Evaluation of the Better Ageing: Promoting Independent Living budget measure

for the Australian Government Department of Health

May 2021

AHA Australian Healthcare Associates
Australia's largest health & human services consulting firm

Suggested Citation

Australian Healthcare Associates, 2021, Evaluation of the *Better Ageing: Promoting Independent Living* budget measure, Australian Government Department of Health.

AHA Australian Healthcare Associates
Level 6, 140 Bourke St, Melbourne VIC 3000
Locked Bag 32005, Collins Street East, VIC 8006
1300 242 111
aha@ahaconsulting.com.au
www.ahaconsulting.com.au

Acknowledgement of Country

In the spirit of reconciliation, the authors acknowledge and pay respect to the traditional custodians of Country, the Aboriginal and Torres Strait Islander peoples, and their continuing connection to land, waters, sea, and community.

AHA is located on the lands of the Kulin Nation. We pay respect to Elders past and present.

Abbreviations

Term	Definition
AC-ID	Client Aged Care Identification
ACAT	Aged Care Assessment Team
ACNA	Access Care Network Australia
ACPR	Aged Care Planning Regions
ADL	Activity of daily living
AHA	Australian Healthcare Associates
ANOVA	Analysis of Variance
APP	Australian Privacy Principles
AT	Assistive technology
AX-ID	Unique Client Assessment Identification
CCF	Aged care clients, their carers and families
CE	Confidence ellipses
CHEERS	Consolidated Health Economics Evaluation Reporting Standards
CI	Confidence intervals
CHSP	Commonwealth Home Support Programme
DARP	Data Access and Release Policy
DEX	CHSP service utilisation data from Department of Social Services Data Exchange
DSS	Department of Social Services
EQ-5D-5L	5-level EQ-5D, a measure of health-related quality of life
FAQ	Frequently asked questions
FTE	Full-time equivalent
GP	General practitioner
GST	Goods and service tax
HRQOL	Health-related quality of life
ICER	Incremental cost-effectiveness ratio
IT	Information technology
LGBTI	Lesbian, gay, bisexual, transgender and intersex
M	Mean (average)
N-R	Non-reablement (clients who did not undergo reablement)
NSAF	National Screening and Assessment Form
OT	Occupational therapy
PIL	Promoting Independent Living budget measure
PWI	Personal Wellbeing Index, a measure of subjective wellbeing
QoL	Quality of Life
R	Clients who underwent reablement

Term	Definition
RAS	Regional Assessment Services
ROC	Rest of country
SD	Standard deviation
SLK	Statistical Linkage Key
SMART goals	Specific, measurable, attributable, realistic and time-bound goals
the department	the Australian Government Department of Health
W&R	Wellness and reablement

Contents

Tables

Figures

1 Executive summary

The Department of Health (the department) engaged Australian Healthcare Associates (AHA) to evaluate the *Better Ageing: Promoting Independent Living* (PIL) budget measure. The evaluation was conducted between February 2019 and December 2020.

1.1 PIL budget measure

The PIL budget measure allocated $29.2 million to trial and strengthen reablement approaches within entry-level aged care.

The aim of the measure was to support Regional Assessment Services (RAS) and Commonwealth Home Support Programme (CHSP) providers to deliver services that promote greater client independence, thereby reducing or delaying the need for more complex aged care support services.

The measure comprised a trial of a reablement model and a range of national complementary support strategies.

1.1.1 Reablement trial

The trial model has 4 main components:

1. **Active assessment** that enables identification of the client's degree of skill and functional level and guides the choice of goals and strategies that are introduced.

Reablement interventions for clients assessed as potentially benefiting from reablement:

2. **SMART goal setting** that identifies areas where new and existing skills can be developed and enhanced, and then monitors and reviews these goals. This is a vital component, as goals are key to successful reablement.

3. **Broad reablement strategies** or interventions that address areas of need and focus on building or maintaining a client's independence. This can include the provision of **time-limited CHSP services** and other interventions, a hallmark of reablement.

4. **Follow-up**, in which contact is maintained with the client throughout the 8 to 12-week reablement phase to provide encouragement and allow the individual time to practise and learn new skills and techniques. Coaching support is provided over the telephone or in the home. Regular review allows strategies to be refined and provides the opportunity to reinforce and support achievement.

The PIL measure provided funding to:

- train assessors at 5 RAS organisations regarding the trial model
- these 5 RAS organisations to conduct assessments based on the trial model.

Evaluation of the trial model examined:

- training provided to 140 assessors and 12 reablement mentors at 5 trial RAS organisations
- 17,118 trial model assessments and 13,327 traditional (control group) assessments conducted across 20 Aged Care Planning Regions, from July 2019 to June 2020
- CHSP services recommended and those provided, short and long term
- client-reported outcomes.

1.1.2 Complementary supports

The nationwide support strategies are designed to assist CHSP service providers and older Australians, as well as their families and carers, to adopt wellness and reablement approaches. There are 4 strategies:

1. **CHSP provider change management** tools and other supports to assist CHSP providers to embed wellness and reablement (W&R) practices.
2. **CHSP provider workforce training** available in 4 delivery methods:
   a. e-learning modules
   b. podcasts
   c. face-to-face learning
   d. workplace trainer's toolkit.
3. **Community of practice collaborative website,** involving staff from CHSP providers, RAS organisations and the Department, to share better W&R practice and case studies.
4. **Communication resources** to promote acceptance and uptake of W&R approaches, targeting aged care clients and health professionals working with these clients.

Due to the impact of COVID-19 and other issues, implementation of these strategies was delayed until after the conclusion of this evaluation, and therefore did not contribute towards the trial outcomes.

The objectives of the PIL evaluation were:

- to assess the appropriateness, effectiveness, cost effectiveness and implementation of the reablement trial model and the complementary support strategies
- to identify the enablers and challenges to implementing the reablement trial model that promotes greater independence and reduces reliance on ongoing services.

This report presents the evaluation findings in relation to these objectives, and identifies the broader implications, lessons and future considerations for reablement approaches in aged care.

1.2 Findings and conclusions

The aged care sector needs to continuously change to keep pace with an ageing Australian population. People are living longer and generally want to stay in their homes for as long as possible.

However, the ability to keep up with changing needs has not always been demonstrated, as evidenced by the 2017 *Legislated Review of Aged Care,* the 2019 Royal Commission into Aged Care Quality and the *Safety Interim Report*. Traditional models of service delivery that focus on 'doing for' rather than 'doing with', and an over reliance on services by clients, has been linked to accelerated functional decline.

1.2.1 Conclusions

The trial model's focus on active assessment, increased reablement opportunities and client follow-up – amounts to a substantial shift away from the traditional model of assessment. Compared with the traditional model, the trial model is substantially better at identifying reablement opportunities. Rates of clients undergoing reablement increased from 13% at the commencement of the trial to 30% at the end of the trial. This is a significant achievement within 12 months and well above the department's 10% reablement target for RAS organisations.

Despite the scale of this shift, the trial model was successfully embedded within the 5 RAS organisations that participated in the trial. All saw considerable benefit from this approach and 4 advised that they would continue its use beyond the trial.

The trial demonstrated that active assessment is more appropriate, more effective at identifying reablement opportunities and is cost-neutral, compared with the traditional approach.

It was found that once assessors were trained, the cost of an active assessment was similar to the cost of a traditional assessment. Client follow-up throughout the reablement period adds an extra $51 per client per year, however this cost is offset by reduced CHSP service utilisation, saving approximately $100 per client per year.

It was found that active assessment leads to reduced and different service recommendations – for both reablement and non-reablement clients. CHSP service utilisation for trial clients cost around $100 less per year on average, compared to clients assessed using the traditional model. This is largely because trial clients were more likely to receive no CHSP service recommendation. 5% of reablement trial clients and 11% of non-reablement trial clients received no service recommendation following assessment, compared to 1% and 6% for control group clients.

This shift would have a growing impact on the CHSP program if implemented and embedded more broadly.

However, the trial model did not:

- lead to substantial increases in client wellbeing, instead delivering only modest improvements for reablement clients
- increase the rate of short-term services, a hallmark of reablement. This indicates that reablement practice in Australia is not consistent with the principle of a time-limited intervention.

These two negative outcomes are likely because the trial model was essentially an assessment intervention involving RAS organisations, which did not directly involve CHSP providers. More would need to be done after assessment and during reablement to deliver greater benefits to clients.

The evaluation revealed an inconsistent understanding of what reablement means in practice and a complex, and at times disconnected, system of RAS organisations and CHSP providers. Once released, the planned complementary support strategies will likely assist towards addressing this disconnect and in strengthening wellness and reablement approaches.

In Part 3: Lessons, of this report, a reablement model is suggested that would alter the allocation of short-term vs ongoing services at assessment, to better embed the principles of reablement into entry-level aged care.

1.2.2 Implementation of the trial

The trial involved 4 components:

- Active assessment of clients

Reablement interventions, for clients assessed as potentially benefiting from reablement:

- SMART goal setting
- Broad reablement strategies, including time-limited CHSP services where appropriate
- Follow-up of clients throughout the reablement period.

Active assessment

Active assessment was implemented well. RAS assessors received effective training which, combined with ongoing support from mentors, enabled them to conduct active assessments confidently. This led to a significant increase in the rates that clients were recommended reablement in trial regions, along with changes to service recommendations, as described in the following section on trial outcomes.

Reablement interventions

The first 2 components – SMART goal setting and development of broad reablement strategies – were well understood but represent a significant change from traditional practice, and it therefore took time for them to be fully implemented by RAS assessors.

The client follow-up component of the model was poorly implemented, with less than half (45%) of the trial clients receiving follow-up. Factors which contributed to this included:

- inadequate assessor training regarding client follow-up
- lack of guidance about how assessors should conduct follow-up
- unclear and inconsistent approach to recording follow-up activity in the My Aged Care IT system.

Lack of follow-up can reduce the effectiveness of the reablement period and jeopardise reablement success. Effective coaching support for clients is vital for reablement, principally because ongoing coaching support helps maintain a client's motivation so that they can sustain functional improvements. Checking-in with the client also enables strategies to be refined as the client's situation changes, in order to meet reablement goals.

1.2.3 Active assessment outcomes

The trial demonstrated that active assessment is superior to the traditional assessment approach – it is more appropriate, more effective at identifying reablement opportunities and is cost-neutral. Once assessors are trained, active assessments are no more costly than traditional assessments.

Active assessment also led to reduced and different service recommendations for both reablement and non-reablement clients. Fewer clients were recommended for CHSP services and the type of services recommended varied – for example, fewer domestic assistance and transport services.

This change would have a growing impact on the CHSP program if implemented and embedded more broadly.

All RAS organisations participating in the trial embraced an increased emphasis on reablement – demonstrating that it is an opportune time to consider the future directions for reablement.

Appropriateness

Active assessment is more appropriate than the traditional assessment in several ways:

- makes it **easier to screen for reablement opportunities**, thereby building the foundation for maximising wellness and reablement opportunities across entry-level aged care. Assessors consistently reported that client prospects for reablement – whether good or poor – were more easily confirmed at active assessment.

- **provides a more holistic and evidenced-based approach to assessment.** Clients, through the 'show me' approach, could more readily demonstrate their strengths and weaknesses, and assessors reported that they could better identify safety issues and risks in the home.
- **encourages more defined reablement goal setting and tailored reablement strategies.** More open conversations with clients, reportedly led to more targeted questions, which in turn led to the agreement of more specific goals and strategies.

Effectiveness

As well as being more appropriate for promoting greater independence and reduced reliance on ongoing services, active assessment also proved to be more effective as it:

- **identifies more reablement opportunities.** In the trial regions, the proportion of clients undergoing reablement increased from 13% prior to the trial to 30% by the end of the trial. This contrasts with 17% reablement rate at the end of the trial for the rest of the country (excluding WA and Victoria)
- identifies client needs and **matches these to appropriate services**, thereby reducing the rates at which CHSP services are recommended following a RAS assessment, for both reablement and non-reablement clients. No service was recommended for:
  - 5% of reablement trial clients and 11% of non-reablement trial clients; compared to
  - 1% reablement and 6% non-reablement for control group clients.
- encourages assessors to recommend **broader, more tailored supports**, including supports not funded by the CHSP program (general recommendations), particularly:
  - low-risk assistive technology (AT) products
  - services that are similar to those available under the CHSP, for example transport and domestic assistance
  - other strategies for independence.

Trial clients were almost twice as likely as control clients to receive one or more general recommendations (46% and 24% respectively). These general recommendations were specifically targeted towards reablement and client independence. General recommendations are not funded under the CHSP program and can include any strategy or community funded intervention.

Assessors were also more likely to make unique general recommendations tailored to client need, rather than repeating standardised general recommendations – a practice which was observed in non-trial regions.

Client wellbeing

A client wellbeing measure was used to assess the following 7 life domains: standard of living, health, achievements in life, relationships, safety, community connectedness and future security.

It was found that active assessment led to a small but statistically significant improvement in reablement client-wellbeing after 6 months. All other clients reported a decline in wellbeing over the period, including those who had traditional assessments.

Despite this modest improvement for trial reablement clients, they remained at a lower level of personal wellbeing than all other cohorts throughout the 6-month period.

Our assessment is that trial client wellbeing outcomes were diminished or not achieved due to 2 key factors:

- About 20% of all clients did not receive the CHSP services recommended at assessment, including reablement period services. This likely compromised client wellbeing. This also suggests significant unmet demand for most CHSP service types, including allied health, domestic assistance, and transport.
- The planned PIL complementary support strategies were not implemented during the trial.

This meant that the reablement trial was essentially a trial of a RAS assessment intervention only – unsupported by CHSP providers and other parts of the aged care system. For example, complementary supports such as training and change management strategies targeting CHSP providers would have reinforced the increased emphasis on reablement and, if effective, would have led to better client outcomes.

1.2.4 Cost effectiveness

It was found that once assessors were trained, the cost of an active assessment was similar to the cost of a traditional assessment.

Client follow-up throughout the reablement period adds an extra $51 per client per annum, however this cost is offset by reduced CHSP service utilisation, saving approximately $100 per client per annum.

Trial model costs

The trial model cost $238 per client more than the traditional model, comprising an extra:

- $129 for RAS assessor training
- $54 for RAS mentor resources
- $55 for additional time spent conducting assessments and follow-up.

This additional cost is estimated to reduce to $51 per client for subsequent years, as the training costs and need for mentors diminish.

This additional $51 per client is largely due to the client follow-up component. During post-trial interviews, RAS managers indicated that the active assessment component of the trial model, once embedded, could be conducted within the time allocated for traditional assessments.

Once embedded, active assessment (without follow-up) is therefore cost-neutral compared to traditional assessment. Benefits from active assessment, such as more appropriate and tailored service and general recommendations, could therefore be realised without material change to RAS funding allocations. However, additional potential benefits could be realised through client follow-up if implemented effectively.

CHSP services and cost

CHSP service utilisation for trial clients cost around $100 less per client per annum, compared to clients assessed using the traditional model. This saving is largely because trial clients (both reablement and non-reablement) were less likely to receive a recommendation for a CHSP service.

However contrary to expectations, where clients were recommended for CHSP services, there was no evidence that the trial model led to more short-term services (up to 12 weeks) and fewer ongoing services. This was not expected as reablement interventions are designed to be time-limited.

Linkage of CHSP service utilisation data to My Aged Care data found that reablement clients and non-reablement clients – from the trial, WA and Victorian regions – had a broadly similar service profile in terms of the proportion who receive short-term vs ongoing services.

In fact, despite WA and Victorian reablement models being purportedly more mature, fewer of their clients received short term services (both 25%) compared to the trial (28%) and rest of country (29%) cohorts.

Once implemented, the trial model:

- costs $51 more than traditional assessments, due to the extra time involved in client follow up during the reablement period.
- results in CHSP service cost savings of $100 per client per annuum, due to relatively more clients being assessed as not requiring any CHSP services.

While the trial showed that active assessment results in more clients not being recommended for CHSP services, there is no evidence that the interventions for reablement clients are more time-limited than for non-reablement clients.

If the trial model was implemented nationally, it is estimated that for new clients receiving a RAS assessment there would be a $6.2 million additional cost outlay in the first year, and subsequent savings of $6.7 million in the second year and $6.9 million in third year.

839,373 clients received CHSP services in 2019-20, at a cost to government of approximately $2.53 billion. In this context the additional cost to implement the trial model is relatively small and is offset by subsequent cost savings.

These estimates do not include potential 'downstream' costs savings through deferring clients' need for other services such as residential aged care and hospital services.

1.2.5 Lessons from implementation

As detailed in Part 3: Lessons, of this report, the trial provided several positive lessons, as well as revealing how parts of the aged care system will need to change if the promising trial results, and reablement more broadly, are to be fully effective.

National implementation would require substantial change management for RAS organisations, CHSP providers and the community in terms of their expectations of home care. If the trial model is implemented effectively it would assist in preparing the home care sector to meet the changing needs of the ageing Australian population.

A highlight of the trial was the strong support by all levels of RAS organisations for the trial model. RAS organisations saw considerable advantages to this approach compared with the traditional approach.

Despite early challenges, these RAS organisations built a shared understanding of reablement – absent at the outset of the trial – and enthusiastically supported an increased emphasis on reablement in entry-level aged care.

The assessment outcomes presented in Part 2: Outcomes of this report, show the substantial and positive change in assessment practice achieved. Trial RAS organisations continue to apply the trial model despite the trial ending. This momentum can be built on and presents an opportunity for the department.

Other lessons which could be relatively easily addressed are the need to:

- develop guidance for the remaining RAS organisations to implement the trial model
- enhance the My Aged Care IT environment.

The remaining lessons however, point to systemic factors that will take some time to overcome and which therefore pose greater challenges for the department.

The department's draft documents and resources for the PIL budget measure – including the CHSP provider training and change management resources, and the broader communication resources – address some of the lessons outlined below. But they will need to be part of a broader sustained strategy to overcome the more challenging barriers.

A key challenge is the need to rethink the relationship between RAS organisations and CHSP providers. Although the system was intentionally designed for each to operate separately, this has been over emphasised and at times the relationship has become dysfunctional.

This makes it difficult to respond to time-limited service interventions, a hallmark of reablement, and can compromise effective collaboration and coordination to ensure clients' needs are met. For clients undergoing reablement and those with complex needs, this is particularly important.

Other lessons from the reablement trial, that should be considered for a broader rollout of W&R approaches across aged care, include the need for:

- client expectations of automatic CHSP service entitlement – a demonstration of entrenched attitudes – to be shifted progressively over time
- operational models of RAS organisations and CHSP providers – which currently do not fully support the trial model – or an increased focus on reablement of entry-level aged care clients
- sufficient CHSP services to be available to meet increasing rates of clients undergoing reablement, particularly reablement-focussed service types such as allied health services and assistive technology (AT)
- consistent understanding of, and approaches to, wellness and reablement to be embedded throughout the aged care system.

1.3 This report

Given the breadth of the PIL budget measure, the evaluation report comprises 4 parts:

Part 1: Executive summary. An overview of the measure and the evaluation findings, including trial outcomes and their implications, lessons learnt and how this can inform future directions.

