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The reablement function on My Aged Care is designed so that the Support Plan can be finalised but also kept open for the support period to allow additional edits to be made (by the assessor who completed the assessment). The timeliness Key Performance Indicator (KPI) will not be impacted. The timeliness KPI ends at the "finalise Support Plan & keep open for support period."

For a smaller sub-set of older people, CHSP restorative care may also be appropriate, where assessment indicates that the older person has potential to make a functional gain. Restorative care under CHSP involves evidence-based interventions led by an allied health worker or professional that allows a person to make a functional gain or improvement after a setback, or to avoid a preventable injury.

The department's expected proportion is that assessment organisations recommend a period of reablement, which will include reablement based strategies and short-term support from the Aged Care Assessor and, where required, a referral to short-term CHSP Reablement based support services, to a minimum of 10% of older people.

The following Steps/Activities are required for facilitating reablement:

- Consider if the older person would benefit from short-term reablement support, particularly if the older person has experienced some functional loss and expresses the desire to improve independence and/or regain confidence and capacity to resume activities, including connecting with their community.
- Consider assistive technology or home modifications for reablement support. Support at Home participants for example, if the older person would benefit from a shower chair under the AT-HM scheme or for CHSP clients, an equipment and products referral to assist them with showering and preserve their dignity, instead of having a support worker to attend and shower them.
- Where reablement is to be provided by one or more CHSP providers, recommend a period of reablement on the older person's Support Plan. This function allows assessors to identify older people who would benefit from reablement and allow assessors to make changes to the older person's Support Plan during the reablement period. Users accessing the older person's record (such as older people and service providers) will be informed that the older person is undergoing a period of linking support and/or reablement.
- Focus on elements of functional tasks that an older person can complete, and discuss what specific assistance they would benefit from in order to complete the task by themselves (to maintain and continue the independence to live at home)
- Discuss strategies an older person can employ to more easily manage day-to-day tasks (e.g., transport planning to meet goals around the use of public transport to maintain usual activities)
- It is important to ask what goals the older person wants to achieve. This can be as simple as making a cup of tea without help, or to understand their bus timetable. A goal could be walking to the local bus stop to go shopping, or to get to regular senior's events. Even small goals go a long way towards building self-confidence and regaining (or maintaining) skills to get back to doing things for oneself, to be more independent;
- When looking at what goals the older person could achieve, start by asking what a good day looks like for them? Then work out with the older person what goals they need to achieve to have more of those good days.
- Consider the older person's need for a mix of short-term, episodic, or ongoing services across CHSP service types (e.g., short-term personal care, episodic allied health, ongoing transport). Review this approach regularly to ensure the intensity of services matches the older person's needs.

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- Maintain regular contact with the older person and providers and during the period of reablement.
- In consultation, determine when the reablement period should be finalised and what ongoing support (if any) may be required for the older person.
- Develop local knowledge of reablement-type services in the region. Discuss with local providers their capacity and willingness to take on short-term older people as part of a reablement episode.
- An expanded in-depth description of Supporting Independence: Reablement including older person scenarios is at APPENDIX E – Wellness and reablement.

Department of Health, Disability and Ageing website:

- Commonwealth Home Support Program (CHSP) 2025-27 Manual | Australian Government Department of Health, Disability and Ageing
- Wellness and reablement resources
- Living Well at Home – CHSP Good Practice Guide

5.10.2. Linking supports

The department has established services that will assist clients requiring support to access aged care services, including Care Finders, and Elder Care Support services.

Where a client's complex circumstances may be impeding their access to aged care services, linking service support will assist in linking them to the various services they require to live in the community with dignity, safety and independence. The aged care needs assessor must determine if a client requires linking support.

Linking service support activities are aimed at working with the client to address areas of vulnerability that are preventing access to receiving mainstream aged care support, to the extent that the client is willing or able to access aged care services. The issues include homelessness, mental health issues, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage and cognitive decline.

Linking service support through the assessment organisation is limited to short-term case management or care coordination to the Point of Effective Referral. It is not designed to provide ongoing support services. The role of the aged care needs assessor is finalised when:

- a referral for services is accepted by a service provider.
- the client has accepted responsibility for managing their own referral for services;
- the client has made a choice not to proceed with aged care needs assessments or aged care needs assessment related services; or
- the outcome of the aged care needs assessment is that no further action is required by the aged care needs assessor.

Elder Care Support workers can be key partners in delivering culturally safe, trauma-aware, and healing informed assessments. With a client's consent, Elder Care Support workers could attend an assessment to provide trusted experience for the older person. The assessor should work closely with Elder Care Support staff to facilitate a warm handover.

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This collaboration ensures continuity of care and supports a culturally safe and trusted transition for the older person into aged care services.

If an Elder Care Support worker has not been engaged prior to the assessment, the assessor should assist the older person in connecting with Elder Care Support services delivered by Aboriginal Community Controlled Health Organisations. This support can help build trust, improve understanding of the aged care system and facilitate a smoother transition into services.

Department of Health, Disability and Ageing website:

- List of Elder Care Support Providers | Australian Government Department of Health, Disability and Ageing

If longer term support is needed, with consent from the older person, Elder Care Support workers or care finders should be engaged to help clients navigate the aged care system.

