.
- Cost estimates are based on HACC unit costs for the range of HACC service types.
- Low level HACC services such as Respite, Centre Based Day-care (standard) and Social Support are not included in the cost estimate as the need for these services is less likely to change as a result of the project.

Cost Components: Cost components include direct client care costs, training and project management. (Note: evaluation is noted but not included in the costing of the Project).

Client Costs: The cost estimate is based on each client receiving the following services over the eight week period:

- care coordination - 2 hours per client per week: includes initial eligibility assessment, coordination of services and review of client progress;
- allied health - 8 hours per client: includes clinical consultations if needed; and participation in case conferencing;
- personal care - 12 hours per client;
- domestic assistance - 4 hours per client;
- nursing care - 2 hours per client;
- home modifications - $2,000 per client: examples include grab rails, small ramps and minor modifications;
- assistive equipment - $300 per client: examples include personal alarms and walking frames; and
- other food services - 5 hours per week for six weeks: includes meal preparation and nutrition education at home.
### Table 5: Client Cost Estimates by Individual Client and all Project Clients

<table>
<thead>
<tr>
<th>Service type</th>
<th>Service hours per 8 weeks</th>
<th>Cost per client</th>
<th>Cost for 50 clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination</td>
<td>16</td>
<td>$800</td>
<td>$42,000</td>
</tr>
<tr>
<td>Allied health</td>
<td>8</td>
<td>$500</td>
<td>$25,000</td>
</tr>
<tr>
<td>Personal care</td>
<td>12</td>
<td>$439</td>
<td>$21,950</td>
</tr>
<tr>
<td>Domestic assistance</td>
<td>4</td>
<td>$132</td>
<td>$6,600</td>
</tr>
<tr>
<td>Nursing care</td>
<td>2</td>
<td>$131</td>
<td>$6,550</td>
</tr>
<tr>
<td>Home modifications</td>
<td></td>
<td>$2,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Assistive equipment</td>
<td></td>
<td>$300</td>
<td>$15,000</td>
</tr>
<tr>
<td>Meals and other food services</td>
<td>5 hours per week for 6 weeks</td>
<td>$356</td>
<td>$17,800</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$4,658</strong></td>
<td><strong>$234,900</strong></td>
</tr>
</tbody>
</table>

*Total client service costs = $234,900*

**Training**

Training costs will include:

- Purchasing training packages e.g. TARGET and Silver Chain = $50,000
- Trainer for five x 2 day sessions @ $2000 per day = $20,000
- Cost of staff attendance (includes travel and replacement costs): 20 staff at an average of $180 per staff member per day for 10 days = $36,000

*Total training costs = $106,000*

**Evaluation**

Evaluation of the project will be undertaken by an independent evaluator selected by DADHC and is not included in these cost estimates.
**Project Management**

- A project facilitator will lead the project development and implementation. Cost estimate:
  
  - 3 days per week for 6 months project development $24,000
  - 3 days per week for 12 months project implementation $48,000
  - Allowance for travel between project site and Facilitator’s Base/Office: $1000

  _Total Project Facilitator Costs = $73,000_

- Client costs will be paid to the project budget holder. It is assumed that this will be the lead HACC agency which will manage project funding and acquit unspent funds at the end of the project.
- The project budget holder will administer the funds and collate data for the project evaluation: Cost estimate: 2 days per week x 12 months = $29,120
- An allowance is also made for brokered allied health workers to attend project meetings and training: Cost estimate: $10,000

  _Total Project Budget Holder Costs = $39,120_

  _Total Project Management Costs = $112,120_

**Total Project Costs**

- Client service costs $234,900
- Training $106,000
- Project management $112,120

  _TOTAL: $453,020_

**In Summary**: This Chapter has presented a model for a re-ablement pilot project suitable for implementation in Far North Coast NSW. Chapter 6 presents the conclusion to the report.
CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS
This document reports on a service improvement project which aimed to investigate and scope the introduction of re-ablement concepts and practices to Home and Community Care Services (HACC) services on the Far North Coast. The main objective of the project was to develop a re-ablement model for future piloting by service providers providing HACC services to older people and operating in the Far North Coast.

Government policies, national and international literature were reviewed and local service providers were consulted to ensure a thorough understanding of the issues involved in re-ablement generally, and in a model for the Far North Coast specifically, were identified and incorporated in to the model.

A Far North Coast Re-Ablement model for a Pilot Project was developed, presented in Chapter 5, based on the following recommendations:

6.2 RECOMMENDATIONS
1. That the Clarence Valley be the selected pilot site.
2. That the Clarence Valley pilot builds a multi-disciplinary team through brokering allied health expertise on a sessional basis from other geographic areas, e.g. Coffs Harbour, other professional situations, e.g. private employment, or other agencies, e.g. Department of Health.
3. That cost estimates include allowance for sessional allied health staff to attend client case conferences, project meetings and training, as well as direct client work.
4. That generic intervention programs be identified and used whenever appropriate.
5. That support workers, re-ablement assistants and aides be trained and supported in the use of generic interventions.
6. That the choice of multi-dimensional assessment tool(s) be made by participating agencies.
7. That the TARGET package (which includes a training component) be adopted for the Clarence Valley trial and that negotiations about this be conducted with the University of Auckland.

8. That interventions in the Clarence trial be evidence-based and cover a range of physical and emotional needs according to client circumstances.

9. That the Clarence trial develop a re-ablement response to socialisation needs in collaboration with local HACC Social Support services.

10. That the duration of Clarence re-ablement intervention programs have an average length of 8 weeks, allowing for shorter or longer programs as needed.

11. That the model be underpinned by service agreements that include a whole-of-organisation commitment to the re-ablement pilot from participating agencies.

12. That information sessions about re-ablement be presented to participating agencies prior to the final approval of service agreements, so that agencies are making an informed choice.

13. That training programs be sourced externally where possible or developed locally as needed.

14. That regular training/support sessions for all staff be timetabled into the project plan.

15. That selection criteria for the program include a positive attitude towards a re-ablement approach by the client, their families and carers and the option that they can withdraw without penalty.

16. That project working groups be established early in the life of the project so that participating agencies, the funding body and other related services can formulate agreement on project protocols which form the basis of formal service agreements.

17. That the Northern Rivers Home Care Branch be the budget holder, lead agency and care coordinator for the Clarence Valley pilot project subject to further investigation of the feasibility of this arrangement and endorsement by Home Care management.

