Productivity Commission

Inquiry into Caring for Older Australians

Response to Draft Report

by

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Contains no confidential information

Thank you for the opportunity to respond to the ideas expressed in the draft report *Caring for Older Australians.* I will restrict myself in this response to what I believe is one of the most critical issues – whether the community care system as conceptualised within the report will actually promote the independence and wellness of older Australians, one of the stated primary aims of a future system. From my reading of the report I do not believe that the rhetoric of encouraging independence is presently accompanied by a model for service provision that will actively promote it and provide older people seeking assistance with the opportunity to maximise their independence and wellbeing.

Independence Paradigm

I have been arguing for a number of years that an independence paradigm for home care services is one in which individuals who are referred for support because they are having difficulties managing at home are first assisted to maximise their functioning across all domains before consideration is given to what ongoing services they might need. I consider that not only does such a strategy make absolute sense in terms of community benefit, because if the intervention is time-limited it is an efficient way of using limited resources by reducing the demand for ongoing services, but given that such assistance can be shown to be effective and can be provided cost effectively, being assisted to function as well as possible, whatever one's age, is surely a right that we would like to accord to everyone in our community. As stated in the report, it is also what older Australians told the inquiry:

*"they wanted 'support' in older age to be able to manage their own lives and remain independent (to the extent that is possible)"*p.76

Promoting independence - early intervention, prevention or care?

While I have in the past described Silver Chain's independence programs as both early intervention and preventative this was in terms of an individual's aged care career. Individuals participating in these programs are already experiencing difficulties and the programs aim to help them overcome these difficulties by helping them regain function or by doing things differently, as well as adopt strategies that are going to help them continue to age as well as they can. Hence I have in recent years referred to the programs as restorative. On page 143 of the report, in a paragraph that follows on immediately from a description of the current evidence for the effectiveness of restorative care, it is stated that one of the difficulties faced by governments is appropriately allocating resources between preventative and early intervention and care programs. It therefore appeared that restorative programs were being categorised as only about early intervention/prevention rather than being a critical component in a paradigm for the provision of home care services that actively promotes independence by addressing people's care needs in a different way.

Current evidence

As discussed in the report, a number of studies, both controlled trials and service evaluations, have been conducted around the world that have found restorative home care programs (or their equivalent) to be effective both in improving individuals' functioning and wellbeing and reducing their need for ongoing services . The report then goes on to say that more research is needed as there are still some unanswered questions, a statement that as a researcher I of course support. However it should be pointed out that the UK government considers that there is sufficient evidence to promote, support and fund the development of

home care re-ablement services across the country (£70 million in 2010, £150 million in 2011/12 rising to £300 million p.a. 2012-2015).

As the report noted, research to date, which includes a study we conducted in Silver Chain looking specifically at this issue, has not identified any particular characteristics of individuals that are associated with doing better in a re-ablement or restorative service (like Silver Chain's HIP). In the UK services are sometimes targeted just at individuals after hospital admission, and others at referrals for home care coming from the community, but within these broad target groups everyone receives the service. The results of a prospective longitudinal study comparing the cost effectiveness of traditional home care vs services that included re-ablement found that there is a 98% probability that re-ablement is cost effective for home care costs and 78% probability for health as well as home care costs. The randomised controlled trial we conducted on the home independence program (HIP) also demonstrated that receiving HIP before HACC (if still needed) is more cost effective, in terms of both aged care and health and aged care, than just receiving HACC for people over 65 who were referred for personal care and were not selected apart from not having a terminal illness or a diagnosis of a progressive neurodegenerative disorder. These results provide strong support for the adoption of an independence paradigm in which everyone referred for home care is given the opportunity to participate in a short term restorative program before receiving ongoing home care services if still required.

It should also be noted that while there is a body of evidence for the effectiveness of time limited restorative/reablement services, and also for a broad range of individual interventions eg exercise, home modification, task analysis and design, chronic disease self management, aids and equipment (again usually delivered as time limited interventions) there is no evidence yet, that I am aware of, that generic wellness-focused home care services as compared to more traditional services improve client outcomes. This is not to say that we should not therefore have a wellness focused system as theoretically such a system would result in better outcomes and would philosophically match the stated objectives for the system we and older people themselves clearly have. It is also important that if an individual is assisted to make functional gains via a restorative service that these gains are retained or are further built on, which is likely in a system which is focused on what people can do and helping them do as much as they can for as long as they can, rather than just doing things for them which has been the more traditional approach.

Critical elements of restorative approach as operationalized by HIP and UK reablement services

Before discussing the ideas presented in the PC report as to how restorative services fit into a reformed aged care system, I think it is important to understand how services such as HIP or reablement services in the UK work.

Target group: As already noted, the service is provided to everyone within broad target groups. For example in the HIP randomised controlled trial the service was provided to everyone over 65 who was referred for personal care, who were not terminally ill or had an advanced progressive neurodegenerative disorder. In the UK depending on the local government authority the target group is either: everyone referred for social care or just those referred from a hospital or from the community, regardless of age.