Part 2: Outcomes. Analysis and exploration of the appropriateness, effectiveness, and cost-effectiveness of the reablement trial.

Part 3: Lessons. Findings and lessons about the preparedness, support and implementation of the reablement trial. This part also addresses the implications for embedding the trial model and reablement more broadly into entry-level aged care to inform policy and program design.

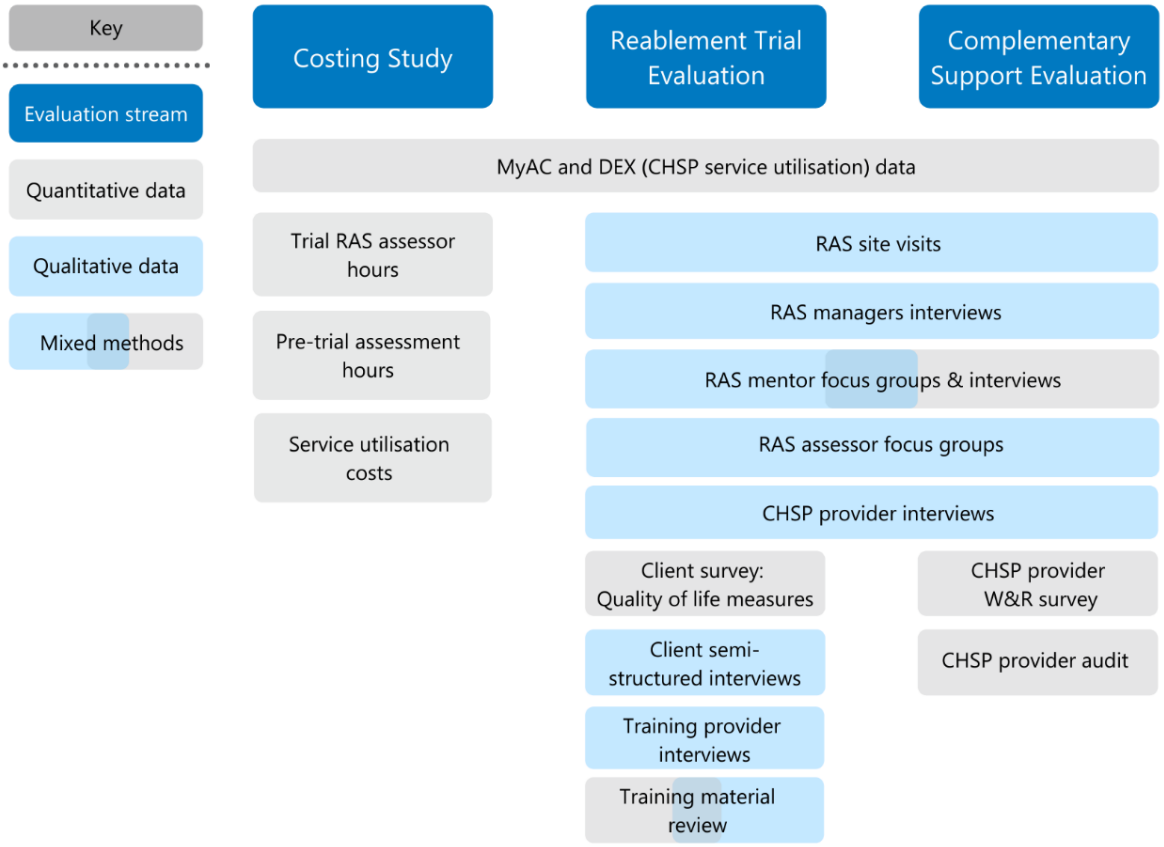
Part 4: Technical supplement. A transparent outline of the methodology, including the trial protocol, cost-effectiveness evaluation approach and explanation of the data sources used to inform the entire evaluation. This part also provides supplementary data tables for Parts 1, 2 and 3.

1.4 Data sources and trial samples

Evaluation activities were conducted from February 2019 to December 2020. As shown in Figure 1-1, there were 3 main evaluation work streams:

- costing study
- reablement trial evaluation
- review of the complementary support strategies.

Figure 1-1: Data sources for each evaluation stream



17,118 trial assessments and 13,237 control (traditional) assessments were conducted from July 2019 to June 2020. Evaluation data was drawn from several samples depending on the data source and time period, and whether the client consented to the collection of quality of life data.

To allow client and service outcomes to be considered within the evaluation timeframe, the evaluation focused on assessments conducted during the first 6 months (July to December 2019), totalling 7,113 trial and 5,553 control clients.

Of this 'first 6-months' cohort, a subgroup of 3,002 trial and 1,561 control clients consented to participate in the trial and allow their client outcomes to be assessed. Of this subgroup, reliable client-reported outcomes data was obtained and analysed for 1,127 trial and 440 control clients.

2 Outcomes

This Part 2 of the report addresses the following evaluation objective:

- Assess the **appropriateness**, **effectiveness** and **cost-effectiveness** of the reablement trial model.

It presents findings regarding the trial outcomes. It compares the trial assessment, client and service outcomes with those of the traditional assessment approach of RAS organisations; and provides a cost-effectiveness analysis. This part is set out as follows:

Section 1: Reablement trial

Section 2: Evaluation samples

Section 3: Conclusions

Section 4: Appropriateness, examines how well the trial assessment approach met individual client need and if it was 'fit-for-purpose'.

Section 5: Effectiveness, includes assessment outcomes, client-reported outcomes, and service outcomes.

Section 6: Cost-effectiveness, compares the costs of the trial and traditional assessment approaches.

2.1 Reablement trial

The trial model has 4 main components:

1. **Active assessment** that enables identification of the client's degree of skill and functional level and guides the choice of goals and strategies that are introduced.

Reablement interventions for clients assessed as potentially benefiting from reablement:

2. **SMART goal setting** that identifies areas where new and existing skills can be developed and enhanced, and then monitors and reviews these goals. This is a vital component, as goals are key to successful reablement.
3. **Broad reablement strategies** or interventions that address areas of need and focus on building or maintaining a client's independence. This can include the provision of **time-limited CHSP services** and other interventions, a hallmark of reablement.
4. **Follow-up**, in which contact is maintained with the client throughout the 8 to 12-week reablement phase to provide encouragement and allow the individual time to practise and learn new skills and techniques. Coaching support is provided over the telephone or in the home. Regular review allows strategies to be refined and provides the opportunity to reinforce and support achievement.

The PIL measure provided funding to:

- train assessors at 5 RAS organisations regarding the trial model
- these 5 RAS organisations to conduct assessments based on the trial model.

Evaluation of the trial model examined:

- training provided to 140 assessors and 12 reablement mentors at 5 trial RAS organisations
- 17,118 trial model assessments and 13,327 traditional (control group) assessments conducted across 20 Aged Care Planning Regions, from July 2019 to June 2020
- CHSP services recommended and those provided, short and long term
- client-reported outcomes.

2.2 Evaluation samples

Evaluation data was drawn from several samples depending on the data source and time period, and whether the client consented to the collection of quality of life data. These samples are shown in Table 2-1.

As shown, 17,118 trial assessments and 13,237 control (traditional) assessments were conducted between July 2019 and June 2020. A further 79,739 assessments were conducted for rest of country (ROC) clients.

To allow client and service outcomes to be considered within the evaluation timeframe, the evaluation focused on assessments conducted during the first 6 months (July to December 2019), totalling 7,113 trial and 5,553 control clients.

The 'second 6-months' cohort was excluded from the services delivery data analysis as there was potentially insufficient opportunity for services to be put in place.

Of the 'first 6-months' cohort, a subgroup of 3,002 trial and 1,561 control clients consented to participate in the trial and allow their client outcomes to be assessed. Of this subgroup, reliable client-reported outcomes data was obtained and analysed for 1,127 trial and 440 control clients.

Table 2-1: Reablement trial samples

Client group	Description	Trial	Control	ROC	Total
National group	All clients having their first assessment during July 2019 to June 2020. Used to examine CHSP service recommendation and delivery patterns.	17,118	13,237	79,739	**110,094**
Nested national group	All clients from the first 6 months of the group above. Used to calculate short vs ongoing CHSP services.	7,113	5,553	33,565	**46,231**
PIL group	All clients consenting to participate in the trial, July to December 2019. Used to examine CHSP services and general recommendations patterns.	3,002	1,561		**4,563**
Nested PIL group	All consenting clients followed up from the PIL group above. Used to examine client-reported outcomes.	1,127	440		**1,567**

2.3 Conclusions

The aged care sector needs to continuously change to keep pace with an ageing Australian population. People are living longer and generally want to stay in their homes for as long as possible.

However, the ability to keep up with changing needs has not always been demonstrated, as evidenced by the 2017 *Legislated Review of Aged Care,* the 2019 Royal Commission into Aged Care Quality and the *Safety Interim Report*. Traditional models of service delivery that focus on 'doing for' rather than 'doing with', and an over reliance on services by clients, has been linked to accelerated functional decline.

The trial model's focus on active assessment, increasing reablement opportunities and client follow-up, amounts to a substantial shift away from the traditional model of assessment.

Despite the scale of this shift, the trial model was largely embedded within the 5 RAS organisations that participated in the trial. All saw considerable benefit from this approach and 4 advised that they would continue its use beyond the trial.

2.3.1 Outcomes

The trial demonstrated that active assessment is a more appropriate and more effective approach at identifying reablement opportunities and is cost-neutral, compared with the traditional approach.

It was found that active assessment leads to reduced and different service recommendations – for both reablement and non-reablement clients.

CHSP service utilisation for trial clients cost around $100 less per year on average, compared to clients assessed using the traditional model.

This is largely because trial clients were more likely to receive no CHSP service recommendation. 5% of reablement trial clients and 11% of non-reablement trial clients received no service recommendation following assessment, compared to 1% and 6% for control group clients.

This shift would have a growing impact on the CHSP program if implemented and embedded more broadly.

However, the trial model did not:

- lead to substantial increases in client wellbeing, instead delivering only modest improvements for reablement clients
- increase the rate of short-term services, a hallmark of reablement. This indicates that despite the trial, reablement practice in Australia is not consistent with the principle of a time-limited intervention.

These two less positive outcomes are likely because the trial model was essentially an assessment intervention involving RAS organisations, which did not directly involve CHSP providers. More would need to be done after assessment and during reablement to deliver greater benefits to clients.

2.3.2 Trial challenges

Linkage of CHSP service utilisation data to My Aged Care data revealed useful, additional insights into service utilisation.

Analysis of 2019-20 service utilisation data found that nationally, when a service was recommended to a client, about one-fifth of services were not received.

This suggests significant unmet demand. Most CHSP service types were represented, including allied health, domestic assistance and transport. The trial model did not appear to influence this trend, i.e. trial clients were just as likely as rest of country (ROC) clients to be recommended a service and not receive it.

This has significant implications for the trial and outcomes of wellness and reablement approaches more broadly. If services had been delivered consistently during the trial, it is likely that more meaningful change in client reported outcomes may have been observed.

In addition, delayed roll-out of PIL complimentary support strategies, such as those supporting CHSP providers to embed reablement, most likely diminished the effectiveness of reablement, and ultimately of active assessment, in improving client reported wellbeing.

Service utilisation data was also used to determine the proportion of clients who received short-term vs ongoing CHSP services. Analysis revealed that fewer WA and Victorian clients received short-term services (25% each) compared to other cohorts including the trial (28%) and ROC (29%) cohort.

This suggests that neither the trial model nor the purportedly more mature reablement models in WA and Victoria, influence the proportion of clients who receive short-term CHSP services.

In addition, reablement clients – including reablement clients from the trial, WA and Victorian regions – received similar proportions of short-term and ongoing services. If corroborated, these findings have implications beyond the trial, to reablement practice more broadly.

The evaluation revealed an inconsistent understanding of what reablement means in practice and a complex, and at times disconnected, system of RAS organisations and CHSP providers. Once released, the complementary support strategies will likely assist towards addressing this disconnect and in strengthening wellness and reablement approaches.

In Part 3: Lessons, of this report, a reablement model is suggested that would alter the allocation of short-term vs ongoing services at assessment, to better embed the principles of reablement into entry-level aged care.

2.4 Trial model appropriateness

The trial model represents a fundamental shift in assessor practice. Given this significant departure from the traditional model, we evaluated whether the trial model is an appropriate assessment for entry-level aged care clients.

Appropriateness was assessed by examining how well this approach met individual client need and, if it was 'fit-for-purpose', how the trial model compared with the traditional model of assessment and client follow-up.

2.4.1 Summary

It was found that the trial model assessment is superior to the traditional model in meeting the department's W&R objectives. It is more appropriate – and of higher quality – than the traditional model of assessment because it:

- identifies more reablement opportunities and builds the foundation for maximising W&R outcomes across entry-level aged care
- provides a more holistic, evidence-based approach to assessment, whether the client undergoes a period of reablement or not
- provides more tailored support plans, including more defined goals and recommending a broader range of reablement strategies to clients.

2.4.2 More appropriate assessment

The department's 2018 *My Aged Care assessment manual* (Department of Health 2018a) outlines the objectives which RAS organisations are expected to fulfil.

One of these objectives defines the appropriateness or 'fit-for-purpose' of an assessment. The Manual's opening section states that clients are to be assessed holistically by delivering '*tailored support plans that are based on a client's goals and current care needs and consider wellness and reablement approaches*' (Department of Health 2018a, p.9).

Despite this requirement, interviews with stakeholders, including the department's expert Reablement Working Group and non-trial RAS organisations, found that assessment is not consistently approached with a W&R focus. Interviews with CHSP providers also revealed that a W&R approach was not given sufficient focus or attention during assessment.

The following sections outline our key findings about the trial model's appropriateness.

Reablement is a person-centred, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Reablement consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team.

The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Reablement supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as involvement of their social network. Reablement is an inclusive approach irrespective of age, capacity, diagnosis or setting. (Metzelthin et al. 2020).

Identifies more reablement opportunities

One of the first decision-points for an assessor and a client to discuss is whether the client is suitable for reablement, and if so, how a client can best retain and enhance their independence through reablement. This is a key decision-point for all RAS assessments, because it determines whether reablement is an option. If it is, the remainder of the assessment can focus on:

- which time-limited reablement intervention or period would suit each client
- reablement goal setting and strategies to assist the client to achieve these goals.

Compared with the traditional model, the trial model is substantially better at identifying reablement opportunities. Rates of clients undergoing reablement increased from 13% at the commencement of the trial to 30% at the end of the trial. This is a significant achievement within 12 months and well above the department's 10% reablement target for RAS organisations.

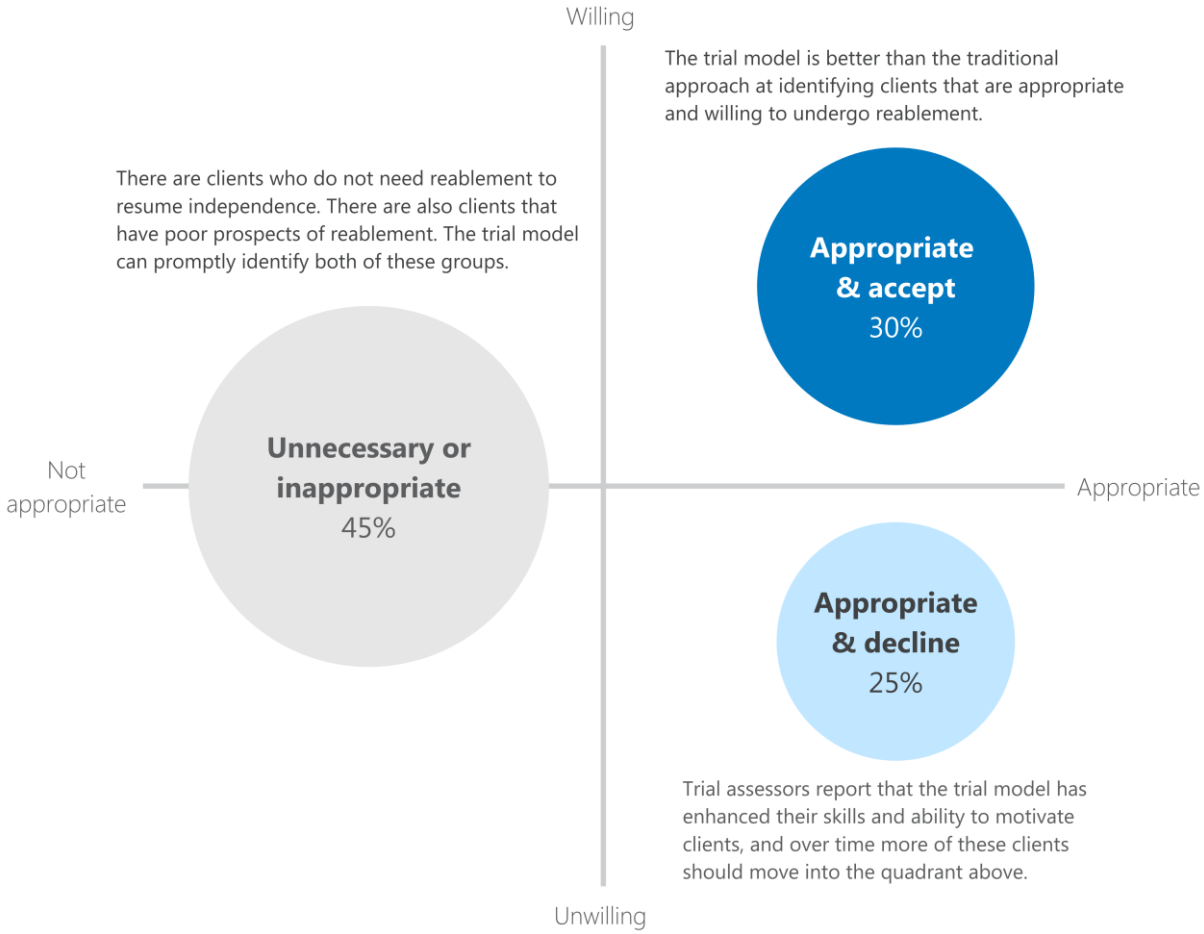
The trial model achieved this by acting as a screening tool to appropriately identify reablement opportunities, as well as identifying those clients who have poor reablement prospects or do not need reablement at all.

Managers and assessors from trial RAS organisations consistently reported that the trial model improved an assessor's ability to appropriately identify and readily screen clients into 3 groups, consisting of those with:

- good reablement prospects that are willing to try reablement
- good reablement prospects that are initially reluctant to try reablement
- poor reablement prospects that are not appropriate to undergo reablement.

Figure 2-1 below illustrates the trial assessors' collective estimate of reablement suitability across the range of clients they assess.

Figure 2-1: Reablement rate range under the trial model



According to trial RAS managers, the proportion of clients who are appropriate for, and accept reablement, is likely to increase as assessor skills improve. This means that the rate at which clients undergo reablement may become higher as the trial model becomes more embedded. Based on this feedback, over half of all clients having an assessment could benefit from a reablement period.