Cost estimates have been developed (see Chapter 5) which take into account local constraints and issues.
The research team considers that the model could be successfully implemented on the Far North Coast, and that its implementation would contribute significantly to the well-being of older people in this region.

ASLaRC management and staff wish to acknowledge the support and advice provided by the DADHC project manager, whose knowledge and guidance greatly enhanced this project.
REFERENCES


Commonwealth of Australia *Aged Care Act (1997).*

Commonwealth of Australia *Home and Community Care Act (1985).*


APPENDIX 1

Re-ablement of Frail Older People Project

Letter/Information Sheet
for prospective focus group participants
Dear (Service Provider X),

Recently the NSW Department of Ageing Disability and Home Care (DADHC) provided funding to Southern Cross University’s Aged Services Learning and Research Centre (ASLaRC) to investigate and scope the introduction of re-ablement concepts and practices to Home and Community Care (HACC) services on the NSW North Coast.

This research project is in response to an emerging paradigm for the provision of HACC services for frail older people, which challenges the traditional home care goals of ‘maintenance’ and ‘support’ and the underlying assumption that people, as they age, will inevitably experience decline in function. This new model, known under various terms (re-ablement, active ageing, successful ageing, wellness, restorative, re-enablement, active service model) emphasises a capacity-building restorative approach. Its principal aim is to maintain and restore, to the extent possible, an older person’s capacity to live as independently as possible. For this project the term being used for this approach is re-ablement.

Across the western world the approach to the delivery of HACC services is being reconsidered by governments and service providers alike, primarily for two reasons:

1. as mentioned above, the emerging evidence base (in part based on changes in disability service provision) of the positive difference a ‘re-ablement’ approach can make to ageing; and
2. the expected increased burden on the home care service system over the next few decades resulting from the significant growth in the number of older people generally and those living with significant levels of disability specifically.

DADHC wants to explore the possible benefits that a re-ablement approach may have to delivery of home care services on the North Coast of NSW. The final project outcome will be the development of a re-ablement model for piloting by selected HACC service providers operating in the NSW North Coast (Stage 2). Development of the pilot model will be informed by international and national re-ablement literature and tailored for local conditions based on feedback provided from local service providers and DADHC. To obtain this input from local HACC-funded service providers, three focus groups will be run in Tweed Heads, Lismore and Grafton.

We would like to invite your organisation to participate in this research project by having one or two of your staff members attend a focus group meeting in (XXX local area) (see attached Invitation for meeting details). The purpose of the focus groups will be to:

- share with participants our understanding of the re-ablement model;
- gain an understanding of current related models in operation in your local area;
• obtain your feedback on the re-ablement model including perceived challenges/barriers to its implementation within North Coast organisations;
• ascertain implementation priorities for your local area; and
• identify which services might be suitable/amenable to using such a model.

Participation in the focus group will require a half-day commitment and involve a short presentation on the re-ablement model concept and approaches trialled to date, followed by some work in small groups and responding to questions about re-ablement and local implementation priorities. Responses will be recorded on butchers’ paper and, with the permission of the focus group participants, the proceedings will also be audio-recorded to assist with later analysis.

This research may be submitted to a peer-reviewed journal for publication at a later date and may be presented at conferences, but only group data will be reported.

Participation in this project is completely voluntary and participants may choose at any time to discontinue without negative consequences. Prior to the focus group starting, participants will be presented with a Consent Form to read and sign.

This research has been approved by the Southern Cross University Human Research Ethics Committee. The approval number is: XXX. If you have any concerns about the ethical conduct of the research, please contact:

Ethics Complaints Officer
HREC
Southern Cross University
PO Box 157
Lismore NSW 2480
Tel: (02) 6626 9139
Email: sue.kelly@scu.edu.au

All information is confidential and will be handled as soon as possible

Should you wish to discuss further any of the issues raised by the Project or you would like feedback please do not hesitate to contact the Chief Investigator (see contact details below).

Yours sincerely

Professor Colleen Cartwright
(Chief Investigator)
Director, ASLaRC
Southern Cross University
Ph: 02 6659 3382
Email: colleen.cartwright@scu.edu.au

Ms Judith Gooden
Project Officer
DADHC
Ph: 02 66211421
Email: judith.gooden@dadhc.nsw.gov.au
APPENDIX 2

Re-ablement of Frail Older People Project

FOCUS GROUP CONSENT FORM
FOCUS GROUP CONSENT FORM
(This consent form is based on the National Statement on Ethical Conduct in Human Research (National Statement/NS))

Title of research project: **Re-ablement of Frail Older People Project**

NOTE: This consent form will remain with the Southern Cross University researcher for their records.

Please tick the box that applies for each statement, then sign and date the form and give to the researcher

---

I agree to take part in the Southern Cross University research project specified above.  
Yes [ ] No [ ]

I have been provided with information at my level of comprehension about the purpose, methods, demands, risks, inconveniences and possible outcomes of this research, including any likelihood and form of publication of results.  
[ ] [ ]

I agree to participate in a focus group relating to re-ablement  
[ ] [ ]

I agree to allow the focus group meeting to be audio-recorded.  
[ ] [ ]

I agree to make myself available for further interview if required.  
[ ] [ ]

I understand that my participation is completely voluntary.  
[ ] [ ]

I understand that I can choose not to participate in part or all of this research at any time, without negative consequence to me.  
[ ] [ ]

I understand that any information that may identify me will be de-identified at the time of analysis of any data. Therefore, any information I have provided cannot be linked to me. (*Privacy Act 1988 Cth*).  
[ ] [ ]

I understand that neither my name nor any identifying information will be disclosed or published.  
[ ] [ ]

I understand that all information gathered in this research is confidential. It will be kept securely and confidentially for 7 years at the University.

---
I am aware that I can contact the researchers at any time with any queries.

I understand that the ethical aspects of this research have been approved by the SCU Human Research Ethics Committee.