Key Performance Indicators have been set by the department for assessment organisations to increase the referral of older people to time limited Linking Services Support. This KPI specifies that 2.5 per cent of all clients will receive a time-limited Linking Services Support to address areas of vulnerability that are preventing access to receiving mainstream aged care support. Support may include short-term case management and non-aged care support.

Delivering linking support/care coordination to vulnerable older people

Facilitating linking support can greatly benefit some older people whose circumstances may impede their access to aged care services. Linking support may be conducted by providing short-term case management or care coordination to the point of effective referral. Activities are aimed at working with the older person to address areas of vulnerability which prevent access to receiving mainstream aged care supports or care, to the extent that the older person is willing or able to access aged care services. Issues leading to vulnerability could include homelessness, mental health concerns, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage, cognitive decline and/or living in a remote locality.

Assessment organisations are expected to provide short-term case management services for vulnerable older people who require linking services.

Identifying a vulnerable person for linking support

The IAT is designed to assist an assessor to identify the complexity of an older person who may require linking support. Assessor judgment also plays a significant role, noting the presence of the same risk in different people may signify varying degrees of vulnerability. If applicable, the assessor selects from the following complexity indicators.

The older person:

- is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, wellbeing, and ability to remain living in the community,
- is at risk of, experiencing (or suspected to be experiencing) abuse,
- has emotional or mental health issues which significantly limits self-care capability, requires intensive supervision and/or frequent changes to support,

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- is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support,
- has experienced adverse effects of institutionalisation and/or systems abuse (e.g., spending time in institutions, prisons, foster care, residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and wellbeing,
- is exposed to risks due to drug and/or alcohol related issues and is likely to cause harm to themselves or others,
- is exposed to risks or is self-neglecting of personal care and/or safety and is likely to cause harm to themselves or others,
- has a cognitive impairment (e.g. memory problem or confusion) that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support.

The assessor may also need to consider challenges faced for people living in remote or very remote regions.

The assessor then selects, if applicable, the 'Risk of Vulnerability Cohort' from the following options within the IAT

a) from a culturally and linguistically diverse background
b) an Aboriginal and/or Torres Strait Islander person
c) Living in a rural or remote area
d) Financially or socially disadvantaged
e) A Veteran
f) Homeless
g) at risk of being homelessness
h) a Lesbian, Gay, Bisexual, Transgender or Intersex person
i) A person separated from your parents or children by forced adoption or removal
j) A socially isolated individual
k) Other (assessor to specify)

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Further information on identifying and supporting vulnerable cohorts is included in Chapter 12: Supporting diverse experiences and needs.

Following this, the assessor will decide whether the person would benefit from Linking Support by considering and selecting (if applicable):

(a) whether complexity indicators impact the older person's ability to live independently in the community

(b) whether urgent intervention is required and

(c) whether the older person has indicators that impede access to delivery of aged care services.

Where the access to delivery of aged care services might be impeded, the assessor is to recommend Linking Support and short-term case management.

Linking support and short-term case management activities

The level of linking service support offered by assessors is time-limited and is not designed to provide ongoing support services.

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However, it is understood that in some circumstances due to ECS services not being available in their area or due to preferences of older people who have already established trusted relationships with an assessor from an Aboriginal and Torres Strait Islander assessment organisation, an assessor may have a role in providing ongoing case management services to their clients.

The activities that an assessor chooses to undertake when providing linking support will be dependent on the needs, circumstances, and preferences of the older person, and may include one or more of the following:

- **Information provision and tailored advice –** provision of clear, reliable, up-to-date, and relevant information and advice to older people regarding service options and pathways.

- **Guided referral** – facilitation and management of the process of linking a vulnerable older person to appropriate service pathways within or outside the aged care system. This includes monitoring the success of the referral process and ensuring that linking to the appropriate services is achieved.

- **Service coordination –** where an older person's needs are complex and require a range of services spanning multiple sectors, the assessment organisation oversees the coordination of these services.

- **Advocacy activities –** for the vulnerable older person to gain access to the identified support services, the assessment organisation may be required to speak, act, and write to the identified service providers on behalf of the vulnerable older person.

- **Case conferencing/multidisciplinary service coordination –** provision of comprehensive, integrated service coordination for older people with high-level needs. This involves using a case conferencing/multidisciplinary service coordination approach which brings together a number of team members and a suite of services across sectors in order to meet the older person's needs at different levels.

- **Establish local knowledge and networks –** the assessment organisation establishes local connections with service providers which support vulnerable people in their region.

- **Administrative tasks –** establish and undertake the administrative functions necessary to support the smooth and seamless progression of vulnerable older people through the required services. Some examples are:
    - Contact the relevant service providers on behalf of the older person (e.g., legal services, health services, housing services etc.)
    - Obtaining the necessary older person information from various sources and organisations
    - Compiling and completing the necessary forms on the older person's behalf
    - Organising relocation services for the older person, if required (e.g., removalist and utility services)
    - Organising cleaning services for the older person's place of residence, if required
    - Documenting the older person's progress.

It is expected that assessors will work closely with vulnerable older people on a low income, or who are living with hoarding behaviour or in a squalid environment and at risk of homelessness, or who are unable to receive the aged care services they need. Where there

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