In addition to the technical skills required to implement the trial model, so-called 'soft skills' are particularly relevant for convincing those clients who are deemed appropriate but who decline reablement. All trial RAS managers emphasised the importance of skills such as active listening and motivational techniques to build support for W&R approaches.

The assessor training program devotes time in its foundational classroom training to these skills, and the need to maintain a client's motivation during the reablement period was seen as crucial to reablement success by assessors and mentors alike.

Provides a holistic and evidence-based approach

A hallmark of reablement is that it is a person-centred, holistic approach that aims to increase or maintain independence. An assessment approach that captures more information – about the client, their carer and/or family members and their home environment – is not only more holistic, it also results in higher-quality assessments.

The chosen assessment approach has a strong influence on the extent to which a holistic approach to assessment can be achieved. For example, interviews with trial managers consistently found that the trial model was more holistic and of higher quality than the traditional model. This view was supported by all mentors, although they reported that the quality was influenced by the learning curve involved in the trial model. It took time for some assessors to embed the new assessment approach, particularly with regards to writing up the assessment in sufficient detail.

The majority of trained assessors surveyed reported that the trial model of assessment is more inclusive, and often '*provides better insight into the client's situation.*' When asked why – managers and assessors stated that with this more open approach, a client can actually demonstrate what they can do, rather than simply telling the assessor what they can do. This enables the assessor to:

- capture the 'whole client story', including a more accurate and stronger assessment of client need
- confirm client strengths and weaknesses based on an evidence-based 'show me' approach, in addition to identifying safety issues and risks in the home
- record richer information in the assessment (one trial manager noted that '*we have noticed a huge difference when you compare to previous assessments*').

Assessors also showed strong support for the trial approach because clients are encouraged to focus on what they can do safely and what they value, instead of focusing on what they cannot do. In the words of one assessor, *'you can pinpoint what they are doing really well and where they actually do need support.'*

This contrasts to the traditional approach to assessment, where assessors principally rely upon verbal confirmation from the client as to what they can and cannot do.

Encourages a more tailored assessment approach

Interviews and focus groups with trial RAS staff, along with analysis of My Aged Care assessment data, indicated that two particular components of the trial model allowed for a more tailored assessment approach to clients:

- identifying SMART (specific, measurable, attributable, realistic and time-bound) goals, and
- developing broader reablement strategies.

Mentors reported that the trial model encouraged assessors to develop more defined goals with reablement clients. This contrasted with the traditional model in which, as one mentor explained, '*goals used to be very general, for example "client would like safety assessment" but now they are more like "client would like to shower without having to hold the shower screen for support".*

Another mentor raised a further advantage to clearer goal setting, observing that '*Providers say they can see a difference between before and after the trial…the goals we make with the client focus attention for the allied health professional to show exactly why the client has been referred.*' Mentors and assessors alike felt active assessment encouraged open conversations with the client, and that asking more detailed questions led, in turn, to more specific goal setting.

The trial model was also more appropriate at identifying genuine client need for services. Managers and assessors from trial RAS organisations reported that getting clients to demonstrate what they could do made it easier to identify the services each client actually needed, as well as making it easier to have sometimes difficult conversations with clients, their carers and family members.

CHSP service and general (non-CHSP) recommendations

CHSP service recommendations are for services funded under the CHSP program. For example, an assessor during discussions with the client may recommend that a client receive a CHSP-funded transport service.

Unlike CHSP service recommendations, general recommendations are for services or strategies the client can pursue independently and are not funded under the CHSP program. This can include services funded by the local council, such as a community bus service, or the purchase of a long-handled brush to help with cleaning around the home.

General recommendations can be reablement strategies, as they can assist clients to achieve their reablement goals. General recommendations may also be made for a client's general wellbeing and safety, such as a recommendation which encourages a client to consider advance care planning or an emergency care plan.

One manager summed it up well, stating that the trial model *'takes the sting out of the tail when you are saying no to services.'*

Again, this benefit extended to clients not undergoing reablement, as managers and assessors reported that an active assessment better identified the ongoing services they needed.

2.4.3 Appropriate for clients

We interviewed 50 clients to gain their perspectives on their assessment experience, either with the trial model or traditional model. Interviews were conducted approximately 10 to 14 days following assessment, so that clients would have sufficient time to reflect on the assessment while still being able to accurately recall it.

Trial clients mostly found the assessment to be a positive experience and it was generally well-received by clients. They consistently reported not feeling troubled by being asked to demonstrate how they undertook basic tasks around the home. Some went on to say that they felt it was, in the words of one client, *'a sensible, and reasonable way of assessing a person's needs.'*

As an indicator of the client's perception of appropriateness, each was asked to rate their satisfaction with the assessment process on a scale, where zero was very unsatisfied and 10 very satisfied. Clients were generally satisfied with both assessments, although clients assessed through the traditional model had a slightly higher average score of 9.4 compared with an average satisfaction rating of 8.5 for trial clients.

A significant factor in the difference between these scores was the unmet expectations of 4 trial clients and their family members, who expressed disappointment at not getting assessed as eligible for particular CHSP services.

This demonstrates the importance of managing expectations throughout the reablement journey, starting from a client's first encounter with the aged care system (we explore client expectations more in Section 3.3 of Part 3: Lessons of this report).

This overall satisfaction with the assessment process was supported by assessor survey responses. The majority of assessors reported that clients had largely been accepting of both the active assessment approach (77%) and the concept of reablement (62%), despite the assessors needing to convince some of the initially reluctant clients to try reablement.

Assessors stated that clients:

- were mostly positive, as active assessment focused on what the client can do and often increased confidence; as one assessor observed, *'It helps people to feel empowered again, rather than doctors and family telling them they're old and discussing what they can't do'*.
- appreciated being asked about what was important to them and saw the value in SMART goals
- were open to thinking about alternative, and at times lateral, solutions to helping them stay independent, contrasting with *'the old system that was making people further dependent on the system'*.

2.5 Trial model effectiveness

This section presents findings and implications for each of the 3 categories of outcome measures used to collectively assess the effectiveness of the trial model:

1. **Assessment outcomes**, including rates at which clients undergo reablement, the rate and type of CHSP service recommendations and the rate and type of general recommendations
2. **Client-reported outcomes**, including personal wellbeing, health-related quality of life and independence
3. **Service outcomes**, including the number and type of CHSP services delivered, and the extent to which these services were ongoing or not.

2.5.1 Summary

The trial model was found to be effective at:

- identifying more reablement opportunities, more than doubling the rate at which clients undergo reablement
- identifying genuine client need for support, thereby increasing the proportion of clients for whom no CHSP services are recommended following a RAS assessment, for both reablement and non-reablement clients
- encouraging assessors to recommend broader supports not funded by CHSP, particularly low-risk AT products, non-CHSP services and other strategies for independence.

2.5.2 Assessment outcomes

Client cohorts

For this analysis, we grouped clients into 5 cohorts:

1. **Trial** – Clients assessed by a trial RAS organisation (17,118)
2. **Control** – Clients assessed by a control RAS organisation (13,237)
3. **Rest of country (ROC)** – Clients assessed by non-trial and non-control RAS organisations, except those in Western Australia or Victoria (79,739)
4. **Western Australia** – Clients assessed by Western Australian RAS organisations (15,621)
5. **Victoria** – Clients assessed by Victorian RAS organisations (39,315).

Clients assessed in WA and Victoria were separated from the other cohorts, as their models of assessment and approach to reablement are purportedly more advanced than those elsewhere. While this may not be reflected in the rate of reablement (see Victoria's lower rate), it is reflected in the quality of their reablement models including increased collaboration between assessors and CHSP providers.

Findings throughout this and subsequent sections of the report show how these cohorts experienced substantially different assessment and service-related outcomes when compared with trial, control, and rest of country clients.

Proportion undergoing reablement more than doubled during the trial

We examined the My Aged Care assessment data extract provided by the department to assess whether the trial model influenced the rate at which clients undergo reablement.

It was found that trial clients were more likely to undergo reablement than both control clients and those in the rest of the country (ROC).

Table 2-2 shows that the trial model effectively increased the proportion of clients that underwent reablement, from 13% before the trial to 30% during the trial, making it the highest rate of reablement in Australia. This is a substantial increase, doubling the rate recorded by trial RAS organisations before the trial commenced.

Should the department decide to roll the trial model out nationally, it would be reasonable to expect significant increases in the rate at which clients undergo reablement, well beyond the department's target of 10%.

Table 2-2: Reablement before and after trial commencement

Cohort	Before trial commencement (from July 2018 to December 2018)	After trial commencement (from July 2019 to June 2020)
Trial	13%	30%
Control	6%	14%
ROC	9%	17%
WA	13%	24%
Vic	3%	11%

Interviews with managers, as well as focus groups with assessors from trial RAS organisations, found that the trial model is superior to the traditional approach in identifying reablement opportunities, thereby increasing the rate at which clients underwent reablement. Assessors stated that this was primarily because there was a stronger focus on reablement and better engagement with the client.

This not only means that more reablement opportunities were identified, it also means that clients who were at first reluctant to try reablement could be encouraged and persuaded to do so. One trial manager stated that: *'Assessors are more invested in client outcomes – and find more opportunities to build support for reablement approaches.'*

Rates of undergoing reablement decline with age

The rate at which clients underwent reablement declined with age – a trend consistent before, during and after the trial across both trial and control regions (Figure 2-2).

Figure 2-2 illustrates reablement rates by age group for trial (top graph) and control (bottom graph) client cohorts. Reablement rates are shown before the trial (July 2018 to December 2018), during the trial (July 2019 to December 2019) and after the trial (January 2020 to June 2020). As shown:

- In trial regions, reablement rates for each age group maintained or increased after the trial – most notably for the 90 and over age group, which increased from 23% to 27%
- In control regions, reablement rates for most age groups reduced after the trial, e.g. the 90 and over age group decreased from 12% to 8%
- In all regions, reablement rates were highest for clients aged between 65 and 79 years; however, older clients were recommended for reablement at much higher rates in trial regions than non-trial regions.

This indicates that assessors in trial regions who undertook active assessments, deemed reablement to be more appropriate regardless of the client's age.

Figure 2-2: Trial and control region reablement rates by age group and time period

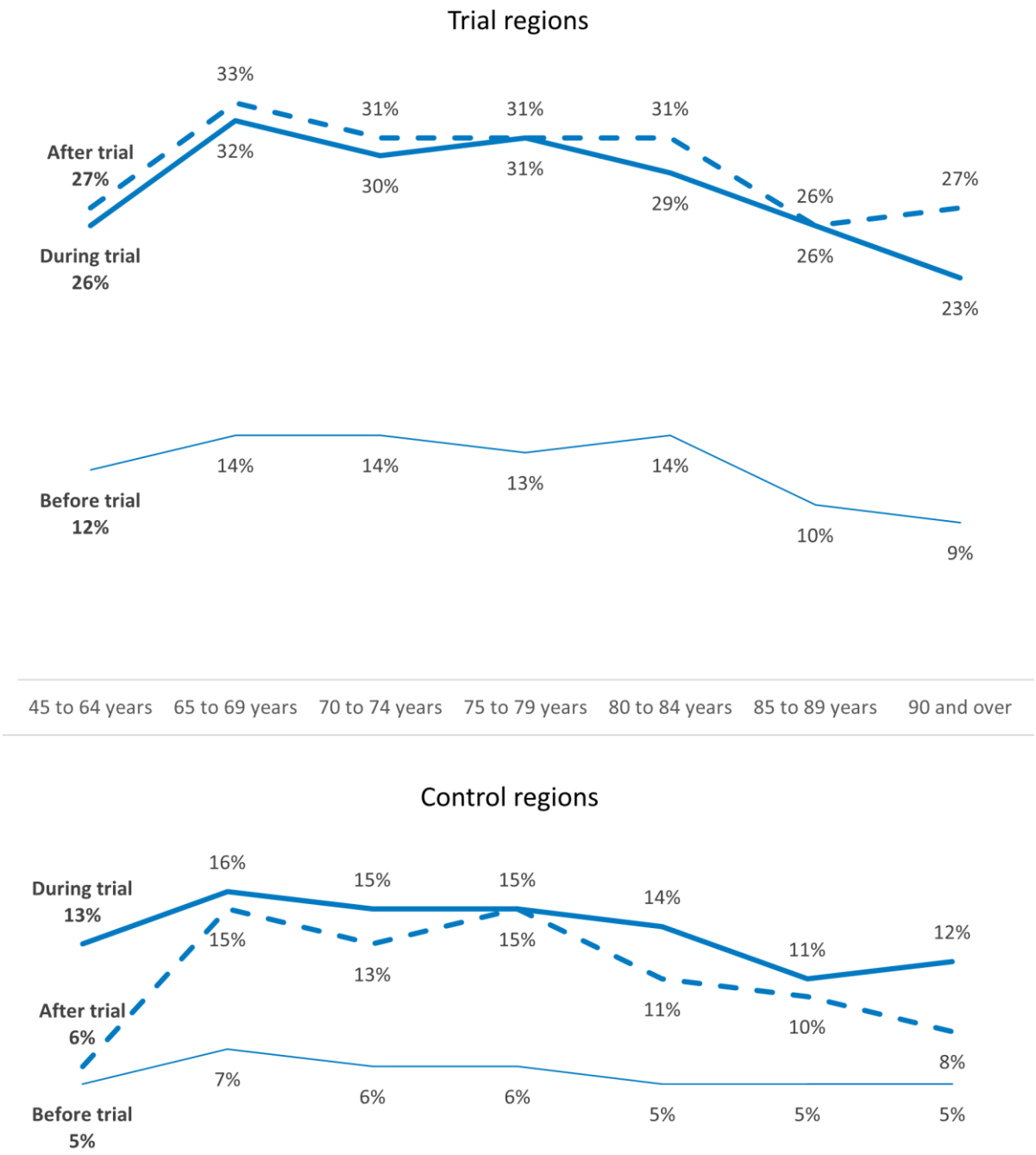


Table 2-3: Trial and control region reablement rates by age group and time period

Age group	Trial – Before	Trial – During	Trial – After	Control – before	Control – during	Control – after
45 to 64	12%	26%	27%	5%	13%	6%
65 to 69	14%	32%	33%	7%	16%	15%
70 to 74	14%	30%	31%	6%	15%	13%
75 to 79	13%	31%	31%	6%	15%	15%
80 to 84	14%	29%	31%	5%	14%	11%
85 to 89	10%	26%	26%	5%	11%	10%
90 +	9%	23%	27%	5%	12%	8%

Considerable variation between trial reablement rates

Comparison of trial RAS organisations showed considerable variation in the rates at which their trial clients underwent reablement. As Table 2-4 shows, the variation was much greater between RAS organisation trial sites (ranging from 21% to 47%) than their respective control sites (ranging from 11% to 16%). The greater range in trial reablement rates indicates variability in implementing the trial model. The factors which caused this variability in trial reablement rates did not influence the traditional model assessment approach in the control regions to the same extent.

Table 2-4: Reablement by trial RAS organisation

RAS	Trial	Control
A	47%	No control region
B	31%	11%
C	30%	16%
D	23%	No control region
E	21%	14%

We examined the My Aged Care assessment data to see whether there were demographic factors, such as age or gender, that might explain the variation in trial reablement rates. We also looked at the rurality of the ACPR (using the department's ACPR classification scheme) for each trial site. Neither demographic factors nor rurality appeared to explain the variability in trial reablement rates, although in some ACPRs samples sizes were small and this may have had a bearing on the observed variation.

Further analysis was conducted using client-reported outcomes collected during the trial (see Section 2.5.3), as poorer quality of life outcomes may indicate differences between trial client cohorts that may have influenced trial reablement rates. However, no association was found between the quality of life outcomes reported by clients and trial reablement rates.

Organisational buy-in to the trial model

We did, however, observe differences in senior management support for the trial, and this might have influenced the extent to which the trial model was implemented.

The two RAS organisations that achieved the highest rates of clients undergoing reablement, both had managers who completed the assessor training (designed to deliver the trial model and reviewed in Section 3.5 in Part 3: Lessons of this report). To complete the training, all trainees had to demonstrate competencies during client assessments, in addition to participating in the 3-day foundational course. To attend and complete this training implies a strong level of engagement with and support for the trial model.

During the course of the evaluation, we also observed that the Trail RAS B manager was not only the most enthusiastic in embracing the trial model, explaining that *'this is the first time we have really understood reablement,'* but has subsequently invested in additional internal training that builds on the training delivered during the trial. This additional training focused on motivational interviewing as the manager believes it is these skills which could further optimise reablement opportunities.

To understand underlying organisational factors that might have influenced the variation in trial reablement rates, we interviewed each trial RAS manager separately during the trial and after it had concluded. They provided the following useful insights into organisational aspects that influenced the trial:

- **Key role of mentors or reablement champions**. Mentors were critical to building support for, and consistency of, practice during the trial. One trial manager reported that the departure of one of its mentors led to a decrease in clients undergoing reablement and to a reduction of support for the trial model in general.
- **Reluctance of team leaders to support the trial**. Another trial manager stated that one of its team leaders did not support the trial, despite encouragement to do so. The rates at which clients underwent reablement was lower in this ACPR than in its other trial ACPRs.
- **Attitudes and aptitude of assessors to adopt wellness and reablement approaches**. Our observations of assessor focus groups during and after the trial, indicate that those who were most supportive of the trial model largely came from those RAS organisations with the highest rates of clients undergoing reablement. The assessor training provider also reported that mentors and assessors from these RAS organisations generally understood and supported the principles underlying active assessment more quickly and comprehensively.

Trial RAS managers also reported other factors outside their control that could explain some of the variation between reablement rates. One key factor was CHSP service availability, principally reablement-focussed service types, such as allied health and AT. Managers stated that reablement is not always recommended in some ACPRs, even where the client has good prospects of reablement success, because assessors know that the recommended services are often unavailable.

CHSP providers also report limited reablement-focussed service availability, which is discussed in greater detail in Section 3.6 in Part 3: Lessons. Our analysis of service outcomes in Section 2.5.4 support these views: when a service was recommended, about one-fifth of those clients did not end up receiving that service.

Lower rates of CHSP service recommendations

CHSP service recommendations are a key outcome of a RAS assessment, as they are made to assist clients to achieve their goals. It has been reported, however, that not all service recommendations arising from a RAS assessment benefit the client – for example, a client may miss an opportunity for reablement if they become over-reliant on services.

The trial model reduced the overall rate at which CHSP services are recommended after a RAS assessment. Trial clients – both reablement and non-reablement – were less likely to be recommended a service, compared with control and rest of country (ROC) clients (Table 2-5) except for WA.

The fact that non-reablement clients had the most significant increases in receiving no service recommendation, suggests that the trial model is effective in identifying genuine needs for all clients, not just those undergoing a period of reablement.

Table 2-5: Proportion of clients with no service recommendation

Cohort	Reablement	Non-reablement
Trial	5%	11%
Control	<1%	7%
ROC	1%	6%
WA	8%	16%
Vic	<1%	6%

Furthermore, for clients who were recommended services, trial clients were recommended fewer services on average than all other cohorts, again with the exception of WA, as shown in Table 2-6.