If I have concerns about the **ethical conduct** of this research, I understand that I can contact the SCU Ethics Complaints Officer. All inquiries are confidential and should be in writing, in the first instance, to the following

Ethics Complaints Officer  
Southern Cross University  
PO Box 157  
Lismore NSW 2480  
Email: sue.kelly@scu.edu.au

__________________________

Participants name:_______________________________________________

Participants signature:____________________________________________

Date: __/ __/ __

If you wish to receive a summary of the results, please provide your email address and tick this box: ☐

Email: ……………………………………………………………………………..
APPENDIX 3

Re-ablement of Frail Older People Project

SELECTED FOCUS GROUP TRANSCRIPS
1. What do you think about the re-ablement approach? What do you think are its best elements, key issues?

| Requires a philosophical change | For most services when we go in there, we go in for the long haul and re-ablement is going to be a total shift from this, to support someone to move out of the system, and this will be an interesting and challenging shift.  
This sits well with me because it’s similar to the disability model which is my experience; it’s about setting small goals to get to the big goal.  
I think the model is actually a philosophy that has been used by the Regional Integrated Services (RIS) program in the Clarence. They didn’t want people on home services forever so their philosophy was to get people back to being independent in their personal care. I can see for a certain target group that it would work.  
Almost sounding like transitional aged care services (TACS) without the ACAT assessment requirement.  
If we don’t think of HACC in episodic terms, then this creates inequity. The only fair way is to have an episodic attitude. Compare HACC with Com Packs, which only last for six weeks, you can achieve an enormous amount in six weeks! So it’s about changing organisations’ attitudes; if you know HACC services only lasts for six weeks, then you change the way you do things. |
| Best elements of approach | Isn’t it also about getting demand met where it’s needed to be met?  
Every organisation has a process and their processes are probably really good, but what re-ablement gives service providers is a model to run by. Its something you could give the whole family to look at beforehand, not just a set of processes which can often be very confusing to a family in crisis.  
What is really good (about the re-ablement approach) is that it identifies clients’ real needs by taking a case-management approach and looking at what people really need rather than just throwing everything at them. Getting an understanding of what’s needed for a client and if that is “two days a week with a group of people” then so be it, and then its just a case of finding a way to make that happen e.g. organising for the neighbour to take them or whatever.  
In the ideal world – won’t a re-ablement approach be far more cost effective for services and funding bodies, because what have you got to lose really? If then re-assessed and it’s a no-win situation then you have lost nothing, you will have given it a go and you truly know that they need to be in the HACC service system network.  
Just thinking about the home mods, how many people could shower independently if they had one thing done, like the hob? How many direct services could be cancelled if you got rid of that hob? |
| Key issue: Workers resistance | Tied into re-ablement is the phenomenon of beneficence; people wanting to do good, what do you about that? People think by doing and giving they are being loving and caring. In our work if you actually put your hands behind your back you help more. This phenomenon is big out there.

To change the culture of how people looked at service provision, that is the biggest thing. The ‘to do for’ approach is fairly entrenched and convincing people they don’t need another daughter or son and they don’t need ‘to do for’ is the hardest thing, especially for people who like to do things for people. Its fine for them, it can even be fun, but it doesn’t help the client. |
|---|---|
| Key issue: Client resistance | In Home care it’s the fear thing that operates with clients. They tend to hold on to services because they fear that when they really need the service it won’t be available- so often there are people getting home care who don’t really need it. What they need is social support programs. A re-ablement approach could free up funds.

Implicitly and sometimes explicitly there is a culture of entitlement and not just in aged care but across all the community services. Explicitly its terminology like ‘assessment’, ‘eligibility’, ‘benefits’ and ‘entitlements’. So when we work with people sometimes their goal is to get everything they are entitled to. How will this culture of entitlement be addressed in a re-ablement approach and what will be in place to support workers on the ground working with clients and facing this culture of entitlement?

For our client base there is still an expectation of dependency and if you try and address that, it is as though you are trying to take away something that they have a right to. So you will really have to tread carefully in how you present this kind of support.

In our HACC services generally people don’t come off it unless we can encourage them to move to a package of care. Generally our veterans also have that feeling that if they decline a service, or stop using it, they won’t get it back, even though we assure them that if its needed it will be restored. It’s a generation thing, the “I don’t want to lose it” mentality. (General agreement from other participants). |
| Limitations of the HACC sector | Enhancing the role for support workers raises the issue of their poor remuneration and the limited capacity of service providers to increase their pay.

Raises questions about insurance – When we are talking about support staff are you talking about the field staff that go in and vacuum or are you talking about the coordinators? |
| Constraints of current HACC model | Reality of funding and time constraints is that staff tend ‘to do for’ clients because it’s quicker.

How could re-ablement type assessments take place whilst we are currently bound to DADHC’s CIARR (Client Information and Referral Record)? |
HACC is much more output driven rather than outcome. In fact with tightened funding and increased demand it is getting more output driven e.g. we used to assist clients individually to do shopping but now it’s more common to collect a list and do it for them. Re-ablement sounds like an outcome driven approach and outcomes are not able to be measured as easily as outputs. How will the funding model deal with this?

Wouldn’t you need to have more resources in the beginning? Over time it might even itself out but you have put in that initial intensive support?

On a daily basis, each client in the re-ablement model will receive a more intensive level of direct service initially than someone on a maintenance model. But it is so much easier and quicker to just shower and dress a person than it is to teach them to do it themselves. A half-hour shower assist in a maintenance service could be a two hour re-ablement service; it will probably have to be. So re-ablement will look expensive on a daily basis, and it will only look economical over time, when the number of people supported is higher than in the maintenance model.

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am sceptical; I think re-ablement could be just another way to for government to justify cut backs.</td>
</tr>
</tbody>
</table>

2. Do you know of re-ablement type practices that are already occurring in your organisation or other local organisations?

<table>
<thead>
<tr>
<th>Lismore</th>
</tr>
</thead>
</table>
| I think that all services already use this kind of model in a small way. For us, if it is a new client we don’t just go in and assess them for domestic assistance but also assess a client’s networks, e.g. Do they need social support? MoW? Home Mods? Its not done in isolation but done with other service providers (but in our case there is only one other provider which is Community Health). So assessment is done in a collaborative way, its not perhaps as formal as the re-ablement approach and it is on a smaller-scale version but it is the same philosophy.  

Most Centre-based day care services on North Coast have moved from the bingo hall approach to follow a wellness approach as much as possible i.e. providing individualised activities. 

As well as usual personal care and domestic services work we are involved in ComPacks and Transition Care programs (NCAHS funded). With these programs, our staff know from the outset that they are short-term and time-limited. They know their role is to help the person get back to being as independent as they can. As far we are concerned re-ablement is Transition Care and at Home Care, we are doing it already!