Assessment, goal setting and problem solving: Assessment is comprehensive multi-dimensional and in sufficient depth within each area of difficulty to understand the origin of the difficulty and together with the individual and family work out what their goals are and what strategies are likely to be most effective in helping them achieve their goals. The initial assessment often goes over two visits and is essentially ongoing throughout the service with a particular focus in the areas the client/family has identified as particular problems and wishes to address. There is also a focus from the start on assisting the older person and their family to overcome, or plan how to approach, both their immediate and longer term difficulties/problems. "Quick wins" are identified and implemented, as are solutions with longer lead times. For example: some basic aids and equipment eg. shower chair, non-slip strips in shower might be put in immediately or the individual/family is given information about other small aids and equipment and where to purchase them; referrals for larger pieces of equipment or for hand rails may be made.
As already noted, assessment is an ongoing process throughout the service and as individuals achieve their goals and re-establish independence they are discharged. A care plan for ongoing services, based on these assessments and discussion with the client and family, is drawn up for those individuals (about 30%) who still need assistance at the end of the restorative service, and services are arranged.
In one of the reports from the UK which reported on some interviews with reablement coordinators, one coordinator described the process as essentially an extended assessment and problem solving process which even if it didn't result in all individuals regaining any function it sorted out immediate problems and ensured a much better care plan going forward. (This is an important consideration for individuals with higher/more complex care needs that might be considered not to have "rehab potential" when considering whether everyone should be targeted by a restorative/reablement service)

Support: Care worker/rehab assistant visits to support essential everyday activities are provided if needed until independence is regained (eg. showering), or if needed more frequently than the coordinator/care manager visits, to support specific enablement/restorative strategies such as a strength and balance program etc. Phone support and follow up is used between face to face visits.

Core restorative/reablement strategies: Within Silver Chain's independence programs all the Care Managers (who are currently all health professionals) can implement any of the core program strategies regardless of their professional background and the discipline that a particular intervention originated from. However specialist referral can be made to a particular professional within the team if it is considered that clients' needs are not being adequately addressed within the program. In the UK the reablement service coordinators do not have to be health professionals but are given specific reablement training. Some teams do have OTs whilst other teams have to refer outside the team for OT or any other allied health or nursing service. My understanding is that no difference in client outcomes has been found between the teams with or without their own OTs.
Silver Chain, with funding through Health Workforce Australia, is currently developing training for Care Coordinators to be able to take on the Care Manager role in our independence programs. This training and all supporting documentation etc. will be available to other agencies.

Expectations: Individuals receiving a reablement or Silver Chain independence service know that it is time limited and that the idea is to help them overcome the difficulties they are experiencing and if they need ongoing support at the end of the service, that they will be referred to a service(s) that will provide that support.
Multivariate analysis of the outcomes for more than 4000 individuals who had participated in HIP showed that a client who was not already receiving home help services when they were referred was 5 times more likely to not require ongoing services on discharge than one who was.

Elements/key concepts of community care system in draft PC report and appendices

Australian Seniors Gateway: information, assessment (needs and financial) and referral, care coordination (if needed) and electronic client records

Building block approach: Restorative identified as a specialist service

Applied Aged Care Solution's Model for intake:

- Initial triage re information or assessment
- Two levels of assessment – eligibility and comprehensive
- Eligibility assessment possible by any mode; comprehensive face to face or telephone
- Access to low resource services not dependent on identified care needs and possible directly from level 1 assessment
- Access to restorative program only through level 2 assessment

Inconsistency of current recommendations/model with independence paradigm and current evidence

My primary concern is that restorative services are being defined as specialist services. Some of the problems I see with this are that:

- Restorative services would not be provided as the basic entry level of service whereas it is at that point in the care continuum that evidence for their efficacy exists and there is also some evidence that they are less effective when lower levels of service are already in place.
- Individuals with low resource needs would not be given the opportunity to maximise their functioning.
- As a referral to a restorative service following comprehensive assessment would be needed and there are no indications that individuals with particular characteristics should be targeted (as the majority benefit), that rather than most people being referred, it would work the other way and few people would be referred.
- Individuals referred to a restorative service would be assessed multiple times. This is currently happening in WA within the new assessment framework. An individual who is referred to HIP has already been assessed for eligibility by the CRCC, then received an an in-depth assessment by the regional assessment service (RAS), then is assessed within HIP and if they require ongoing services are referred back to the RAS for assessment and care planning.
- How the restorative service would be funded and how this could be done without inadvertently incentivising the service to retain clients longer than necessary or encourage clients to become independent as quickly as possible, is not clear.

- If restorative services remain as specialist services and the domain of health care professionals it is likely that there will be delays before individuals receive the service as there is a shortage of community-based allied health care services. This will be another reason not to refer to them. Also if restorative services are developed as specialist services within professional groups rather than as an inter-disciplinary or generic program individuals will be less likely to have the opportunity to maximise their functioning across all domains.

Refined model - Independence services as part of the Gateway

The alternative I propose is a model in which there are independence services as an integral part of the gateway. They would be basic entry level services available to everyone experiencing difficulties managing in the community who was not terminally ill or had an advanced degenerative disorder. They would operate very similarly to the reablement services in the UK or to Silver Chain's independence services, as described earlier in this paper. They would be staffed by care coordinators with high level assessment skills who were committed to an independence philosophy and had also received training in reablement/restorative interventions as well as problem solving and coaching. The independence coordinators would themselves be supported by a multidisciplinary team of health professionals who would be available for specialist referrals and provide ongoing mentoring and support. Eligible individuals who wished to receive the service would be referred after the initial eligibility assessment, the service would be limited to 6 weeks unless the care coordinator could support an extension on the basis that progress towards a client achieving their goals would be severely compromised. The care coordinator would complete the financial assessment and care plan for those individuals requiring ongoing care. The restorative service itself would be free to encourage people to participate.