Table 2-6: Average number of service recommendations per client

Cohort	Reablement	Non-reablement
Trial	2.7	2.2
Control	3.0	2.5
ROC	3.4	2.7
WA	2.5	2.0
Vic	3.3	2.7

Trial assessors consistently reported that the trial model was better at identifying genuine client need. The changes in service recommendations also indicate that historically, service recommendations may have been influenced by client preferences, rather than based on demonstrated need. One assessor stated that, '*Unlike the more traditional approach, it is fantastic for weeding out the needs versus the wants. It takes the sting out of the tail when you are saying no to services.*'

WA, a state with an established focus on reablement and the most experience with the trial model, recorded 8% (reablement) and 16% (non-reablement) clients who had no service recommendation during the trial period. Trial client rates of no service recommendations (5% for reablement and 11% for non-reablement clients) were more in line with WA's than any other cohort. Moreover, trial reablement clients were recommended an average of 2.7 services, while non-reablement clients were recommended an average of 2.2 services. This reveals that the trial regions were approaching rates of service recommendations which are similar to WA, 2.5 and 2.0 for reablement and non-reablement respectively.

In trial regions, of assessments where the client was recommended reablement but no CHSP service was recommended, 75% received a general recommendation, compared to 58% for control and 42% for rest of country regions. For assessments where reablement was not recommended and a CHSP was not recommended, 48% had a general recommendation in trial, 47% in control and 33% in rest of country regions. For reablement clients this shows an increased focus on alternative, non-CHSP solutions to meet client needs. General recommendations are discussed in greater detail in Section 2.5.2.

Types of service recommendations

We further examined the data to see whether the trial model changed the demand for particular CHSP service types.

It was found that the trial model influences the way some CHSP services are recommended but not others. Trial clients were less likely to receive domestic assistance (32% vs 44%), transport (28% vs 34%), home maintenance (23% vs 30%) and social support individual (10% vs 13%) recommendations, when compared with control clients.

This shift in CHSP recommendations may reflect the focus on genuine client need which assessors reported above (previous page). It may also reflect the larger proportion of trial clients receiving general (non-CHSP) service recommendations that mirror CHSP service types such as domestic assistance and transport.

Table 2-7: Services recommended by service type and cohort

Services	Trial	Control	ROC	WA	Vic
Sample size	**15,304**	**12,283**	**74,390**	**13,073**	**36,965**
Allied Health and Therapy Services	34%	32%	36%	19%	54%
Domestic Assistance	33%	44%	43%	42%	43%
Transport	28%	34%	33%	22%	11%
Home Maintenance	23%	30%	32%	20%	35%
Home Modifications	20%	20%	22%	14%	22%
Social Support Individual	10%	13%	14%	9%	9%
Meals	7%	9%	9%	5%	9%
Social Support Group	7%	7%	8%	7%	10%
Nursing	6%	7%	8%	2%	6%
Goods, Equipment and Assistive Technology	6%	6%	6%	14%	<1%
Personal Care	5%	7%	7%	7%	8%
Flexible Respite	5%	6%	8%	2%	5%
Specialised Support Services	4%	3%	5%	1%	7%

Service recommendations and reablement

The changes to service recommendation patterns were compared between reablement and non-reablement clients.

A pattern that emerged was the mirroring of certain service type recommendations between the trial and WA clients. This is particularly evident for non-reablement clients across several service types; for example home maintenance service recommendations were made at similar rates for trial (23%) and WA (20%) non-reablement clients – see Table 2-8 over.

All other non-reablement clients in the control, the rest of country and Victorian cohorts were recommended home maintenance at a rate above 30%. This pattern also emerged for home modifications and, to a lesser extent, transport services.

Additionally, domestic assistance and transport services were recommended at a substantially lower rate in the trial regions for all clients when compared to all other cohorts.

Based on our analysis, we believe this reduction could be due to a combination of several factors:

- A higher proportion of trial clients were not recommended a service, which may indicate that the trial model was better at identifying genuine client need.
- General (non-CHSP) recommendations were used to supplement or replace CHSP service recommendations – for example see Figure 2-4 in Section 2.5.2, which shows a higher proportion of trial clients were recommended general domestic assistance (26% vs 17%) and transport (31% vs 14%)
- The availability of domestic assistance CHSP services varied between regions. It may be that if an assessor knows a CHSP service is not readily available to a client, they are less likely to recommend that service.

Table 2-8: Services recommended by service type, cohort and reablement sub-groups

Service type	Trial R	Trial N-R	Control R	Control N-R	ROC R	ROC N-R	WA R	WA N-R	Vic R	Vic N-R
Sample size	**5,139**	**11,979**	**1,788**	**11,449**	**13,625**	**66,114**	**3,810**	**11,811**	**4,506**	**35,409**
No service recommendation	**5%**	**11%**	**1%**	**7%**	**1%**	**7%**	**8%**	**17%**	**<1%**	**7%**
Service recommendation	**95%**	**89%**	**99%**	**93%**	**99%**	**93%**	**92%**	**83%**	**99%**	**93%**
Allied Health and Therapy Services	55%	26%	60%	27%	67%	30%	35%	14%	79%	51%
Domestic Assistance	36%	32%	38%	45%	42%	44%	49%	40%	47%	43%
Home Maintenance	22%	23%	24%	31%	30%	33%	18%	20%	33%	35%
Social Support Individual	11%	10%	12%	13%	14%	14%	9%	8%	9%	8%
Home Modifications	33%	14%	41%	16%	45%	18%	23%	11%	38%	20%
Transport	24%	29%	38%	34%	33%	33%	22%	22%	11%	11%
Nursing	7%	6%	9%	7%	9%	7%	2%	2%	6%	6%
Personal Care	5%	5%	7%	7%	7%	7%	8%	6%	9%	7%
Meals	7%	7%	8%	10%	9%	9%	5%	6%	9%	7%
Specialised Support Services	5%	4%	3%	3%	7%	5%	2%	1%	7%	7%
Social Support Group	7%	7%	8%	7%	9%	7%	6%	7%	11%	9%
Flexible Respite	4%	5%	3%	6%	7%	8%	1%	3%	4%	6%
Goods, Equipment and Assistive Technology	11%	3%	11%	5%	11%	5%	24%	11%	<1%	<1%

Note: Other CHSP services with small sample sizes and percentages of recommendations are not shown – including Assistance with Care and Housing, Centre-based Respite, Other Food Services and Cottage Respite. Full details can be found in Part 4: Technical supplement of this report.

Increasing rates and types of general recommendations

We examined general (non-CHSP) service recommendations because, like CHSP service recommendations, they are a key outcome of a RAS assessment and are often made to assist clients to achieve their goals.

Note that the general recommendations analysis predominantly involved a smaller number of trial and control clients (than for CHSP service recommendations), as shown in Table 2-9. This is because general recommendations, unlike CHSP service recommendations, are made in free text fields of the My Aged Care data collection and require substantial resource to collate and analyse.

It was found that trial clients were almost twice as likely as control clients to receive one or more general recommendations (46% and 24% respectively). The increased use of general recommendations indicated a broader range of reablement strategies were being used to address areas of client need.

The types of general recommendations that increased during the trial were also informative; they targeted reablement and client independence. This means that the trial model not only increased the rate of general recommendations, but at times it also replaced CHSP service recommendations with general recommendations, for both reablement and non-reablement clients.

Trial RAS managers and assessors stated that the trial model effectively promoted the use of general recommendations as reablement strategies to help clients remain independent. Assessors and clients also reported that they were open to thinking about broad strategies.

The types of general recommendations made varied between the trial and traditional approaches, as shown in Table 2-9.

It was more common for trial clients to receive general recommendations for low-risk AT products, non-CHSP services and strategies for independence that were tailored to the client's circumstances and goals. Control clients on the other hand, more often received general recommendations for emergency and advance care planning support. These were frequently worded identically, and as such appeared to be standardised and not as tailored to the circumstances and goals of the client.

This indicates that the trial model encouraged assessors to make general recommendations that are more targeted to maintaining or increasing a client's independence.

Table 2-9: General recommendations made, by category and cohort

Category	Trial	Control
Number of clients	**1,382**	**380**
AT products	42%	30%
Non-CHSP services	35%	33%
Strategy for independence	10%	3%
Emergency care support	9%	25%
Advance care planning	3%	8%

Increasing diversity of general recommendations

As indicated (previous page), as a result of an active assessment that identified genuine client needs, trial assessors were more likely to make a broader range of general recommendations that were tailored to the client's circumstances.

To investigate the diversity of general recommendations made between cohorts, we calculated the percentage of unique general recommendations as a proportion of all general recommendations (Table 2-10). A higher percentage indicates greater diversity, whereas a lower percentage indicates that the exact same text was input into the general recommendation field on two or more occasions more frequently. A lower percentage indicates that an assessor simply entered a standardised recommendation, as opposed to something more tailored to the client's needs.

For example, the general recommendation 'Develop Emergency Care Plan' was entered into the field identically 9,525 times during the trial. However, in trial regions, just 6% of general recommendations had this wording, while in control region 14% had this wording.

For this analysis we included all 71,075 general recommendations made during the trial (July 2019 to December 2019).

As shown in Table 2-10:

- in trial regions 70% of general recommendations made for clients undergoing reablement were unique; close to double that of control reablement clients (39%)
- Similarly, trial non-reablement clients were also highly likely to receive a unique general recommendation (67%), compared to just 27% for control non-reablement clients.

Table 2-10: General recommendations - Unique recommendations as percentage of all recommendations, by cohort and reablement sub-groups

Cohort	Reablement	Non-reablement
Trial	70%	67%
Control	39%	27%
ROC	38%	34%
WA	53%	47%
Vic	56%	48%
Total	**53%**	**43%**

Trial RAS assessors remarked that because an active assessment was conducted throughout a client's home, rather than sitting down at a couch or table, they were able to more frequently identify opportunities for intervention or action that would normally be missed during a traditional assessment.

These increased opportunities to identify interventions would result in a CHSP service or a general recommendation that was better tailored to the needs of the client.

AT product recommendations

Given the recent national review of AT, and the prevalence of AT product recommendations in the trial region, we examined these recommendations in more detail. Low-risk, simple AT products are also an affordable and largely accessible reablement strategy that can promote greater client independence.

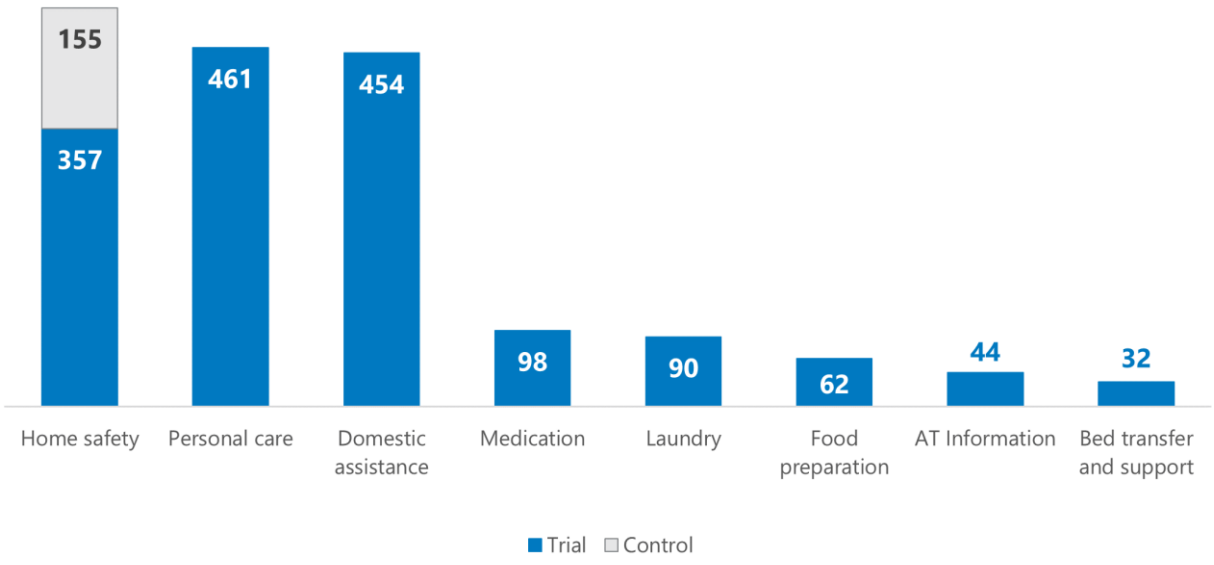
A greater proportion of trial clients received recommendations for AT (42%) compared to control clients (30%). Trial clients that received AT general recommendations also received on average twice as many (2.9) compared to control clients (1.5), and these recommendations included a wider range of AT product categories.

The 3 AT categories most commonly recommended during the trial targeted home safety, personal care, and domestic assistance. As shown in Figure 2-3, control client assessors only recommended AT products that related to home safety (mainly personal and smoke alarms), while all other service categories were only recommended by trial assessors. This indicates that trial assessors made broader general AT recommendations than control assessors did.

When speaking with assessors, a common observation was that by having the client 'show them' what they could do around the home, assessors were given greater opportunities to view and assess the client's living situation. This in turn helped the assessors identify more opportunities to recommend AT products and broader non-CSHP services that could improve a client's independence and reduce reliance on CHSP services, that may have otherwise been recommended.

It also highlights the effectiveness of the assessor training program, which provided a module on low-risk AT products that are useful for activities of daily living.

Figure 2-3: Top 8 AT product category recommendations, by target Activity of Daily Living (ADL) and cohort

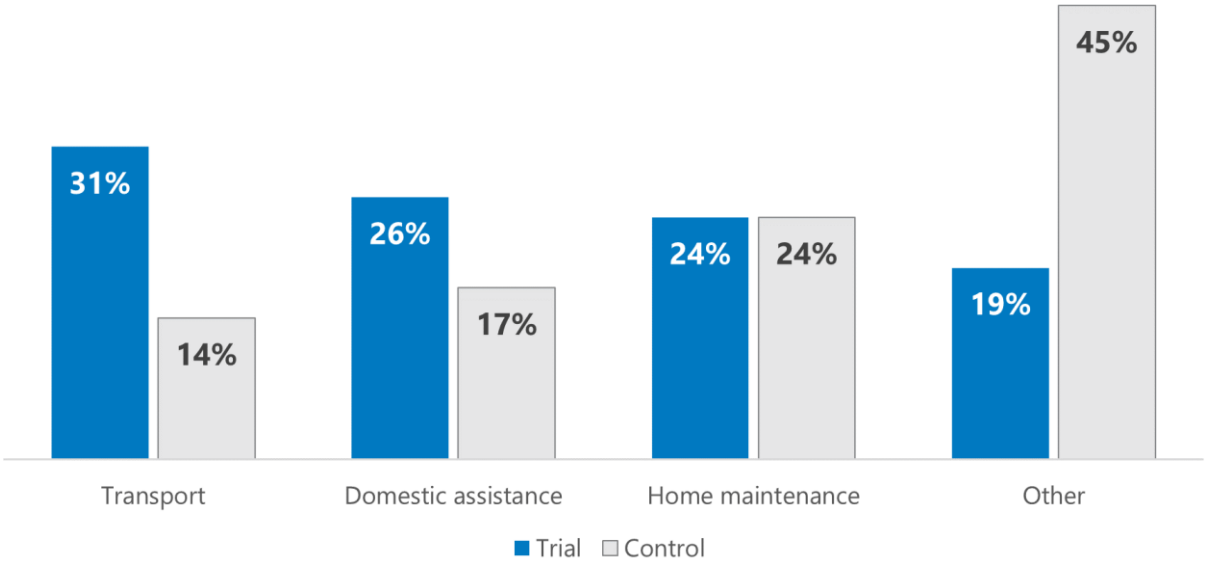


Note: Where AT product recommendations target the same ADLs that a CHSP service type targets, we have used the name of that CHSP service type. For example, a recommendation for a long-handled duster would be categorised as a domestic assistance AT product recommendation.

Reductions observed in trial client's domestic assistance and transport CHSP service recommendations, appear to be at least in part, driven by an increase in trial clients receiving general recommendations for domestic assistance and transport, as shown in Figure 2-4.

These are recommendations for services that sit outside of the CHSP program and indicate that assessors may have been more likely to look for broader solutions to meet client need. It is also conceivable that limited CHSP service availability may have increased non-CHSP solutions for these services in trial regions.

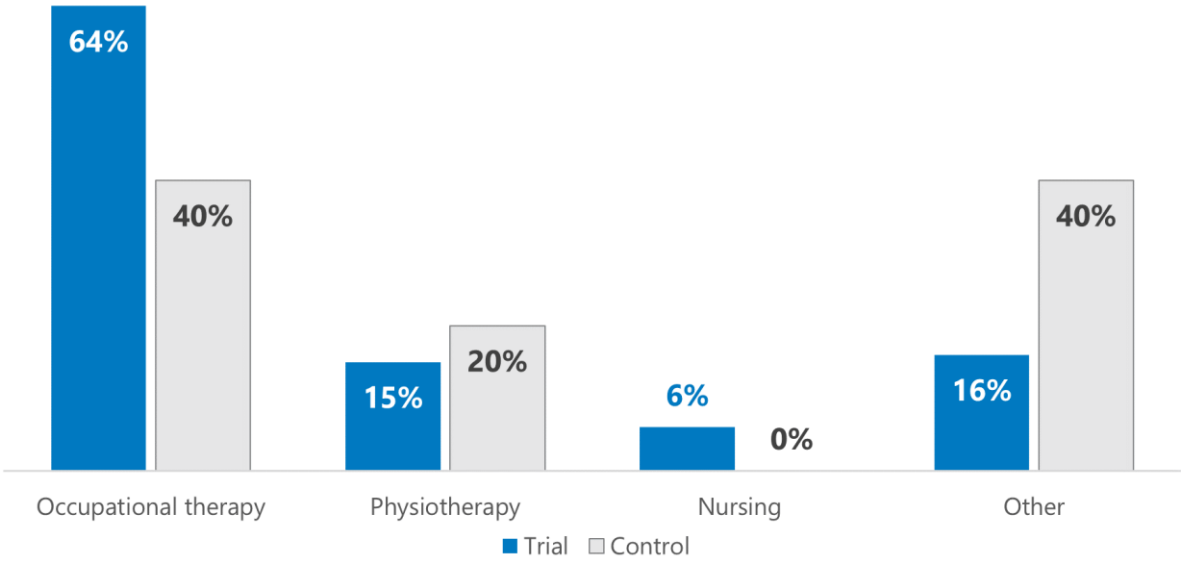
Figure 2-4: Activity of Daily Living (ADL) support general recommendations, by category and cohort



A similar picture emerges when analysing general recommendations that align with allied health service types (Figure 2-5). As shown, for control clients there was a notably higher frequency of occupational therapy (64% vs 40%) and nursing services (6% vs 0%) as a general recommendation.

Assessors frequently commented that CHSP-funded allied health services are limited, and these general recommendations suggest that trial assessors looked outside of the CHSP program for timely solutions.