For the last two years the NCAHS has run a Transitional Age Care program, which is Commonwealth-funded and administered by the Department of Health. It operates across all the NSW area Health Services. They are packages and have very clear eligibility criteria and these reflect re-ablement principles i.e. they are concerned with improving clients’ functionality. These packages are time-limited and funding is attached to them. In terms of outcomes, we have been able
to collect very clear data that supports the evidence that was presented here today. But I also think that in part the good outcomes achieved are also because the program is honed – i.e. it has in place very specific criteria and an assessment process that supports it to produce good outcomes.

<table>
<thead>
<tr>
<th>Tweed</th>
</tr>
</thead>
</table>
| Community Options has lots of common aspects with re-ablement and I think we have already changed the culture that needed changing. This wasn't done for any other reason than that demand in the Tweed Shire was so great because of its ageing population; there was a big equity issue here and we had to address it. … (Last financial year we had 310-330 COPs clients, compared to when I first came into the service in 2004 and there were 40 COPs clients and give or take a few they had been the same 40 people for the last 12 years.

At Spiritus we have a Rewards program (and this is probably what keeps our CAPs packages full) that supports clients to remain social and in the community. Clients have their normal Care Plan but also have a rewards goal. End up achieving their intrinsic goal but extrinsically also by giving them rewards as well e.g. free pedicure, manicure, and meals. Currently only able to provide this for our CAPs clients’ ….. Another program that is similar is our Chronic Condition self-management course, it includes an action plan and a management plan that is meant to be done in collaboration with GPs but in a way it’s the clients who are building it with support of the Facilitators of the group (but the GPs get the money for it from Medicare). It is looking at a restorative model so it’s actually skill building and at least initially providing some facilitation to guide patients through the processes.

We have services operating both in the Gold Coast and the Tweed. Just recently we have been successful for HACC funding in Queensland for a person enablement program. The program is based on many of things you put up (in the PowerPoint presentation) but we really haven’t begun transitioning clients across, but when we start taking on new clients we would like to start taking on this approach.

We predominately service the veteran community but we also service others. Whilst I think we still have a long way to go, we have started to make the cultural changes required. ….. Our nurses do a lot of case management so we have progressed this type of approach over the last year or two, so that now our Care Plans are focussed on what a client can do. ….. A big change in our organisation is that we now do audits on our new clients at three months post-admission. One of the tools used has changed the way we do our Care Plans, there now has to be a goal set for the client and that choice must be discussed and agreed to by the client and the client has an element of independence about their Care Plan. An example of this is an 80 year old (male) client, he had as part of his Care Plan that he would help with the dusting, whilst the carer did something else. This was from a man who had never done any cleaning in his life; his wife (an invalid) thinks we are just wonderful. The reality is that he is at risk if the wife goes off to hospital because he doesn’t even know how to make a meal; so we are moving him towards independence in a really slow way. These audits have changed our culture.
Looking at our COPS/ HACC case workers, they are a multidisciplinary team in-house and it has an RN (ex ACAT) and a multitude of other skills & experience (psychology, social science) and whenever there is something that the team requires that they don’t have they will broker out for it – i.e. they will buy in an OT, physio, dietician, continence nurse whoever they need, for the hours they need, to make sure the put together the right Care Plan for a client (we can’t afford to have these types of professionals on staff full-time). The Care plan is looking at transitioning clients to a stronger independence position. For us inside our COPs model it is multi-disciplinary team and it’s been built around that independence focus for three-four years now.

We do set goals with our clients but often they are those huge ones like wanting to remain independent and at home. We realise these may be too broad and that clients actually want to set smaller goals, something that is achievable like walking to the post box, and then building from there, they may not reach that big goal.

One thing our organisation has worked on in the last few years, because we only have limited funding, is to not try and be the be-all and end-all for clients. That has taken a lot of work because it is a lot of work linking into other models/services to help our clients achieve outcomes. The hardest thing is linking in with who does what because it is not captured anywhere. We all have a vested interest in working together but it is getting together to work together to get these outcomes for clients.

Grafton

Council has already started the process of training around this approach, trying to focus on what people can do rather than what they want. .....And we are already working as a multidisciplinary team on two of our NCAHS-funded programs.

With the TACS program we have lots of clients through and that works really well, They are usually brought on intensively to start and have meals provided for all seven days and then people are eased off slowly down to five days then three days and then they are usually gone within about 6-8 weeks (MoW).

We get referrals for respite for carers and more often than not it’s for in-home respite...... We started to do something like this (re-ablement approach) with a six week component service, where we look at the care recipients needs and wants and this led to people not getting in home-respite but being part of a group program (which is much cheaper service). Just because you have a disability doesn’t mean you have to stay at home in-doors. That’s that cultural change stuff as well. Mostly it’s working.

I think that forever and a day we are going to be out there on our own, this is how we provide our service now (short term- time-limited) i.e. we are not about developing ongoing relationships with clients. We do the work and then they forget about us and the aim is to make them independent (Home Modifications).

This sounds like the program we are about to start in MacLean with
MoW clients and also aged clients who have lost their wives. We are starting a cooking group; it will be interesting to see how it works.

3. **What enablers / barriers do you think your region faces if it were to adopt a re-ablement approach?**

| Geographic and client spread | This area is quite large in terms of geographical distance and a lot of villages are isolated in terms of lack of services on the ground (they may have some HACC services such as MoW but often there is no home care service and a lack of transport too - both community and public. If there were to be a re-ablement approach, how do you get around this reality?

In the rural setting the time taken by travel can be quite significant. In current model there is an allocation of two hours. This is just not feasible when providing assistance to clients who live in remote rural areas. Part of the cost structure for re-ablement would need to address these travel /transport issues in rural areas. The costs of sourcing external expertise would also be another additional cost for rural services

Will there be a metro vs. rural Model? Often when policies are introduced that are state-wide they do not fit both geographic areas. E.g. assessment in rural areas cannot happen in 48 hours – have to source that expertise and then get that person to go out and see the client – all that takes much longer than 48 hours

We need to consider distance, this is the biggest barrier to provision of any sort of service – invariably those most in need tend to live out in bush and for services this is very cost prohibitive. |

| Chronic shortage of allied health professionals | Concerned about how a multi-disciplinary team would be achieved in an isolated area like the FNC – given we are already unable to access OTs?

If there is a centralised team doing re-ablement then a real barrier it will face is that clients could be waiting three months for assessment!

Think we are all trying to take a re-ablement approach with our clients but it’s very frustrating because we often can’t get an OT for three months or access. That will be the reality check for re-ablement.

..concerned about the multidisciplinary team members that are needed to do the assessments given that we already have shortages of physios, OT’s and people to modify equipment. Where are we going to find these physios or occupational therapists given we currently have 6-8 months waiting list to get people assessed now? I can see that as a barrier.

That’s also an issue with the NSW Program for Appliances for Disabled People (PADP). There’s all this new money coming in for equipment but you need a prescription for the equipment and if you haven’t got the OT to do that, you don’t get the equipment. |
| Worker - Skill Shortages & Training | Agree that the skill base of care workers is important (for implementing re-ablement approach) but the organisations also have a duty of care to provide the correct number of workers with the right qualifications, which could be an issue for re-ablement if we are looking at the current skill level of our care workers.  

I agree trying to get staff is very hard, I just advertised two positions, not support worker positions but got two responses for one job and none for the other, and it's the same for support workers. It's a big issue!  

In working with home care what we have in the FNC is an ageing population but no influx of young workers. So far us, what we found really difficult was recruiting people who had enough of a skill base that with a limited amount of training would be able to be put on the job. So recruitment is a really big issue, for home care especially, because we have such a huge workforce capacity and the level of training our recruits still need when they come into the service. |
| Service/ Funding shortages | The HACC service providers are all very 'tasky' and support workers go in and ‘just do it’ and leave as opposed to re-ablement which requires spending that bit of quality time to get clients involved. Where’s the funding to do that? How are organisations that provide HACC services going to be able to move to that model when they are so stretched as it is?  

I find the challenge is actually making the referral, it can take me three days and lots of missed calls and when I finally do get through I first have to go through a run of initial questions, which can take upwards of 20 minutes, only to be told at this stage that they don’t currently have capacity to provide that service. |
| HACC sector working relationships | Although there are clearly lots of barriers and constraints to implementing the approach in this area, I believe we have a really good attitude when we think a new service will work; as service providers here we have a history of going that extra mile to implement new services. Everyone gets along well here! |
| Region Specific: Clarence Valley | In the Clarence there are some OTs but not sufficient to keep up with demand for assessments and prescription writing.  

Older people in Clarence might be different to Tweed – typically the older couple have traditional gender roles so the women haven’t ever done the outside jobs, and houses do not lend themselves to independence because of outside loos and steps. Because of these realities we are not likely to be able to ever reduce the need for traditional home care.  

Public perception in the Valley is that there is no transport available – if you can’t drive yourself, you can’t get anywhere and that’s just not true.  

With MoW we often have problems with people living far out of town but we usually can overcome this with a neighbour/family coming into town or a TACS worker or nurse who may visit the client once or twice a week and we send meals with them. |
4. What strengths/weaknesses do you think your organisation faces if it were to implement a re-enablement approach?

| Requires organisational support | To implement the Transitional Aged Care program in Health has been a challenge because NSW Health is very big and it has its own culture of doing business. However after two years we now have a suite of staff up and down the coast that look at client independence rather than creating dependence. We have gone through some of the hard ‘argy-bargies’ with staff and made the necessary changes. I think you were correct when you said it needs senior executive strength, good mentoring and the selection of the right staff. The success of the Transitional Age Care program has been because it very much has been driven from the top and this has helped avoid some of the even more difficult ‘argy bargies’ |
| Worker resistance | Support workers are so lowly paid and at the same time, there is this huge and growing expectation on them, from organisations, to take on more responsibilities but with no change to their remuneration. So the move to professionalise is resisted. Our workers are often not willing to do training as there’s nothing in it for them!

When we (Home Care NSW) introduced Com Packs there was an initial reluctance from staff, but after ten months it gained impetus and momentum and now staff find the program invigorating and energising. They enjoy the short-term nature of the program and feel good that client has improved and that they have helped that client say ‘bye-bye’.

| Organisational capacity to support staff training | There are barriers to training, it is always an issue about time and we don’t have the casual staff to cover for it or have the financial resources to pay for it. I estimate I could release staff for training for one day a week, maximum.

We have 40 staff on team but we are always scrambling to allow training for our support workers. Even half a days training for ten people would severely stretch our service as it creates big problems for back-up.

DADHC has previously tried training key workers in its Home Care branches but this type of training approach just falls off after a while because often people leave or lose interest as they are being asked to take on additional responsibilities without additional resourcing or pay to do so.

| Client resistance | Anecdotally, I am aware that if you don’t have staff with the same beliefs or foundations in terms of ‘re-habing’ and one goes in and is just like a daughter and is all lovey-dovey and another staff member goes in and uses the re-hab model and takes ‘a lets do it’ approach then I will get the calls from the family complaining saying “I don’t like that one – I like that one”.

| Masked socialisation needs | Loneliness often underlies service need, people are desperate for contact. If this need could be met directly then I think we would see a reduction in demand on other HACC services.

Increasing number of people are accessing our social programs and once they establish a connection with peers, they begin to take a lot...
of control in the things they do. First they begin to support each other, then they form networks outside the group, their moods lift, and carers feel better; so there is less residential respite needed.

I have recently analysed what our guys (community transport staff & volunteers) actually do i.e. the service they are providing at a case-by-case level. Lots of our volunteers are picking clients up and taking them somewhere, usually to medical appointments but the real purpose appears to be social, they are out with the client for an 1.5-2 hours and they are being like a daughter or son and taking them for coffee. As the demand for medical appointments grows and grows we haven’t got sufficient volunteers to meet it because our current volunteers are too busy doing this socialisation stuff. I think it would be more efficient to put 20 people on a bus with one driver and socialise those 20 people with a program aimed at doing specifically that. This would free up a lot resources to provide community transport services to other people.

**Goal setting**

At Community Options when we first case manage a client they might have 3-5 goals and that might take 3-5 or 8 months for us to work with them to achieve and then when there is nothing left and everyone has agreed that its been completed to their satisfaction the client goes off. Then the clients get a letter saying if you think that you need us again just ring us. When they re-refer they come back into intake and they usually come back with just one thing. They don’t save up five goals, they come back as soon as they have one thing. Whilst we don’t set a time for COPs the mean average time we have a people on the books is four months. Ex-clients who return with one goal set are often dealt with in two weeks.