Figure 2-5: Allied health referral general recommendations, by category and cohort



2.5.3 Client-reported outcomes

We also measured client-reported outcomes to see whether there was a change in personal wellbeing (PWI) and health-related quality of life (utility score). Client-reported outcomes were collected immediately prior to assessment by the RAS assessor.

These clients were then contacted 6 months after assessment to collect the same client-reported outcomes, enabling comparison between trial and control clients as well as identifying any influence the trial may have had over these 6 months. Full details of data collection are available in *Part 4: Technical supplement* of this report.

Personal Wellbeing Index

The Personal Wellbeing Index is a measure of subjective wellbeing that evaluates an individual's average level of satisfaction on a scale of zero to 100 points, across 7 life domains: standard of living, health, achievements in life, relationships, safety, community connectedness and future security (International Well Being Group 2013).

The Personal Wellbeing Index has been refined with input from 150 researchers in over 50 countries (International Well Being Group 2013) with age-specific normative data for Australia.

For this study, scores were converted to an average PWI score ranging between zero and 10. A score closer to 10 indicates more positively reported personal wellbeing.

Health-related quality of life

Health-related quality of life was measured using the 5-level EQ-5D (EQ-5D-5L), which measures the level of difficulty a person has with various aspects of their life, and includes mobility, self-care, usual activities, pain and/or discomfort and anxiety and/or depression. The scores are converted into a utility score which places a client on a continuum of health-related quality of life, between zero (worst possible health state) to one (best possible health state).

The utility score for the current study was calculated using the UK general population value set, as an Australian value set for the EQ-5D-5L has not, at the time of writing, been developed. This approach is consistent with recent EQ-5D-5L research undertaken with a general population sample in South Australia (McCaffrey et al. 2016).

Independence

Independence was measured at follow-up 6 months after a client's assessment, using a single-item measure: how satisfied are you with your level of independence? This was asked to see whether there were any differences in self-reported independence between the trial and control cohorts after their respective reablement periods had concluded.

Personal wellbeing

Reablement trial clients reported a small but statistically significant improvement in their personal wellbeing during the trial, while all other clients' personal wellbeing decreased after 6 months (Figure 2-6). Normative PWI scores for those aged over 76 years are provided in the figure for reference (Khor et al. 2020).

While there was a statistically significant difference in personal wellbeing improvement between cohorts – the magnitude of this difference was small, and the extent to which clients derived any meaningful benefit from the trial model of assessment may be negligible. A greater effect may have

been observed had CHSP service provision been consistently delivered in accordance with a wellness and reablement approach (See Section 3.7 for further discussion).

This validated measure (PWI) is broad and is a good indicator for general wellbeing. After an extensive period observing and interacting with RAS organisations and clients, we believe it might be one of the most appropriate validated ways to measure the impacts of RAS assessment and entry-level aged care support.

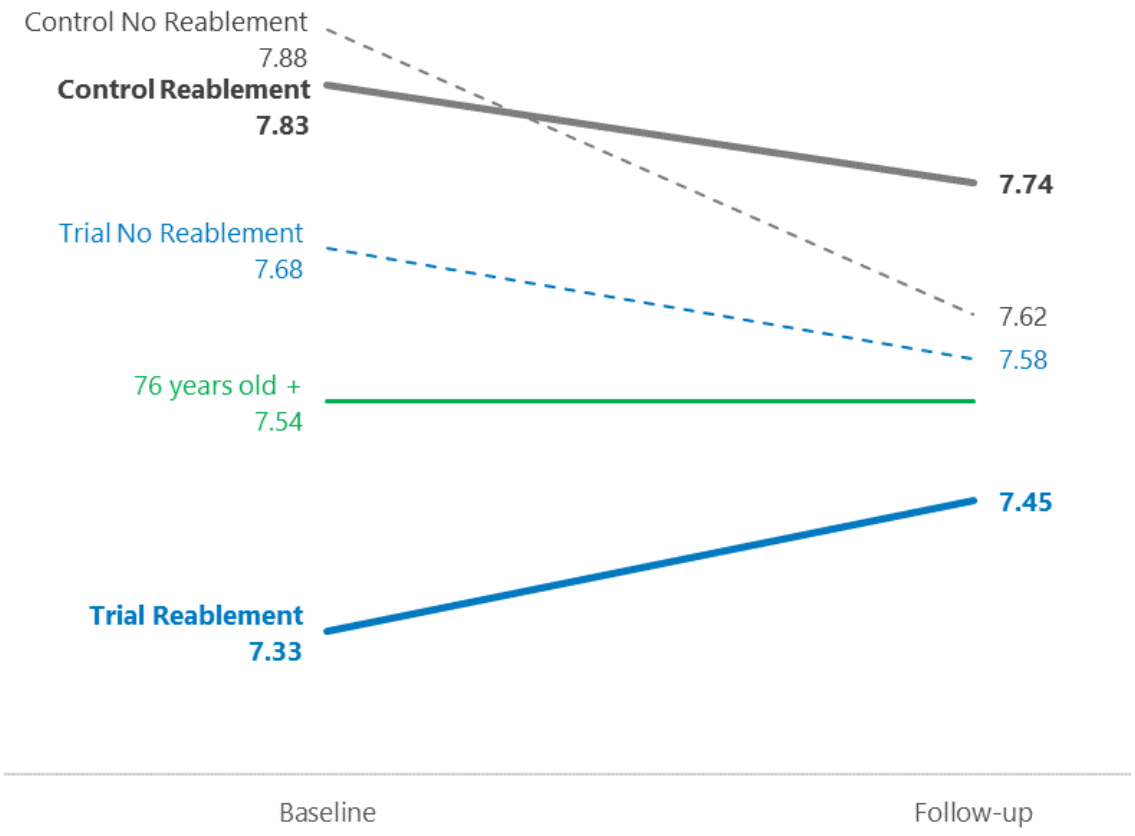
While improvements in wellbeing were observed for trial reablement clients, it is important to note that this cohort of clients had lower wellbeing scores compared to all other cohorts at baseline, which may have afforded them a greater opportunity for improvement over the 6 months of the trial.

All cohorts except for the trial reablement cohort scored within normative ranges for older Australians (Khor et al. 2020), while trial reablement clients were below the normative range. This suggests that trial reablement clients trended toward a 'normal' level of wellbeing 6 months following assessment.

Finally, the small effects observed in client wellbeing may be influenced by the delayed roll out of complimentary support strategies for CHSP services.

While active assessment can be more effective at identifying genuine client need, the client still requires services that are supported to deliver a W&R approach, and this aspect of the trial was lacking. Coupled with findings presented later (Section 2.5.4), whereby for all clients, 20% of recommended services were not delivered – there is a clear need to support not just high-quality assessment of clients, but also high-quality service provision that is readily available within the reablement period.

Figure 2-6: Personal wellbeing at assessment and follow-up, by cohort and reablement



Health-related quality of life

During the trial, self-reported health-related quality of life increased for all clients, including control and trial clients (Figure 2-7). This indicates that both the trial and traditional assessments effectively lead to an improvement in client health-related quality of life over a 6-month period.

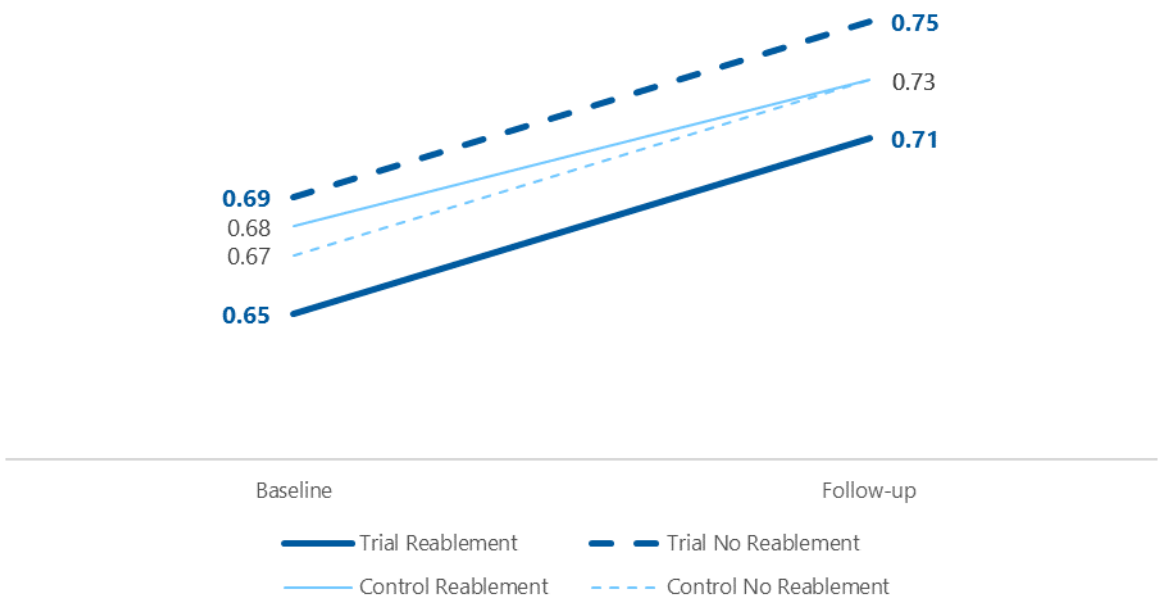
Reablement did not have a statistically significant effect on health-related quality of life. This was an unexpected finding for the evaluation and for the trial managers. They were puzzled by this finding and thought that, like the Personal Wellbeing Index, that there would have been a greater improvement in health-related quality of life for trial reablement clients.

Neither could they explain why the trial reablement clients started at a lower health-related quality of life utility score (0.65). We examined demographic data within the My Aged Care data collection and could not find any contributing factors that could explain this lower baseline score.

As with the PWI, the delayed roll-out of complimentary support strategies for CHSP services may have reduced the impact the trial model had on client health-related quality of life. Nevertheless, changes observed in the trial are consistent with previous research on similar aged care assessment models (Silverchain 2017). In this earlier study, both reablement clients and non-reablement clients evidenced increases in their health-related quality of life between baseline and 3-month follow-up, similar in magnitude to what was observed during the PIL trial.

Broader findings of the PIL trial suggest that if there had been greater CHSP provider buy-in to delivery of services with a W&R focus, this may have resulted in more compelling changes in client outcomes.

Figure 2-7: Average utility (health-related quality of life) score by cohort and reablement



Level of independence

Control and trial clients – whether undergoing reablement or not – reported similar levels of independence 6 months after their assessment, averaging 3.4 out of 5 (where zero is low satisfaction with one's independence and 5 is a high level of satisfaction). This indicates that statistically, neither the trial model nor reablement status significantly influenced self-reported client independence 6 months after assessment.

Similar to the health-related quality of life results, this was a surprising finding to us and the trial managers given the key goal of reablement strategies is to increase the independence of clients.

It is conceivable that clients may have experienced increased independence in some aspects of their lives but not others, and the more general nature of the question they were asked did not appropriately reflect the many ways independence could be interpreted.

2.5.4 Service outcomes

This section presents analysis of service utilisation data provided by the department – for the 2019-20 financial year. Analysis found – consistent with our findings in the 2019 CHSP audit – that at a client level CHSP providers largely delivered services in line with those that were recommended, including those delivered in the trial regions.

However, a significant proportion of service recommendations, around one fifth (20%), were not delivered at all. The prevalence of this is widespread, including the trial and ROC regions. Based on interviews with trial and non-trial RAS staff as well as CHSP providers, this is largely due to CHSP services being unavailable.

If corroborated, these service limitations threaten to undermine the effectiveness of reablement, and assessments more broadly. It is also possible that a certain proportion of these clients may have exited the CHSP program before receiving services.

When comparing the proportions of short-term and ongoing services clients receive across the country, reablement clients are fundamentally the same as non-reablement clients. The trial model did not influence the number of clients receiving short-term services, as the proportions of trial clients who received short-term services (Section 2.5.4) did not differ markedly from proportions observed in other cohorts.

It is not possible to determine from the My Aged Care data whether CHSP providers adhere to time-limited service recommendations.

We suggest in this report (see Part 3: Lessons) that coordination between RAS and CHSP providers needs to be strengthened, and that relying on changes to assessment alone may not be enough to shift what is a complex and at times disconnected system.

Service outcomes client sample

To remove the potentially confounding influence of previous RAS assessments and associated CHSP services, we only examined the service outcomes of new clients.

New clients are defined as those who had not been assessed prior to the 2019-20 financial year. This includes all clients, regardless of whether they did or did not receive CHSP services. The sample is reported across 5 cohorts and by reablement sub-group, as detailed in Table 2-11.

Clients assessed in WA and Victoria are separated from other cohorts as their approach to reablement is purportedly more advanced[1] than those elsewhere in the country. Indeed, findings throughout this section show how these two cohorts experienced substantially different service outcomes when compared with trial, control, and rest of the country clients.

[1] More advanced reablement model does not necessarily mean higher reablement rates, for example Victoria's reablement rates remain consistent with the rest of the country. A more advanced model means that when a client receives reablement there may be more advanced coordination between RAS and service providers to ensure the client being reabled has the best possible chance of meeting their goals and remaining independent.

Table 2-11: Service outcomes client sample

Cohort	Reablement	Non-reablement	Total clients
Trial	5,139 (30%)	11,979 (70%)	**17,118**
Control	1,788 (14%)	11,449 (86%)	**13,237**
ROC	13,625 (17%)	66,114 (83%)	**79,739**
WA	3,810 (24%)	11,811 (76%)	**15,621**
Vic	4,506 (11%)	35,409 (89%)	**39,915**
Total	**28,868 (17%)**	**136,762 (83%)**	**165,630**

Non-concordance not prevalent

Non-concordance – where services were delivered which had not been recommended at assessment – was low across all cohorts, and there was no evidence to suggest that the trial model influenced the level of non-concordance. This finding is consistent with the 2019 CHSP audit, which also found a high concordance between services recommended in RAS support plans and the services delivered by CHSP providers. This indicates that CHSP providers do not routinely deliver services that were not recommended at assessment.

Fewer clients in trial regions received services

Fewer trial and control clients received a service when compared with the rest of the country, WA and Victoria cohorts.

For trial clients, this was because fewer clients were recommended services at assessment, whereas for control clients this is likely a reflection of clients not receiving services despite being recommended for them.

Service types across trial, control and rest of the country cohorts did not vary significantly, whereas the service mix for clients in WA and Victoria were notably different compared to these other cohorts.

Discussion with RAS managers throughout the trial highlighted that service funding and availability is heavily dependent on jurisdiction. Therefore, it is probable that jurisdiction-specific supply constraints had a significant effect on services received.

Matched My Aged Care and DEX (CHSP service utilisation) client records were used to determine the proportion of clients who:

- received no service recommendations
- received a service recommendation, but did not receive a service[2]
- received a service.

Table 2-12 displays these three categories, along with the proportion of clients receiving each service type across the 5 cohorts and 2 sub-groups (reablement and non-reablement). The records show the following.

Fewer trial and control reablement clients received services (67% and 65% respectively) when compared to reablement clients in the rest of the country (74%), WA (72%) and Victoria (86%).

[2] The proportion of clients who received a service recommendation but did not receive a service will be slightly higher due to clients that were assessed later in the 2019-20 financial year whose 2020-21 services are not available for analysis.

While trial and control cohorts had similar rates of clients receiving services, this is likely a reflection of two different influences at play:

- For trial clients, this likely reflects the greater number of clients across both reablement and non-reablement sub-groups that were not recommended a service at assessment (5% and 11% respectively).
- For control clients, this likely reflects the high proportion of clients that were recommended a service but did not receive one (34% for reablement clients and 40% for non-reablement clients).

Fewer allied health, home maintenance and home modification services were received by trial and control clients, when compared with rest of country and Victorian clients. Most other service types were received at similar rates when comparing trial, control, and rest of country cohorts.

Services received by clients in WA and Victoria followed a different pattern compared with other cohorts. For example, just 2% of Victorian clients received transport services, compared with approximately 10% for other cohorts. Discussion with RAS managers in Victoria highlighted that this is likely due to supply side constraints, such as variable funding available for service types between jurisdictions.

Discussions with RAS managers and other key stakeholders throughout the trial, coupled with analysis of publicly available data on government spending on aged care (GEN aged care funding data), indicate that supply side constraints which limit service availability may have an impact on services received by clients in each jurisdiction.

Table 2-12: Services received by service type, cohort and reablement sub-groups

Services	Trial R	Trial N-R	Control R	Control N-R	ROC R	ROC N-R	WA R	WA N-R	Vic R	Vic N-R
Sample size	**5,139**	**11,979**	**1,788**	**11,449**	**13,625**	**66,114**	**3,810**	**11,811**	**4,506**	**35,409**
No service received (total)	**33%**	**48%**	**35%**	**47%**	**26%**	**42%**	**28%**	**38%**	**14%**	**29%**
No service recommendation	5%	11%	1%	7%	1%	7%	8%	17%	<1%	7%
Service recommended, but no service received	29%	36%	34%	40%	25%	35%	20%	20%	13%	22%
Service received (total)	**67%**	**52%**	**65%**	**53%**	**74%**	**58%**	**72%**	**62%**	**86%**	**71%**
Allied Health and Therapy Services	37%	18%	34%	15%	45%	20%	23%	10%	64%	39%
Domestic Assistance	21%	17%	21%	22%	21%	20%	38%	31%	31%	26%
Home Maintenance	9%	8%	8%	8%	13%	13%	12%	14%	19%	18%
Social Support Individual	10%	8%	10%	9%	11%	10%	11%	11%	8%	8%
Home Modifications	15%	7%	15%	5%	20%	8%	15%	7%	16%	8%
Transport	8%	10%	11%	10%	10%	10%	10%	11%	2%	2%
Nursing	6%	5%	8%	6%	8%	6%	1%	2%	10%	9%
Personal Care	3%	3%	3%	3%	4%	3%	6%	5%	12%	10%
Meals	5%	5%	4%	5%	5%	5%	3%	4%	6%	6%
Specialised Support Services	5%	4%	2%	2%	4%	3%	1%	1%	7%	7%
Social Support Group	3%	2%	2%	2%	3%	2%	3%	4%	5%	4%
Flexible Respite	2%	3%	1%	2%	2%	3%	1%	2%	3%	4%
Goods, Equipment and Assistive Technology	4%	2%	2%	2%	3%	2%	16%	7%	0%	0%

Note: Other CHSP services with small sample sizes and percentages are not shown – including Assistance with Care and Housing, Centre-based Respite, Other Food Services and Cottage Respite. Details are in Part 4: Technical supplement of this report.

Unmet demand for services

In order to further understand supply constraints, for each service type we examined the proportion of clients recommended a CHSP service who subsequently did not receive it (Table 2-13).

This analysis was restricted to clients with an assessment in the first 6 months of the 2019-20 financial year, to allow enough time for a service to be put in place.

Overall, when a service was recommended, about one-fifth (20%) of clients did not receive that service. The trial model did not have any influence on this trend; trial clients were just as likely as ROC clients to be recommended a service and not receive it.