We do magic wand exercises with our clients – I have a spangled wand that I take to clients and say: “If you could wave your magic wand, what are three things you would like to be different about your life”. That’s not confrontational it’s about dreaming – they wouldn’t relate to goal setting (directly).

**Assessment & and service delivery**

The multidisciplinary team is a key element of the NCAHS Transitional Aged Care program’s success and involves OTs, physios, nursing staff - this level of professionalism is needed to do the assessments. It also needs a suite of evidenced-based interventions. Part of the assessment process is to re-assess; that is when we get the data on whether clients’ functionality has improved. Whilst lots of people go through the program in 6-8 weeks and show improved functionality and have a reduced need for services there are also many people who still require an old-style home care service.

Transition Care and ComPacks have a case management model attached and that’s partly why those services work so well because there is one person that is the client’s case-manager. Will re-ablement take on case management and be something that each of the services take on?

If (the model selected has) no central assessment agency and it is responsibility of all services to undertake assessment and case management, how does it work when client receives more than one service? Will one service take a lead role?
Whilst the Care Plans we use are brilliant, it actually takes longer for the carer to see what the client can do for themselves and what they are there to support with.

We have that situation here, especially in the Yamba area, where people shift for a sea-change and often have no support systems and then their children come at Easter and the complaints start. It's really good if through case management you can link with those families to start with, even if it's by phone. It doesn't really matter where they live, just so you can have that contact to tell them where Mum is up to and what she is or isn’t achieving and know what their expectations are as well. It's like a case conference I guess, trying to get everyone who is significant in the clients life involved.

<table>
<thead>
<tr>
<th>5. What strategies /activities of re-ablement do you think would be worth pursuing? What would it look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client selection</strong></td>
</tr>
<tr>
<td><strong>Other selection criteria</strong></td>
</tr>
</tbody>
</table>
| **The multi-disciplinary team** | Think the (MDT) team should have a person that is a qualified ‘safety’ person. They might just qualified with a four-day OHS course but a safety person can be really useful on how to move through home rather than always the experts, to take it out of the clinical model a bit.

Would probably need to broker in as well because Health already doesn't have enough allied health people to do what’s needed. It would need some external people, definitely more OTs- we can’t get those, and perhaps physios.

If you are going to take a multi-disciplinary approach then that team needs to be involved from the start in the training of the supervisors and coordinators. They need to all be hearing the same message, all be on the same wave length, and then that will filter down to the staff and out to clients.

We have a physiotherapy aid with TACS and a therapy aid with OT department in MacLean and there are things that they can do that really take the load off the professionals. |
| **Assessment Tools and Approach** | Many assessment tools focus on deficit, would want to find one that focussed on what clients ‘can do’. What about the “I Can” assessment tool?

Community Options across the state uses the ONI tool – there has been lots of work done with the Way Forward and Wollongong Uni around adapting that tool. Don’t know where that’s up to.

Good to look at assessment from different perspectives - i.e. what an RN, physio, OT may assess and ask about and bring them all into the tool. |
| **Who should undertake assessment?** | Would there be a designated service to do initial assessment then refer out & broker services?

One of the things we used to do as Service Coordinators of X is that we were the ones that went out and did the initial assessment. I could see Home Care Service Coordinators fitting very well into this, still have RAC, but have assessment come back into branches at a local level and using their experience and knowledge of accessing local services.

One of the ways around that (the need for highly trained support workers but service providers’ limitations to pay workers more) is that we have a care worker who has extra training and she is able to do re-assessments. She visits the clients where things have changed and she is able to say what needs to be done —e.g. changes to service, OT referral. We pay her a different rate when she is doing that work- compared to when she is just doing her normal services. Use her across three teams.

If you have a comprehensive assessment tool and the care workers are trained in use of it and also have some understanding of what an OT or physio does, and how they work with clients, then they could go in and do assessments. They should be able to pick up if other |
referrals are required. Not everyone is going to need an OT or physio assessment.

Could it work if an experienced coordinator, say a RN, goes to client and assesses them? May need to be referred to rather than having a whole heap of professional people involved tying up resources.

I’d like to challenge the notion that we’ve got to have experts do all of this. Increasingly we can’t make a move without getting an assessment by a physio that costs $350 or $450. I think we can send people in with tools – all of you currently have staff that go in and make good assessments about where changes need to be made – e.g. that a vacuum cleaner is inappropriate or they need such and such equipment may help.

So if you have a limited resource like OTs, are you saying that maybe that OT could train RNs with some of the required expertise that is specific to the needs identified in the assessment? Then the allied professional could be a reference point for those people to go back. Yes, I think that would work.

They wouldn’t be able to touch home mods aspects, they have to be done by an OT, pure and simple. So it could only be the ‘re-haby’ type of things or personal care type of things.

Think anybody could learn to teach falls prevention exercises and its things like that make a huge difference over time.

We (Health) currently do monthly home visits for EACH and EACHD which includes, on most occasions, a team visit with an RN and a Clinical Nurse Consultant along with the Case Coordinator. Suggest you have something along that line which will ensure that those clinical things will be picked up and it is not resting on workers to do that. The staffing needs for these home visits are the salaries of two RNs one day a month for EACH and three days a month for EACHD, so that’s 10 days extra staffing needed every month.

When doing assessments it’s important to have a skilled assessor so as not to build expectations in the first place and to link in with the family, so everyone is on the same page.

If it was just personal care, then not everyone would need that level of assessment or monitoring, would they? I suppose that would come out of the assessment to start with and the establishment of the goals and then a referral could be made if needed to Health for further assessment or ongoing monitoring by a CNC visiting the client etc. As coordinators we can’t make those decisions but we do know if our clients are deteriorating but we don’t know the cause necessarily.
### Goal setting

It seems that the goal is paramount in having a six week re-ablement program. If the client can agree on a specific goal in conjunction with the multi-disciplinary team then they will know that they are going to reach that goal. The goal of just maintaining independence at home seems too broad—that comes into play with the client going “but I’m not independent yet and the service just goes on and on”.

There was a program on the FNC called ‘The Life Moves’ and that included a range of agencies and was about skill building for people with disabilities and it was a short term project – six months. Had the ability to access 20 hours to begin with then reduced. It is same kind of model as re-ablement in that you set types of goals; they were small goals and they were broken down into achievable tasks i.e. the disability model and it worked quite well.