Interestingly, the 3 service types with comparatively lower levels of CHSP recommendations in trial regions – domestic assistance, transport and home maintenance – appear to be those with the largest proportion of clients who were recommended the service but subsequently did not receive it (26%, 36% and 31% respectively).

We found that trial assessors were much more likely to recommend non-CHSP funded domestic assistance and transport options than non-trial assessors.

This indicates that instead of simply recommending a CHSP service, trial assessors looked for an alternative solution for the client when they knew a service might not be readily available.

Table 2-13: Services recommended but not received, by service type and cohort

Services	Trial	Control	ROC	WA	Vic	Total
Sample size	**6,339**	**5,164**	**31,475**	**5,592**	**16,216**	**64,786**
Allied Health and Therapy Services	18%	22%	16%	11%	10%	**14%**
Domestic Assistance	26%	30%	26%	11%	13%	**22%**
Home Maintenance	31%	35%	26%	12%	14%	**23%**
Social Support Individual	24%	28%	24%	18%	13%	**22%**
Home Modifications	14%	19%	12%	6%	6%	**11%**
Transport	36%	39%	31%	19%	17%	**30%**
Nursing	20%	24%	17%	12%	11%	**17%**
Personal Care	18%	21%	23%	12%	11%	**18%**
Meals	22%	28%	21%	13%	11%	**19%**
Specialised Support Services	14%	20%	14%	17%	8%	**12%**
Social Support Group	27%	28%	27%	19%	15%	**23%**
Flexible Respite	23%	34%	25%	21%	12%	**23%**
Goods, Equipment and Assistive Technology	18%	23%	14%	9%	21%	**14%**

Note: Includes only clients assessed during first half of financial year 2019-20.

Analysis is based on the number of clients recommended for each service type – e.g. 18% of trial clients recommended for an Allied Health and Therapy Service did not receive this.

Service types with small sample sizes are not shown in this analysis.

Short-term and ongoing service provision

Short-term services are a hallmark of a reablement approach. We compared the proportion of clients who received short-term services with those who appear to receive ongoing services. Determining short-term vs ongoing services has limitations when using 12 months of service delivery data, since services that start later in the financial year may continue into the following year, data for which was unavailable for this evaluation. As such, the following findings should be interpreted with caution, as ongoing services would become more apparent if examining more than 12 months' data.

To determine whether a client had received services for a short or a long period of time, we calculated the number of service sessions each client received – within 90 days of their first session; between 90 and 180 days of their first session; and beyond 180 days of their first session.

Clients were then assigned to the following groups, based on their number of sessions of services:

- **No service recommendation** – no service was recommended at assessment.
- **Service recommended, but no service delivered** – the client had a service recommendation at assessment but had not received any services in the year.
- **Short-term** – the client received services in only one of the 3 time periods.
- **Ongoing** – the client received services in 2 consecutive time periods, for instance within 90 days of their first session, and between 90 and 180 days of their first session.
- **Complex cases** – the client received a service in the first and third time periods. These clients may have had a disruption to their services and are therefore considered complex cases in the sample.

Table 2-14 demonstrates that:

- Somewhat surprisingly, fewer WA and Victorian clients received short-term services (25% each) than other cohorts including the trial cohort.
- The proportion of reablement clients in trial regions who did not receive a service recommendation (5%) was similar to that of WA (8%), with all other cohorts at 1% or fewer.
- WA and Victorian reablement clients were less likely to be recommended a service and not receive it (12% and 10% respectively). For other cohorts relatively more clients did not receive the recommended services, especially control clients, where 28% were recommended a service they did not receive.

Table 2-14: Short-term and ongoing service provision for reablement clients by cohort

Service duration/ intensity	Trial	Control	ROC	WA	Vic
Sample size	**2,055**	**802**	**5,546**	**1,561**	**2,188**
No service recommendation	5% (102)	<1% (5)	1% (55)	8% (125)	<1% (5)
Service recommended, but no service received	22% (460)	28% (226)	20% (1,113)	12% (186)	10% (211)
Short-term	28% (570)	31% (241)	29% (1,601)	25% (364)	25% (543)
Ongoing	42% (859)	38% (304)	46% (2,548)	53% (844)	62% (1,343)
Complex cases	3% (64)	3% (26)	4% (229)	2% (42)	3% (86)

Data for non-reablement clients are displayed in Table 2-15. As shown:

- Rates of no service being recommended were higher across control, rest of the country and Victoria than those observed for reablement clients (Table 2-14). As for reablement clients, non-reablement clients with no service being recommended were highest for the trial (11%) and WA 16%) cohorts.
- WA and Victoria also had lower rates of clients being recommended a service but not receiving one, 14% and 16% respectively. This likely resulted in a higher rate of ongoing services for these cohorts.
- Rates of clients who received short-term services were similar for trial (23%), control (22%) and rest of the country cohorts (23%).
- Rates of trial clients who received ongoing services (34%) was lower than all other cohorts.

Table 2-15: Short-term and ongoing service provision for non-reablement clients by cohort

Service duration/ intensity	Trial	Control	ROC	WA	Vic
Sample size	5,058	4,751	28,019	5,067	15,239
No service recommendation	**11%** (551)	**7%** (318)	**6%** (1,660)	**16%** (820)	**6%** (1,004)
Service recommended, but no service received	**29%** (1,495)	**33%** (1,608)	**29%** (8,270)	**14%** (736)	**16%** (2,444)
Short-term	**23%** (1,155)	**22%** (1,050)	**23%** (6,577)	**20%** (1,012)	**24%** (3,573)
Ongoing	**34%** (1,724)	**35%** (1,648)	**39%** (10,641)	**48%** (2,419)	**51%** (7.762)
Complex cases	**3%** (133)	**3%** (127)	**3%** (871)	**2%** (80)	**3%** (456)

2.6 Trial model cost-effectiveness

2.6.1 Summary

It was found that once assessors are trained and the model embedded within RAS organisations, the cost of an active assessment is similar to the cost of a traditional assessment.

Client follow-up throughout the reablement period adds an extra $51 per client per annum, however this cost is offset by reduced CHSP service utilisation, saving approximately $100 per client per annum.

Active assessment led to a small improvement in reablement client-wellbeing after 6 months. Details of client-reported outcomes are provided at Section 2.5.3 and statistical analysis is in *Part 4: Technical supplement*.

Trial model costs

The trial model cost $238 per client more than the traditional model, comprising an extra:

- $129 for RAS assessor training
- $54 for RAS mentor resource
- $55 for additional time spent conducting assessments and follow-up.

This additional cost is estimated to reduce to $51 per client for subsequent years, as the training costs and need for mentors diminish.

This additional $51 per client is largely due to the client follow-up component, rather than conducting active assessments. RAS managers indicated in post-trial interviews that the active assessment component of the trial model could be conducted within the time allocated for traditional assessments.

Once implemented, active assessment (without follow-up) is therefore cost neutral compared to traditional assessment. Benefits from active assessment, such as more appropriate and tailored services and general recommendations, could therefore be realised without material change to RAS funding allocations. However, additional potential benefits could be realised from client follow-up if implemented effectively.

CHSP services and cost

CHSP service utilisation for trial clients cost around $100 less per client per annum, compared to clients assessed using the traditional model. This saving is largely because trial clients (both reablement and non-reablement) were less likely to receive a recommendation for a CHSP service.

However contrary to expectations, where clients were recommended for CHSP services, there was no evidence that the trial model led to more short-term services (up to 12 weeks) and fewer ongoing services. This was not expected as reablement interventions are designed to be time-limited.

National costs

Once implemented, the trial model:

- costs $51 more than traditional assessments, due to the extra time involved in client follow up during the reablement period.
- results in CHSP service cost savings of $100 per client per annuum, due to relatively more clients being assessed as not requiring any CHSP services.

If the trial model was implemented nationally, it is estimated that for new clients receiving a RAS assessment there would be a $6.2 million additional cost outlay in the first year, and subsequent savings of $6.7 million in the second year and $6.9 million in third year.

839,373 clients received CHSP services in 2019-20, at a cost to government of approximately $2.53 billion. In this context the additional cost to implement the trial model is relatively small and is offset by cost savings in subsequent years.

These estimates do not include potential 'downstream' costs savings through deferring clients' need for other services such as residential aged care and hospital services.

2.6.2 Data limitations

The costing study was based on assessment and CHSP service data. There are important assumptions and limitations to this study which limit the utility of the results. These include:

- **Time-bound.** A longitudinal study over multiple years would provide greater confidence in assessing the extent to which CHSP services become ongoing or not. Costings are based on one year's (2019-20) service utilisation (DEX) data, which may not be representative of client CHSP service profiles.
- **Not all clients costed.** The study examined new assessments, and excluded existing and 'grandfathered' clients – those who have transitioned from previous home care programs to the CHSP. These clients often have a different service profile than those entering the CHSP in more recent years. Around 30% of CHSP clients were excluded on this basis.
- **CHSP supply side constraints.** Further work is needed to determine how the limited supply of CHSP services influences service delivery across the nation. Costing was based on the services delivered, but about 20% of service recommendations were not delivered, for both trial and non-trial client cohorts.
- **Trial model not yet mature.** The trial model requires time to become fully embedded. It is likely that a similar evaluation conducted after another 12 months, would provide a clearer picture of the influence of the trial model on CHSP service delivery.
- **Impact on other forms of care.** The study did not address 'downstream' costs savings', such as those associated with delaying a client's entry to more costly forms of care – such as Home Care Packages, residential aged care and hospital care.
- **Transitional costs** are based on the roll-out of the trial model. Different approaches (and hence different costs) may be adopted for a national roll-out, for example if training was conducted closer to the location of trainee assessors.
- **CHSP service duration.** The study assumes that, on average, CHSP clients receive services for 36 months. This estimate is based on *Deloitte Access Economics Draft CHSP Data Report* (Deloitte Access Economics 2019) and there is likely considerable variation due to client circumstances.

2.6.3 Cost of assessment

The cost of assessment in trial regions was compared with the cost of traditional assessment. The following elements of the trial and traditional model were costed:

- RAS assessment cost, comprising base hours (as currently funded) and top-up hours for the trial model.
- PIL training cost for assessors and mentors, delivered by the training provider (ACNA).
- PIL mentor cost, comprising RAS mentor salaries.

As itemised in Table 2-16, these costs total $400 per assessment for the traditional model and $637 for the trial model.

Analysis and consultation identified that the increased trial model assessment costs were largely 'once off' upfront costs to train all assessors and fund mentors to deliver the trial model. It is expected that these additional costs will reduce after the first year of implementing the trial model, as the training costs and requirement for mentors diminishes as the trial model becomes embedded.

As itemised in Table 2-17, estimated assessment costs excluding these 'once off' transition costs, total $451 per assessment for the trial model; which is $51 (12.8%) greater than the traditional model ($400).

This additional $51 is largely due to the client follow-up component. RAS managers indicated in post-trial interviews that the active assessment component of the trial model could be conducted within the time allocated for traditional assessments. Once implemented, active assessment (without follow-up) is therefore cost neutral compared to traditional assessment.

Basis of calculations

The department advised that RAS organisations currently receive $400 to provide a 2.5 hour assessment, and to cover their travel and overhead costs. For the trial model assessment group, a top up assessment time of 1.1 hours was added, costing $55 ($54.92 rounded). This includes the additional time identified for reablement client follow-up, delivered under the trial model.

For the trial model, PIL training costs and the PIL mentor costs per client averaged $129 ($129.19 rounded) and $54 ($53.55 rounded) respectively (Table 2-16).

The above costs ($400+$55+$129+$54) total $637 per assessment under the trial model.

As itemised in Table 2-16, assessment costs total $400 per assessment for the traditional model and $637.66 for the trial model during the period of transition to this model.

Table 2-16: Initial cost per assessment during transition to trial model – Comparison of trial and traditional approaches

Resources	Traditional	Trial	Mean difference
Sample size	**380**	**853**	**Not applicable**
RAS assessment – traditional ($160 per hour)	2.5 hours $400.00	2.5 hours $400.00	0.0 hours $0.00
RAS assessment – top up ($50 per hour)	Not applicable	1.1 hours $54.92	1.1 hours $54.92
ACNA training	Not applicable	1.0 hour $129.19	1.0 hours $129.19
RAS mentors	Not applicable	1.0 hour $53.55	1.0 hours $53.55
Total cost per assessment	**$400.00**	**$637.66**	**$237.66**

As itemised in Table 2-17, following the transition year the above trial model costs ($637) are expected to reduce to $451 per assessment.

The reduced costs are based on trial RAS manager feedback and include the following assumptions:

- Top up hours reduce from 1.1 hours to 0.5 hours per assessment as the trial model becomes embedded.
- 10% assessor turnover per year, and therefore only 10% of assessors need to be trained each year after the first year of implementation.
- Reduction in the required mentor resource, from 2 full-time equivalent (FTE) per RAS organisation to 0.5 FTE each year after the first year of implementation.

As shown in Table 2-17, once initial training is completed and the trial model is embedded, it is expected that assessment costs will average $451.31 per assessment under the trial model; which is $51.31 greater than under the traditional model.

Table 2-17: Ongoing cost per assessment – Comparison of trial and traditional approaches

Resources	Traditional	Trial	Mean difference
Sample size	**380**	**853**	**Not applicable**
RAS assessment – traditional ($160 per hour)	2.5 hours $400.00	2.5 hours $400.00	0.0 hours $0.00
RAS assessment – top up ($50 per hour)	Not applicable	0.5 hours $25.00	0.5 hours $25.00
ACNA training	Not applicable	0.1 hours $12.92	0.1 hours $12.92
RAS mentors	Not applicable	0.25 hours $13.39	0.25 hours $13.39
Total cost per assessment	**$400.00**	**$451.31**	**$51.31**

2.6.4 Total cost – assessment and CHSP services for new clients

For new clients receiving a RAS assessment, the cost of the trial model and of the traditional model were estimated and compared nationally (rest of country) over a three-year time horizon. Rest of country excludes WA, VIC, trial and control RAS regions.

Costs comprise:

- assessment cost, including ongoing assessor training and mentoring.
- cost of CHSP services provided subsequent to an assessment.
- transitional costs in the first year, associated with training and embedding the trial model into RAS organisations nationally.

Assessment and CHSP service utilisation and costs were derived from the My Aged Care and DEX service utilisation data for the trial period.

It was calculated that the ongoing total annual costs are similar under both models. For year 1:

- Assessment costs total $26.9 million under the traditional model (Table 2-18) and $30.3 million under the trial model (Table 2-19), an increase of $3.4 million (12.6%) for the trial model.
- CHSP costs total $148.2 million under the traditional model (Table 2-18) and $138.4 million under the trial model (Table 2-19), a reduction of $9.8 million (6.6%) for the trial model.
- Transitional 'once off' assessment costs total $12.5 million for the trial model.

In total (Table 2-20), the trial model is $6.2 million more costly (3.5% of $178.6 million), however excluding $12.5 million 'once off' transition costs, the trial model is $6.3 million less costly than the traditional model, and this continues into years 2 and 3 ($6.7 million and $6.9 million less costly).

Savings in CHSP services under the trial model involve several factors. Most significantly, more clients received no CHSP services following trial model assessment, than for traditional model assessments.

For clients who received services, the average CHSP cost was similar under both models.

Calculations for the traditional model

For year 1, total national costs (rest of country) were calculated for the traditional model, as follows (see Table 2-18):

1. Identified the number of new clients receiving an assessment in July and August 2019 (n = 11,200) and multiplied this by 6 to estimate the full year (n = 67,200)
2. Multiplied 67,200 clients by $400 cost per assessment, to derive total assessment cost of $26.9 million.
3. So that the costs represented a full year of CHSP services, prior year clients who continued to receive CHSP services in the current were added. For year 1 this was based on clients deemed to be receiving ongoing or complex CHSP services (n = 15,524), totalling 82,454 CHSP clients (67,200 + 15,524) for year 1.
4. Determined the proportion of each cohort (new clients and prior year continuing) who received short vs ongoing services, and who received reablement vs non-reablement clients.
5. Determined the average annual cost per client of CHSP services for each cohort, based on services recorded in DEX service utilisation data and the unit costs reported in the Deloitte Access Economics Draft CHSP Data Report.
6. Assumed clients received CHSP services for an average of 1.5 years. We therefore retained new clients from the previous year, but halved their annual cost to reflect their remaining 0.5 year in the CHSP program. Clients who received short-term services were assumed to have exited the CHSP in the year in which they entered the CHSP.

For years 2 and 3, a 3% sample growth was assumed each year.

As shown in Table 2-18, costs under the traditional model total $178.6 million for year 1.

Table 2-18: Rest of country, total cost under traditional model – new clients

Client type	Cost per client	Year 1	Year 2	Year 3
Reablement clients	$1,958	10,315	10,625	10,943
Non-reablement clients	$1,462	56,885	58,591	60,349
Prior year clients – reablement	$3,147	2,765	2,851	2,936
Prior year clients – non-reablement	$2,894	12,489	12,876	13,262
Total CHSP clients	**$1,797**	**82,454**	**84,943**	**87,490**
CHSP service cost	$1,797	$148,207,261	$152,699,033	$157,276,452
RAS assessment cost (new clients)	$400	$26,880,000	$27,686,400	$28,516,800
Total cost of traditional model		**$175,087,261**	**$180,385,433**	**$185,793,252**
Adjusted for CPI		**$178,589,006**	**$183,993,142**	**$189,509,116**

Calculations for the trial model

For the trial model, the above costing process was replicated, but using the proportions of reablement vs non-reablement and short vs ongoing clients observed within trial regions for the cohorts each year (67,200 in year 1).

Average annual costs per client within trial regions were then applied, as described in step 5 above.

As shown in Table 2-19, under the trial model costs total $184.8 million for year 1, including $12.5 million transition costs.

Table 2-19: Rest of country, total cost under trial model – new clients

Client type	Cost per client	Year 1	Year 2	Year 3
Reablement clients	$1,663	18,346	18,896	19,463
Non-reablement clients	$1,360	48,854	50,320	51,830
Prior year clients – reablement	$2,819	4,497	4,636	4,776
Prior year clients – non-reablement	$2,922	9,848	10,152	10,457
Total CHSP clients	**$1,697**	**81,545**	**84,004**	**86,526**
CHSP service cost	$1,697	$138,403,737	$142,592,276	$146,874,667
RAS assessment cost (new clients)	$451	$30,307,200	$31,216,416	$32,153,143
Assessment transition cost for year 1	$186	$12,499,200		
Total cost under trial model		**$181,210,137**	**$173,808,692**	**$179,027,810**
Adjusted for CPI		**$184,834,340**	**$177,284,866**	**$182,608,366**

As shown in Table 2-20, total annual costs are broadly similar under both models. For year 1, the trial model is 3.5% ($6.2 million/$178.6 million) more costly, but in year 2 the trial model is 3.7% ($6.7 million/$183.9 million) less costly.