### Training for Support Worker/Coordinator

Will need trained support workers to make the shift.

If it were longer term training think it would have to be accredited training.

What about training some key workers to train other staff? We have 175 care workers, so it would take an awful long time to train all of them.

What about trained staff then being provided with a video to take back to their organisations to help train staff by presenting an in-house workshop?

I think a lot of coordinators have done a Cert IV in Train-the-Trainer, so certainly the skills base exists to do that (in-house training). But the real issue is being able to take time out of the office.

Would want support workers to have really strong knowledge about what equipment out there is available. This can sometimes make a difference between an older person coping and not coping e.g. pick-up-stick, shower chairs, long-handled brush’s to wash out shower/bath. If workers have this knowledge it will go a long way to getting people to trial things that may assist them.

The training would need to be really targeted and focussed on the movers and shakers (in organisations providing HACC services) – it needs to work with the really ‘on-side’ people.

The curriculum is there in the disability sector. It’s about having a look what’s there and integrating that into the education we have got at the moment – we have the disability support workers - so now its just about transferring the essential things over – you talk about learned helplessness and once people have a grasp of that – it starts to come together for both for the staff and their clients.
For us we could do the project, we have done heaps before but it's about making sure the coordinators are trained because that's where your strength comes from – so they can support the staff working underneath and everyone knows the outcomes expected.

**Funding/Reporting**

When you are reporting back (to DADHC) I think you should be able to report on how much service you are not giving – 50 hours for six weeks would need to be equated to 12 months service.

**The pilot – project management approach**

In our dementia rehabilitation pilot, which was quite a big project, we had a designated person to gather all the information and check that the data was collected in an appropriate way.

**The pilot - service model**

I think the HACC flexi-service model (there is one at Kyogle and one at Evans Head) works extremely well for really isolated communities. The service does everything: as the Coordinator I do the assessments but we also provide MoW, social support, transport, support groups, respite and home mods. It’s like a one-stop shop and also because we are placed in the Neighbourhood Centre there are other services available too such as emergency relief, counsellors, Brighter Futures, Centrelink, indigenous workers. I think re-ablement could work with this model but would depend on how assessment is done.

If we want to see where the blocks are, isn’t that actually an argument for a larger pilot so it’s able to test some solutions too? What about larger but apply benchmarking – i.e. X type clients need this Y type of service, so keep it contained. Also it is good to include clients from those remote areas that already pose challenges for service provision.

It probably needs lead workers more than a lead agency i.e. similar to the ComPacks model where assessment is done as quickly possible and then services are brokered out depending on goal. Yes, I agree it needs a multi-disciplinary team but this team might vary depending on the client.

Because not one service here provides everything and even if you broker, you broker to more then one service at different times. If those services aren’t on board with the program or don’t have the cultural change needed to understand what re-ablement is all about then, how will you be able to evaluate the trial? So you either have to have one stand-alone service that provides everything, and because in the Tweed there isn’t one of these, then I think all services will have to be involved.

Something that works well on the Gold Coast is we had a HACC services consortium where Spiritus held the money and when a service provider had a client with needs then the money was accessed.

Consortium was originally modelled on the COPs but amended a little so not meeting to assess clients individually. However it ended up dissolving because so much money on the Gold Coast that participants were competing against the consortium. Because each
provider had respite dollars and social support dollars which they had
to provide outputs on – so the consortium just didn’t get used.

But the consortium did help us learn to work together; so where there
were organisations with a speciality it allowed you to tap into that for
your clients as well.

Looking at the whole of the FNC - a consortium model might work
really well. It has worked really well on the FNC in the past. If you
have a consortium model you will have management there,
management will have set it up. That’s going to be one of your key
things getting management to set it up. It’s not the workers-
management actually have to flow it down and it has to be done in a
constructive manner. If you do a whole lot of different things you may
end up with a whole lot of different objectives which may not be what
you want at the end of the day.

Is there something outside re-ablement research such as a change
management model that may assist the process?

To move it forward more quickly, what about going with agencies that
are already doing something similar – so they already have
management support and are addressing some of the cultural change
required?

I’d rather see something that didn’t just focus on personal care – I
know its less manageable when you incorporate lots of different
services but then you can be much more individual focused and you
really can provide holistic support for someone because its on an
individual, case-by-case basis. For one person it may be socialisation
and cooking, for another it may only be personal care. Once you
isolate them… e.g. if someone has an incontinence problem maybe
they might actually have a mobility problem i.e. find it takes them ten
minutes to get to the toilet – once you start chopping it up into little
sections you lose the ability to get to what’s the real underlying nitty
gritty problem – and the success rate may therefore be depleted.

### Intervention Suggestions

For community transport input what about something like a ‘travel
trainer’ (someone who educate clients on ticketing and trains clients
to use bus services)? But for it to work for us we would need to know
the parameters of it. We couldn’t put in lots of hours and not have any
trips come out of it, outputs are important for us. But could perhaps
provide something regionally that could be used by a number of
services (community transport service provider).

For MoW, client assessment is already being done but we could
move across our existing clients who might be suited to re-ablement.
We would like to see our clients relying on themselves more for some
of their meals. MoW sometimes provides clients with two or even
three meals a day. For most clients we provide five meals a week.
But people need 21 meals in a week – so for these clients MoW is a
very small component of their total meal needs. We would like to
encourage people to use their kitchens a bit more and learn to
prepare a few of their favourite things and make better meals.
What about an older men’s cooking group or Community Transport taking clients shopping?

Our experience is that clients are not interested in learning to cook – they just want a meal (MoW)

Also the Food Authority and new regulations around food handling have made it difficult to let the client get involved in food preparation. What about Transitional Care which provides clients with X meals per week and says the rest you have to cook yourself, and the client may just get take-away the rest of time; it does not support them learning to cook for themselves.

6. Do you think some service types are more appropriate than others?

We could start (Implementing a re-ablement approach) with one Coordinator and ten support workers now (Home Care NSW).

My service is a HACC funded dementia-specific Centre-based day care Centre. If we were going to take on this model for centre-based day care, for it to work overall as a multidisciplinary approach, it would also involve us having to work with the other services and having the other services be on board with that model of service and also agreeing to do it. Think in itself it would only cause complications by having to have multiple services doing different parts of the one Care Plan.

I think from Home Care’s point of view that they would probably find this model quite challenging because traditionally their focus has been just on personal care and domestic assistance, that’s been their focus and re-ablement would require a paradigm shift.

We could do what we currently do for our TACs Clients for other people too. Say they have just come out of hospital without TACs, then we could ease them back from services. Most clients are wanting to get back to their old lifestyle, and they often will take themselves off MoW.

7. Is there a priority order for these strategies/activities?

Firstly we need to identify the cohort we want to work with. Then is there something that could be learnt from Com Packs – these are a group of people who have been in hospital and returning home – they are de-conditioned, they have just had an episode of illness that has set them back, they are the perfect cohort.

Ideally the trial should be separated into separate projects so that you can get staff to begin to think in this way – this project is re-enablement. If work from there, then can roll out new training and develop skills specifically for this project. Once the concept has been grasped, the project has been set up and appropriate training undertaken, then step two would be to gradually begin to look at which of these skills should we begin to be looking at with other clients and in other situations.
(G) Think that a reasonable time for a pilot is 12 months up to two years. First you have to address core issues like the OT and then recruit your support staff. Even before that you would first of all have to establish a model and make sure you’re clear about the eligibility criteria and the client group you are trying to deal with and what you are trying to achieve. Then it would be about setting up the training and communicating to everyone about the approach to take with clients.

8. What support would your organisation need to adopt a re-ablement approach?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Will need to go out to the community and do community education.</td>
</tr>
<tr>
<td></td>
<td>Re-ablement program that takes services out to the community.</td>
</tr>
<tr>
<td></td>
<td>Think this model would suit our people, along with equipment</td>
</tr>
<tr>
<td></td>
<td>( Aboriginal service provider).</td>
</tr>
<tr>
<td></td>
<td>(G) Our service (home modifications) does not currently have</td>
</tr>
<tr>
<td></td>
<td>the capacity to be involved in a trial. Currently there is a wait</td>
</tr>
<tr>
<td></td>
<td>list of 4-6 weeks for small jobs and 8-12 weeks for larger</td>
</tr>
<tr>
<td></td>
<td>modifications. We desperately need another worker on the</td>
</tr>
<tr>
<td></td>
<td>building side and because we are so highly regulated it’s not</td>
</tr>
<tr>
<td></td>
<td>just a case of pulling someone in.</td>
</tr>
</tbody>
</table>

Supplementary Questions

9. How many assessments does your service currently do per week?

<table>
<thead>
<tr>
<th>Location</th>
<th>Assessments Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lismore</td>
<td>Between three HACC workers we do at least six a week (Mid Richmond Neighbourhood Centre).</td>
</tr>
<tr>
<td></td>
<td>For Com Packs in Lismore 10 and 18 in Casino/Ballina (NCAHS – Richmond COPS).</td>
</tr>
<tr>
<td></td>
<td>Currently 15-20 week but likely to go up to 40 (Home Care Service of NSW).</td>
</tr>
<tr>
<td></td>
<td>12 a week (Ballina District Community Services Association)</td>
</tr>
<tr>
<td></td>
<td>Two a day [ten a week) just in Lismore but our service covers three LGAs (Northern</td>
</tr>
<tr>
<td></td>
<td>Rivers Community Transport).</td>
</tr>
</tbody>
</table>

10. What capacity does your organisation have for your support workers and coordinators to undertake training in re-ablement?

<table>
<thead>
<tr>
<th>Location</th>
<th>Training Capacity Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lismore</td>
<td>We have 40 staff on team but we are always scrambling to allow our support workers do</td>
</tr>
<tr>
<td></td>
<td>training. Even half a days training for 10 people would severely stretch our service, it</td>
</tr>
<tr>
<td></td>
<td>creates big problems for back-up (Ballina District Community Services Association).</td>
</tr>
<tr>
<td>Tweed</td>
<td>We currently shut down one day a month and on that day we have staff meeting, review</td>
</tr>
<tr>
<td></td>
<td>clients and do training – we deal with all the important issues that needs everyone</td>
</tr>
<tr>
<td></td>
<td>together and if there is any specific external training on that I think staff should go</td>
</tr>
<tr>
<td></td>
<td>to – that’s the day we program it in. We could possibly cope with that</td>
</tr>
<tr>
<td></td>
<td>(Tweed Valley Respite Service Inc.).</td>
</tr>
</tbody>
</table>
In Home Care the funding dollar for training is tied to the amount of hours you get, e.g. if a Branch does 50,000 hrs it would get X amount of training dollars. Difficulty is the need to do the training two or three times because we are unable to pull all our workers off at the same time.

11. How long do you think it takes to affect cultural change in an organisation?

<table>
<thead>
<tr>
<th>Lismore</th>
<th>We have seen change take-up to three years.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With Com Packs there was an initial reluctance from staff but after 10 months it gained impetus and momentum and now staff find the program invigorating and energising.</td>
</tr>
</tbody>
</table>

Other Issues

12. Security of Tenure

<table>
<thead>
<tr>
<th>Lismore</th>
<th>Our focus is CAPs funding and there is whole question of security of tenure of service. How would complaints be handled even if client is happy for service to stop but a family member is not and they say they are going to complain to the Department? Who would the department support in this instance? It is very clear for CAPs that DOHA would NOT support the service provider. This issue would be a significant barrier for Feros in making this kind of shift to re-ablement and imposing time limits on programs. The whole process, including ending the service, would need to start from the very first contact with the client.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you look at this approach and look at the person-centeredness of the 'enable' then the person you should be supporting is the client. The daughter or other family member is not the client. If Mum says “I don’t want it” and the assessment says Mum can do it then the mother’s wishes should be what is respected.</td>
</tr>
<tr>
<td></td>
<td>Need to look at the process to begin with, when doing any type of goal setting program there needs to be communication with all the stakeholders and the family should be part of that. If family were involved from the beginning this would make this issue obsolete, maybe?</td>
</tr>
<tr>
<td></td>
<td>Surely if Mum is competent and has signed off on the Care Plan or something else, surely the service provider would be covered?</td>
</tr>
<tr>
<td></td>
<td>Whilst we all believe that family should be part of the consultation, there are a lot of fragmented families out there. Often I ask “would you like me to contact your family or anyone else?” Often the clients say “No we don’t talk to our son or daughter”. I will document that that was their choice. So if there is ever a Ministerial then its clear that is was the client’s wish not to have their child as part of their Care Plan.</td>
</tr>
</tbody>
</table>