Table 2-20: Rest of country, cost difference between traditional and trial models – new clients

Model	Year 1	Year 2	Year 3
Traditional model – rest of country adjusted for CPI	$178,589,006	$183,993,142	$189,509,116
Trial model – rest of country adjusted for CPI	$184,834,340	$177,284,866	$182,608,366
Difference – rest of country cost	**$6,245,334**	**-$6,708,276**	**-$6,900,750**
Traditional model – average cost per client	$2,166	$2,166	$2,166
Trial model – average cost per client	$2,267	$2,110	$2,110
Difference – cost (saving) per client	**$101**	**-$56**	**-$56**

2.6.5 Cost extrapolation for all clients nationally

839,373 clients received CHSP services in 2019-20, at a cost to government of approximately $2.53 billion (GEN Aged Care 2020).

This section estimates the total cost of assessment and CHSP services nationally, if all of these 839,373 clients had been assessed under the trial model.

Trial model and traditional model costs are compared, to provide an estimate of the potential annual costs and savings to government once the model is fully embedded nationally.

Table 2-21 shows that the assessment and CHSP service costs for all clients under the traditional model total $2.41 billion per annum.

This cost was calculated through data modelling, and it is noted that it varies marginally from GEN aged care data snapshot data which indicates CHSP funding allocation of $2.53 billion for 2019-20.

Challenges of costing CHSP services for all clients nationally

A significant proportion of CHSP clients recorded in the system transitioned over from the previous home care program which ceased in 2014. As a result, their service mix may be considerably different to clients assessed in 2020.

To reflect the service mix for these long-term clients, average CHSP service costs for ongoing clients (reablement and non-reablement) of $2,936 were applied for all existing clients. This contrasts with new client costs ($1,797) which is a composite of short-term clients ($755), ongoing clients ($2,936) and clients who did not receive services.

Table 2-21: Total national cost under traditional model – all clients

Costs	Cost per client	Clients	Traditional model costs
New clients		**67,200**	
CHSP service cost	$1,797		$120,758,400
RAS assessment cost	$400		$26,880,000
Existing clients	**$2,936**	**772,173**	**$2,267,099,928**
Total		**839,373**	**$2,414,738,328**

As shown in Table 2-22, costs under the trial model total **$2.39 billion** for financial year 2019-20, including $12.5 million transition costs.

Table 2-22: Total national cost under trial model – all clients

Costs	Cost per client	Clients	Trial model costs
New clients	**Not applicable**	**67,200**	**Not applicable**
CHSP service cost	$1,697		$114,038,400
RAS assessment cost	$451		$30,307,200
Assessment transition cost for year 1	$186		$12,499,200
Existing clients	**$2,887**	**772,173**	**$2,229,263,451**
Total		**839,373**	**$2,386,108,251**

As shown in Table 2-23, total costs are similar under both models. For financial year 2019-20 the trial model is $28.6 million (1.2% of $2.41 billion) less costly.

It is noted that the previous Table 2-20 shows an additional cost of $6.24 million in year 1 under the trial model, for newly assessed clients only. Table 2-23 shows a cost saving because it includes the entire CHSP population (839,373 clients), of which assessment costs are only incurred for a minority during the year.

Table 2-23: Total national cost difference between traditional and trial models – all clients

Cost	Cost per client	Clients	Total
Traditional model	$2,877	839,373	$2,414,738,328
Trial model	$2,843	839,373	$2,386,108,251
Difference	**-$34**	**0**	**-$28,630,077**

3 Lessons

This Part 3 of the report presents the lessons identified from implementation of the PIL measure, to inform potential future implementation nationally. It addresses:

- trial preparation, including training 140 RAS assessors and 12 reablement mentors at 5 trial RAS organisations, to conduct assessments based on the trial model
- trial implementation, involving 17,118 trial assessments and 13,237 control (traditional) assessments conducted across 20 Aged Care Planning Regions, from July 2019 to June 2020
- interviews with over 100 consenting aged care clients, their carers and family members in the trial and control regions
- site visits, focus groups and interviews with managers, assessment team leaders, reablement mentors and assessors of all 5 trial RAS and 3 non-trial RAS organisations – almost half of the 17 RAS organisations across Australia – to explore their understanding and approach to W&R, as well as their feedback on the trial model
- interviews with CHSP providers and analysis of the department's 2018 national CHSP provider W&R survey.

This Part 3 addresses the following evaluation objectives:

- assess the **implementation** of the **trial reablement approach**, including the assessor training to equip assessors to deliver the trial model.
- assess the **appropriateness** of the **complementary support strategies**. As these strategies have yet to be released it was not possible to assess their effectiveness or cost effectiveness.
- identify the **enablers** and **challenges** to implementing the reablement trial approach nationally.

This Part 3 presents the implementation lessons for each key stakeholder group and component of the broader entry-level aged care environment, as follows:

Section 1: Conclusions

Section 2: Trial model implementation, covering assessor and mentor training and implementation of the trial model.

Section 3: Communicating with the community, including the attitudes of older Australians, carers and family members, as well as clinicians referring these clients into aged care. It also includes review of the draft communication resources within the PIL complementary support strategies.

Section 4: My Aged Care environment, including the website, contact centre and supporting IT system used to register clients, record assessment and any associated CHSP service recommendation.

Section 5: RAS operational environment, including enablers and challenges to their operational environment in a national rollout of the trial model, as well as wellness and reablement approaches more broadly.

Section 6: CHSP providers, including enablers and challenges to their operational environment in a national rollout of the trial model, as well as wellness and reablement approaches more broadly. This section includes review of the draft provider training supports within the PIL complementary support strategies.

Section 7: Coordination, exploring the relationship and communication between RAS organisations and CHSP providers in providing entry-level aged care.

Section 8: Reablement reimagined, suggests what reablement could look like in the context of entry-level aged care.

3.1 Conclusions

3.1.1 Active assessment

Active assessment was implemented well. RAS assessors received effective training which, combined with ongoing support from mentors, enabled them to conduct active assessments confidently. This led to a significant increase in the rates at which trial clients were recommended reablement, along with positive changes to service recommendations described in the previous Part 2: Outcomes of this report.

3.1.2 Reablement interventions

The first 2 components of the trial model – SMART goal setting and development of broad reablement strategies – were well understood but represent a significant change from traditional practice, and it therefore took time for them to be fully implemented by RAS assessors.

The client follow-up component of the model was poorly implemented, with less than half (45%) of trial clients receiving follow-up. Factors which contributed to this included:

- inadequate assessor training regarding client follow-up
- a lack of guidance about how assessors should conduct follow-up
- an unclear and inconsistent approach to recording follow-up activity in the My Aged Care IT system.

Lack of follow-up can reduce the effectiveness of the reablement period and jeopardise reablement success. Effective coaching support is vital for reablement, principally because ongoing coaching support helps maintain a client's motivation so that they can sustain functional improvements. Checking-in with the client also enables strategies to be refined as the client's situation changes, in order to meet reablement goals.

3.1.3 Embedding reablement

The trial provided several positive lessons, as well as revealing how parts of the aged care system will need to change if the promising trial results, and reablement more broadly, are to be fully effective.

National implementation would involve substantial change management for RAS organisations, CHSP providers and the community in their expectations of home care. If the trial model is implemented effectively it would assist in preparing the home care sector to meet the changing needs of the ageing Australian population.

A trial highlight was the strong support by all levels of RAS organisations for the trial model. RAS organisations saw considerable advantages to this approach compared with the traditional approach.

Despite early challenges, these organisations built a shared understanding of reablement – absent at the outset of the trial – and enthusiastically supported an increased emphasis on reablement in entry-level aged care.

The assessment outcomes presented in Part 2: Outcomes of this report, show substantial and positive change in assessment practice. Trial RAS organisations continue to practice the trial model despite the trial concluding. This momentum can be built on and presents an opportunity for the department.

Other lessons which could be relatively easily addressed are the need to:

- develop guidance for the remaining RAS organisations to implement the trial model
- enhance the My Aged Care IT environment.

The remaining lessons however, point to systemic factors that will take some time to overcome and which therefore pose greater challenges for the department.

The department's draft resources under the PIL budget measure – including the CHSP provider training and change management resources, and the broader communication resources – address some of the lessons as outlined below. But they will need to be part of a broader sustained strategy to overcome the more challenging barriers.

A key challenge is the need to rethink the relationship between RAS organisations and CHSP providers. Although the system was intentionally designed for each to operate separately, this has been over emphasised and at times the relationship has become dysfunctional.

This makes it difficult to respond to time-limited service interventions, a hallmark of reablement, and can compromise effective collaboration and coordination to ensure clients' needs are met. For clients undergoing reablement and those with complex needs, this is particularly important.

Other lessons from the reablement trial, that should be considered for a broader rollout of W&R approaches across aged care, include the need for:

- client expectations of automatic CHSP service entitlement – a demonstration of entrenched attitudes – to be shifted progressively over time
- operational models of RAS organisations and CHSP providers, which currently do not fully support the trial model – or an increased focus on reablement of entry-level aged care clients
- sufficient CHSP services to be available to meet increasing rates of clients undergoing reablement, particularly reablement-focussed service types such as allied health services and assistive technology (AT)
- consistent understanding of, and approaches to, wellness and reablement embedded throughout the aged care system.

3.2 Trial model implementation

This Section presents findings about trial RAS organisations' implementation of the trial model. It begins by reviewing the training provided to equip assessors and mentors or reablement champions, to deliver the trial model. It then explores how well each component of the trial model, designed by the department to increase the emphasis on reablement, was implemented during the trial.

3.2.1 Lessons

RAS assessor and mentor training was largely effective in equipping participants with the skills and confidence to deliver active assessments. This was achieved by combining classroom training with experiential learning, allowing them to observe, and increasingly demonstrate, new practice. The training program was appropriate for assessors and mentors, who often came from diverse professions and had varied work experience.

One notable drawback of the training program was that it was not consistently implemented as intended. We identified a number of areas that would need to be strengthened if the training program is to be successfully rolled out more broadly.

Implementation of the reablement trial increased RAS organisations' focus on reablement and started to build a shared understanding of reablement, which trial managers reported as being absent at the outset of the trial.

The overall trial model was strongly supported by all levels of trial RAS organisations. The components of the trial model that garnered the most support were the active assessment approach and use of broader reablement strategies, both of which were seen as more successful than the traditional approach. There was also support for identifying SMART goals, although assessors took longer to become proficient in this component of the model.

Client follow-up was the least well implemented and the most contested component of the trial model. RAS managers reported that they had not realised that increased assessor resources were required to implement the trial model and therefore follow-up was given lower priority (due to inadequate assessor resources), even though all managers acknowledged the importance of client follow up. Given the significant change the trial model requires to the core business of RAS organisations, this indicates the need for a transitional period for RAS organisations if the model is to be implemented nationally. This is discussed further in Section 3.5, where the operational environment of RAS organisations is explored.

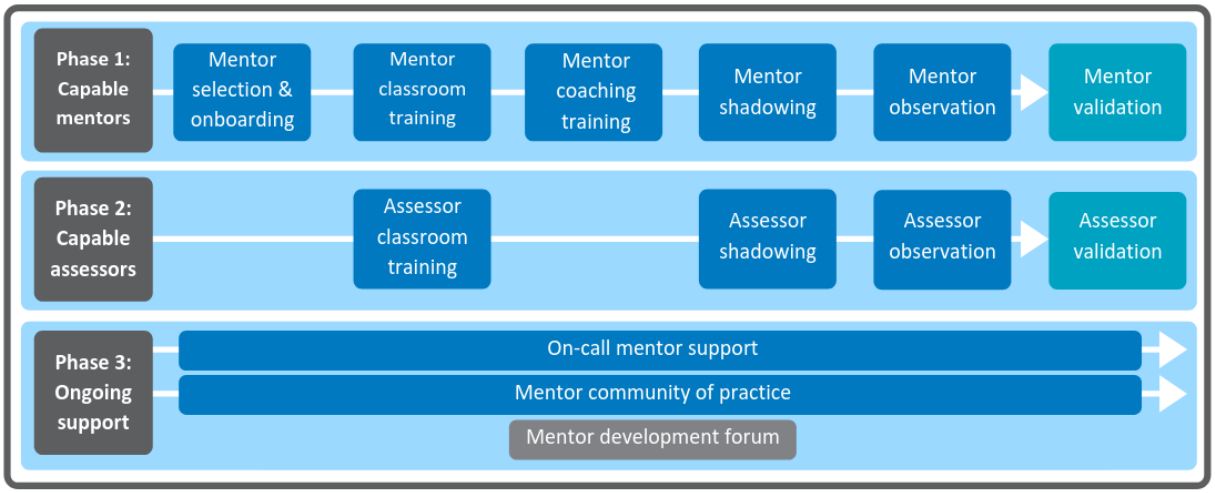
3.2.2 Assessor and mentor training program effectiveness

Access Care Network Australia (the training provider) was contracted by the department to deliver the training program. The program was based on a train-the-trainer model. As illustrated in Figure 3-1, the training program was structured into 3 phases, each of which consisted of several activities:

- Phase 1 – train mentors to assist assessors to deliver the reablement trial model.
- Phase 2 – train assessors to deliver the reablement trial model.
- Phase 3 – provide ongoing support to mentors.

Key findings and implications for a national roll out of the training program are provided below.

Figure 3-1: PIL training program structure



Training program was well-structured

Desktop review of training documentation, plus interviews with the training provider's management and staff, indicated that the program was well structured, met adult learning and assessment principles and emphasised the importance of experiential learning.

The train-the-trainer approach provided on-site expertise for each trial RAS organisation, with mentors available to support assessors during and after their training. The approach catered to different learning styles, which is particularly important for assessors who come from different professions and typically have a range of previous work experience.

Both assessors and mentors responded positively to the overall training program, with one mentor commenting that, *'I actually quite enjoyed the training and it helped cement my understanding of how people learn things.'*

After training, the assessors and mentors felt they understood the principles and benefits of the trial model, particularly the active assessment approach, with one assessor stating that, *'after training, we are big supporters of the active assessment model, and we can see how it is so much better for client.'*

Classroom training was well-received

The classroom training was the foundation of the training program. Mentors and assessors both reported that the classroom training equipped them to conduct active assessments. The experiential nature of the classroom training meant that mentors and assessors had opportunities to:

- role-play active assessment
- observe active assessment via a training video
- view and experience the use of various assistive technology (AT) that could later be suggested as reablement strategies for clients.

Mentors repeatedly reinforced the importance of the experiential nature of the training in developing their confidence in conducting active assessment. One mentor explained that, *'Role playing was a very valuable component of the training and I did find it helpful.'*

We conducted a survey of assessors, which found that they were equally appreciative of the experiential component. They valued the hands-on experience, the real-life scenarios, the explanation of the benefits of reablement to clients and the outline of alternate options to services.

More than three-quarters of the survey respondents agreed or strongly agreed that the training helped them:

- conduct an active assessment
- feel confident in helping clients set reablement goals and identifying reablement strategies.

These findings highlight the need for classroom training, if rolled-out nationally, to be supplemented by experiential learning methods to ensure future assessors can confidently conduct active assessments.

Three of the 15 competencies not adequately covered

The training provider identified 15 competencies which are needed to deliver the trial model:

Core competencies

1. Introduction of assessment and managing expectations
2. Have individual needs been identified i.e. non-judgemental approach
3. Demonstrates person-centred approach
4. Demonstrates holistic approach i.e. physical, cognitive and psychosocial

5. Promotes positive and active ageing i.e. capacity building
6. Demonstrates active assessment
7. Acknowledges client risks and potential hazards
8. Identify everyday AT to meet client need to enhance capacity and client independence
9. SMART goals established with client to meet needs
10. Identify suitable strategies to meet client need to enhance capacity and client independence
11. Demonstrates knowledge of community-based programs outside of CHSP funding
12. Summarises identified client needs and reinforce client goals
13. Formulates a planned pathway to meet goals
14. Demonstrates active assessment in written documentation
15. Identifies appropriate opportunities for reablement focused follow-up

The desktop review of training documentation found that the following 3 core competencies were not sufficiently covered:

- develop SMART goals (Competency 9)
- document an active assessment (Competency 14)
- provide client follow-up (Competency 15).

These three gaps were confirmed with mentors individually at interviews and then again in a focus group. Assessors also identified these gaps in a survey, with only:

- just over half (52%) agreeing or strongly agreeing that the training helped them to understand how to develop SMART goals
- less than half (48%) agreeing or strongly agreeing that the training helped them to learn how to document an active assessment.

When assessors were observed by mentors conducting active assessments, these competencies accounted for the highest number of 'not seen' or 'emerging' competencies. This indicates that, if rolled out nationally, training for these competencies should be strengthened.

Shadowing built assessor confidence

The shadowing component of the training program provided opportunities for assessors to observe an experienced mentor conduct an active assessment with a client, before going out and conducting their own active assessments. Assessors spoke of how crucial shadowing was in consolidating learnings and further building on their training-based confidence.

One assessor stated that, '*I would say [the classroom training] prepared me but it wasn't until I did my shadowing days that it all concreted together. I don't think you could just do the [classroom] training.*'

Furthermore, the assessor survey found that 80% of respondents agreed or strongly agreed that shadowing was valuable because it provided opportunities to: reinforce practice, pick up practical tips from their mentors, and increase their confidence.

These findings indicate that shadowing is an essential component of the training program, without which the training would not be as effective.

Validation to complete training was rigorous

Validation used a checklist to identify how each assessor, when conducting an active assessment, performed against each of the 15 competencies. The validation process was rigorous and well-structured, particularly the mandated use of a standardised observation checklist. This process fostered a consistent practice for the trial model, including active assessment, identifying SMART goals and reablement strategies and identifying opportunities for follow-up. One mentor reported that, '*I found it helpful that I got to go out with an assessor and observe them doing an active assessment: validating the active assessment approach is important for consistency.*'

Ongoing mentor support was valuable

Having access to experts in reablement practice, especially during the validation phase, was highly valued by mentors. These experts were provided by the training provider on an ongoing basis during the reablement trial.

Contact ranged from regular online meetings, to email support and ad hoc phone calls to address queries as the need arose. Mentor consultations indicated that this contact played a key role in developing their confidence and improving their performance in the field. One mentor commented that, *'I still have access whenever I need it, she's very approachable and makes herself available. No complaints there.'*

This would suggest that post-training access to reablement experts is an important component of the training model, particularly in the early post-training period. If the training is rolled out nationally, the existing reablement mentors could potentially be used in this capacity, to train-the-trainer for the next group of mentors.

3.2.3 Shared understanding of reablement improved

Before the reablement trial – despite an emphasis on wellness and reablement in RAS organisations' contracts, statements of requirement and CHSP program documentation – a shared understanding of reablement was not consistent or embedded across aged care.

This gap was confirmed by a number of sources including:

- site visits to trial and non-trial RAS organisations, which revealed variable understanding of reablement, where disagreement between assessors within the same organisation was not uncommon at trial commencement
- the department's 2018 national CHSP provider W&R survey, which found that over half (53%) of all CHSP providers felt that they require more support and information about how to embed wellness and reablement approaches into service delivery
- the 2017 Nous Evaluation of the Regional Assessment Service: Formative Evaluation Report (Nous Group 2017), which identified different interpretation of reablement approaches in RAS organisations.

Focus groups with trial assessors before the trial commenced and after trial completion, revealed key insights into their understanding of reablement and how it changed as a result of the trial.

The following figure is a 'word cloud' which visualises the words which assessors used **before the trial** – when describing reablement. Darker, larger words indicate more frequent use of that word by assessors.

Figure 3-2: Trial assessor 'word cloud' visualising what reablement meant to them before the trial

The following figure is also a visualisation of the words which assessors used when describing reablement, but this time **after the trial** was completed. Some words were used as frequently as before to describe reablement, for instance, 'client', 'empower' and 'independent'.

However, there was a noticeable shift away from words such as 'service' and a greater focus on directional, goal-oriented words including 'achieved', 'ADL' (activity of daily living), 'improve', 'strategy', 'needs' and 'goal'.

Figure 3-3: Trial assessor 'word cloud' visualising what reablement meant to them after the trial

Both mentors and assessors also emphasised that reablement can mean different things for different people. They felt that following training, they better understand that this personalised approach should have supports tailored to the individual's specific goals and needs.

They reported that a reablement philosophy should not be simplistic or narrow. Rather, reablement should be seen as a more holistic approach to helping a client, something the trial model supports. As one organisation said regarding the benefits of the model, '*you can pinpoint what they are doing really well and where they actually do need support'*.

Despite reablement meaning different things, trial RAS managers report that they now have a more consistent understanding of the basic elements of reablement, which they considered to have been absent at the outset of the trial. These elements include:

- **Client motivation**, as reablement support is only effective where targeting clients who are motivated to resume or continue ADLs.
- **Specific goal/s targeting independence or quality of life.** This can include a support that promotes social participation.
- **Time-limited support,** although there was consensus that reablement can, and reportedly does, include ongoing service recommendations to assist a client to fulfil other ADLs. This reflects the holistic philosophy of reablement.

Variable understanding of reablement and disagreements between assessors reduced throughout the trial due to:

- ongoing discussions between trial RAS organisations, at the manager and mentor level. This reportedly led to more consistent practice including recording reablement consistently in the My Aged Care data collection, by selecting the 'reablement period' box.
- greater emphasis and discussion internally within each RAS organisation, reported by assessors and team leaders.

3.2.4 Factors optimising reablement

Focus groups with trial assessors and mentors, and interviews with managers were conducted after the trial was completed, to gain their collective insights on factors that optimised reablement opportunities.

These are summarised below and include:

- Assessor attitudes towards reablement are key to motivating clients and optimising reablement opportunities. Managers concurred that: 'assessors *need to be passionate about reablement: they aren't just motivating the client, they are also motivating the family, health services and providers'*.
- In addition to a good understanding of the aged care system, assessors' skills need to include:
  - Active listening, motivational interviewing and client coaching skills – of note, these were considered collectively more important than clinical qualifications. Managers emphasised the importance of these skills, despite reporting that there was not always enough time to follow-up clients during the trial.
  - Strong writing skills to be able to document assessment information at the right level of detail. Managers stated that this was important, with one expressing the view that: '*The new model has highlighted some weaknesses in assessor capability – integrating information, assimilating…we still have a few assessors who may never be able to do write ups in the time. This is an issue for us in terms of productivity*'.
- Managers and assessors reported that mentors played a crucial role in encouraging and embedding the trial model within their respective RAS organisations – assessors consistently reported seeking advice from their mentor and continue to do so after the trial.

- Through greater interaction with providers, some trial regions reported better responsiveness to reablement service recommendations. Examples include:
  - Communicating with provider care coordinators by telephone led to shorter delays in one aged care planning region.
  - Allied health providers approaching a team leader to better understand the trial model.
  - Other providers engaging more closely with assessors as a result of the more detailed support plans received during the trial.

3.2.5 Active assessment strongly supported

The first component of the trial model is active assessment, which received strong support from all level of RAS organisations, including managers, team leaders, mentors and assessors. They were particularly supportive of its underlying principles and rationale.

Assessors were largely enthusiastic about adopting a 'show me' approach to assessment. Our survey of assessors found that the majority (92%) felt confident in conducting active assessments after their training. This included feeling confident in helping clients set reablement goals (89%) and identify reablement strategies (89%).

Mentors were also supportive of active assessment as, in the words of one mentor, it '*provided a more specific appraisal of a client's personal circumstances and capabilities.*'

There were however a few assessors from one trial RAS organisation that were reportedly unhappy with the active assessment approach and left during the trial. Their manager stated that this was because they felt their role was to provide services and they disagreed with the principle of asking clients to demonstrate ADLs.

The overall high level of support extended to the managers and assessors of the three non-trial RAS organisations we interviewed. Staff at these organisations responded positively to an explanation of the trial model, and quickly grasped the advantages of a 'show me' approach to identifying client strengths and limitations. Managers at these RAS organisations indicated their support for a national rollout and enquired about when this might occur.

According to mentors and assessors, the disadvantage of active assessment was not with the approach itself, but with the documentation it required. All trial RAS organisations reported taking significantly longer to record an active assessment, and this was reflected in the additional time taken to implement the trial model in the first three months of trial implementation.

Compared with the traditional assessment approach, an additional 0.5 to 1.5 hours per assessment was common in the early stages of the trial. However, this time reduced after the department provided guidelines for simpler documentation, and trial mentors and assessors reported that they were able to conduct and document an active assessment within the time allocated by the department for traditional assessments.

3.2.6 SMART goal setting valuable but challenging

Identifying SMART goals – that are specific, measurable, attributable, realistic and time-bound – is the second component of the trial model. This is important for defining what a client wants to achieve – in the reablement context, goals form the basis for developing reablement strategies and shape the reablement period. Without clearly articulated and mutually developed SMART goals, reablement opportunities may be lost.

However, assessors and mentors stated that this part of the trial model was challenging to fully understand and implement consistently. Talking to clients about defined goals was new for many assessors and, as one assessor explained, *'it is not something we find clients really think about'*.

Nonetheless, assessors stated that clients appreciated being asked about their aims and clients could see the value in SMART goals. Managers reported assessors were more invested and engaged in client outcomes through goal setting rather than simply confirming whether a client received a service. Mentors stated that an additional benefit to SMART goal setting was that it helped to manage client, family and carer expectations to realistic levels.

All 5 RAS managers reported increased positive client outcomes, however, the extent to which goal setting improved varied according to the skills of the assessors. 2 RAS managers found this aspect of the trial model particularly challenging, although in contrast, many assessors reported greater job satisfaction because of more tangible goals being set with the client.

It appears that the challenges faced in setting SMART goals was partly due to historical reasons, in that setting such defined goals was not something that assessors had routinely done under the traditional approach.

Assessors reported that goal setting had been more generic, with an assessor explaining that '*we used to make goals like improving independence, and often used these goals interchangeably between clients.*'

Another difficulty identified by both assessors and mentors, was that the training reviewed above did not adequately prepare them to develop SMART goals. Our survey of assessors found that only about a half (52%) of those surveyed agreed that the training helped them to understand how to develop SMART goals.

3.2.7 Broad reablement strategies increased

The third component of the trial model involved identifying broader reablement strategies for clients to achieve their goals. In contrast to the traditional assessment approach, the trial model expected assessors to look beyond CHSP services and develop broader reablement strategies with clients.

This aspect was well supported by all levels of trial RAS organisations. Our review of the general recommendations in My Aged Care data, where non-CHSP reablement strategies were recorded, found a higher rate and broader range of general recommendations made during the trial. As detailed in Part 2: Outcomes of this report, it was found that trial clients were almost twice as likely as control clients to receive one or more general recommendations.

The types of general recommendations that increased during the trial were also telling. They all targeted reablement and client independence – including recommendations such as low-risk AT products and strategies for independence.

Feedback from assessors in our survey supported this finding, as the majority (89%) of assessors reported that they felt confident in identifying broader reablement strategies.

There was also consistent feedback from RAS managers that the trial led to improved reablement strategies that were more targeted and less service focused. One manager commented that while service recommendation rates had declined, client satisfaction had not. Mentors further reinforced this perspective, with one noting that assessors were '*limited only by their imagination…[recommendations] could be non-funded services, community-based activities, other parts of client's life they wanted to improve.*'

3.2.8 Follow-up needs more support

The final component of the trial model – client follow-up and coaching – received the least support during trial implementation. A survey of assessors found that 45% of assessors did not undertake this component.

And although all trial RAS managers acknowledged its importance, the degree to which it was viewed as important varied from 'critically important' in one instance to 'somewhat important' in another.

The managers did not question the concept of following-up and coaching clients, but rather were concerned with the lack of adequate funding and time allowed, with managers observing that, '*coaching [is] only partially supported due to time pressures*' and '*we cannot afford it, with current funding*'. The managers also underestimated the extra assessors needed to provide follow-up for all reablement clients and also continue to conduct active assessments during the trial period.

Other factors which hindered consistent trial implementation of client follow-up, included:

- inadequate assessor training, and a lack of guidance about how assessors should actually follow-up, such as providing coaching support to maintain a client's motivation throughout the reablement period
- inconsistent approach to recording follow-up activity in the My Aged Care IT system.

The lack of follow-up can reduce the effectiveness of the reablement period and can jeopardise reablement success. Trial RAS managers reported that effective coaching support is vital for reablement, principally because ongoing coaching support helps maintain a client's motivation so that they can sustain functional improvements.

Mentors stated that client motivation is often the single-most important factor determining whether a client achieves their reablement goals. Checking-in with the client also enables strategies to be refined as a client's situation changes, in order to meet reablement goals.

3.3 Communicating with the community

Achieving broad community support for reablement is seen as important to its success. This section focuses on the attitudes of older Australians, their carers and family members towards W&R approaches; and the communication resources which target clinicians who refer older Australians into entry-level aged care.

This section also includes our formative evaluation of the PIL complementary support strategies. As these strategies have yet to be released, we assessed their appropriateness in light of our consultations and other evaluation activities with clients, trial and non-trial RAS organisations and CHSP providers.

We interviewed over 100 clients, their carers and family members participating in the trial and control regions of the reablement trial. We then reviewed the draft communication resources developed by the department as part of the PIL budget measure, including:

- *Your guide to Commonwealth Home Support Programme services; Supporting you to live at home* resource
- Healthy active ageing brochure
- GP reablement information leaflet
- Health professional reablement information leaflet.

These communication resources aim to promote acceptance and uptake of W&R approaches. They target two different groups:

- clients, carers and family members
- clinicians that refer older Australians into aged care.

3.3.1 Lessons

Extensive consultations with clients who participated in the reablement trial, RAS organisations, CHSP providers and members of the department's expert Reablement Working Group, repeatedly indicated that older Australians entering the aged care system hold entrenched expectations of automatic service entitlement.

Our interviews found that these views are often reinforced by carers and family members – we observed a leaning towards an ageist view, where older Australians should be 'wrapped in cotton wool'. In addition, focus groups with trial and non-trial RAS assessors, as well as results from the department's W&R survey, collectively showed that client expectations of CHSP services is the most commonly cited barrier to implementing W&R approaches.

As part of the PIL budget measure, the department developed a range of clear and simple public communication resources to provide important messages about managing expectations of CHSP services, including the need for CHSP support workers to 'do with' rather than 'do for'.

While there are some minor areas where these resources can be strengthened, they provide a solid foundation from which to build. However, our assessment is that the overall communication about W&R approaches needs to be strengthened.

Feedback from WA and Victorian Health Department staff – jurisdictions where W&R approaches have been promoted more actively and for longer than other jurisdictions – indicate that community views are stubborn and difficult to shift. These jurisdictions acknowledge that there is still much work to be done, even after a decade of promoting the benefits of W&R in their states.

Collectively, our work with aged care stakeholders indicates that communication resources should be part of a sustained communication strategy, that is:

- **headlined by a national statement** or policy for the general public, which clearly outlines the justification for, and movement towards, a W&R approach across aged care.
- **broad to build acceptance and support** for W&R approaches by coordinating key messages across a wide number of different communication channels in order to combat widespread and entrenched community attitudes.
- targeted, **selectively using different approaches over time** to differentiate between those clients who are open to giving reablement 'a go' once they understand its benefits (30%) and those who are unwilling (10-30%), even after understanding the benefits. The latter group requires a more sophisticated approach to be effective – similar to health promotion campaigns that targeted seat belt wearing and smoking cessation.
- **inclusive of all major groups of referring clinicians**, not only GPs and allied health professionals, possibly leveraging relevant peak bodies to build credibility and the case for change.

This strategy should ideally be rolled out as soon as practicable and precede any national rollout of the trial model. The delay in releasing the draft communication resources represent a lost opportunity to explore their effectiveness during this evaluation.

3.3.2 Managing client expectations

The reablement trial has shown that around 30% of all clients are willing to give reablement 'a go'. However, assessors report that 10% to 30% of all clients preferred to receive ongoing services and declined a reablement opportunity, despite having reasonable prospects of maintaining or improving their levels of independence.

Assessors from trial and non-trial RAS organisations reported that the sense of entitlement to automatically receive services is the single largest impediment to introducing reablement. This was reportedly true for both new and existing clients, although it was more marked for many 'grandfathered' clients (those registered before the 2015 commencement of My Aged Care). One assessor stated that, *'they simply reject the reablement approach, you can't get them off [the services].'*

This position was supported by CHSP providers, both in interviews with AHA and as reported in the department's 2018 national CHSP provider W&R survey. CHSP providers identified clients', their carers' and their family's lack of understanding of W&R strategies, policies, procedures and processes as a key barrier to implementing a national W&R approach.

CHSP providers also cited existing clients as being particularly resistant to a W&R approach. In response to the question about 'barriers to implementing W&R' in the department's W&R survey, the third most common response was about client dependency on services. Clients reportedly preferred to continue receiving services the way they always had.

Related to this attitude of entitlement is the observation from assessors that clients commonly believe that all CHSP services are free. Assessors reported cases where clients are appropriately recommended a particular service, yet they are unwilling or unable to contribute through a co-payment. This feedback highlights the depth and extent of client attitudes and the importance of a sustained communication strategy to change client expectations over time.

Sharpening the key message in communication resources

Communication resources need to prioritise key messages, as there will inevitably be readers that skim or do not read the entire resource. While the *Your guide to Commonwealth Home Support Programme Services* reads well, we believe the key message could have more prominence.

This message – the *'aim of the CHSP program is to build strengths and abilities to help a client remain living independently, with a focus of 'working with' rather than 'doing for'* – should be presented early on in the guide (rather than on page 7).

Additionally, it could be further supported by citing emerging evidence that demonstrates that an over-reliance on services has been linked with accelerated functional decline. This resource needs to not only inform, but to convince clients that a W&R approach is important for them.

Streamlining access to information

There are also opportunities to streamline access to key information by providing a clearer explanation of processes and by managing expectations. Examples include:

- developing a prominent FAQ section, outlining the most important sections which the department wishes the clients, carers and family members to understand.
- using a flowchart to illustrate a typical client journey, including My Aged Care registration and assessment, as well as strategies to maintain independence that could include short and longer-term CHSP services. The flowchart could also show different client pathways depending on

changing personal circumstances, such as a change of circumstance of a carer, an unexpected visit to a hospital or a change in CHSP provider.

- highlighting the cost of services, including client contributions, earlier in the guide (currently on page 14).

Diversifying communication channels

The department may also wish to broaden its reach by using different communication channels such as digital platforms, in addition to brochures and pamphlets. We believe there is value in targeting potential future clients now and broadening the communication channels could assist this. Managing expectations of those who are in the 55 to 65-year-old age group will be as important in coming years, as targeting those about to enter aged care.

By way of illustration, one potential approach the department could consider for clients who are reluctant to embrace reablement is to develop a 'before and after' video presentation, showing where actual clients started their reablement journey and what they ultimately achieved.

This could include a variety of different client cohorts at different stages in their ageing journey or it could use common scenarios which trigger an assessment, such as hospital discharge, or losing a carer or a driving license. The story could be a powerful tool to show what can happen and how independence can be maintained or improved through W&R approaches. Additionally, it could have an extended reach by being posted on commonly accessed channels.

3.3.3 Building support amongst referring clinicians

Health professionals, including GPs, that treat older Australians and refer them into the aged care system, are also an important source of information for clients, carers and family members. Referring clinicians may be amongst the first that set expectations of the aged care system and how it can support clients to remain independent.

Two leaflets target allied health professionals and GPs and cover the important information well, explaining: reablement, its benefits, reablement within the context of CHSP services and how and when to make a referral. While theses provide all the necessary information, we believe they can be more persuasive, by:

- including examples of the emerging evidence, showing that an over-reliance on services accelerates functional decline, emphasising the progression towards 'doing with' rather than 'doing for'.
- highlighting the rigour of the active assessment process in order to build trust and confidence in referring clinicians – during the trial model allied health professionals noted the improved quality of RAS assessments, particularly the more defined SMART goals and targeted reablement strategies, and expressed support in the trial approach.
- reinforcing the importance of using motivational techniques to encourage clients to reach their reablement goals and illustrating its importance by providing individual case studies.

RAS managers and assessors stated that health professionals who refer clients into My Aged Care often did not understand the reablement approach, in one case arguing that *'the entire system including referring professionals needs to be better prepared and educated.'* They emphasised that health professional understanding needs to be addressed as a matter of priority, and that ideally this should have occurred before the trial model commenced but definitely *'well before the trial can be rolled out nationally.'*

We asked RAS managers and assessors which referring health professionals should be the key targets in a communication strategy and they particularly identified:

- hospital discharge planners and social workers
- allied health professionals, particularly OT and physiotherapists
- GPs
- CHSP providers.

Hospital discharge planners and social workers are not specifically targeted in the draft communication resources. It is suggested that this gap be addressed, noting that the evaluation found that clients who suffer an unexpected set back that requires hospitalisation, often have strong reablement prospects.

3.4 My Aged Care environment

The My Aged Care environment, including the website and contact centre, is the starting point for older Australians in their aged care journey. Along with referring clinicians, it is a critical information source that establishes and shapes the expectations and attitudes of clients, carers and family members to aged care.

The My Aged Care IT system also records information about registered clients, their assessment and the CHSP services they are recommended.

This section identifies trial lessons about each of the above parts of the My Aged Care environment.

3.4.1 Lessons

The My Aged Care environment is seen by RAS organisations and CHSP providers to have benefits, foremost of which is a single aged care entry point for clients.

However, RAS staff reported that the My Aged Care website and contact centre do not promote independence, nor do they sufficiently highlight the advantages of a W&R approach to aged care. This is a missed opportunity. Where they could advocate for a W&R approach – through explaining the connection between over-reliance on ongoing services and a client's accelerated functional decline – instead these resources reportedly reinforce client's expectations of CHSP service entitlement. This further entrenches attitudes to automatic service entitlement, which RAS organisations and CHSP providers reported that they have to work hard to overcome.

Trial and non-trial RAS staff and CHSP providers also reported specific issues with the My Aged Care IT system that can impede a W&R approach. A range of different matters were reported, indicating they are not major structural issues.

RAS managers and assessors consistently reported that they need:

- greater flexibility in recording reablement in order to meet changing client circumstances and levels of motivation – an important factor as circumstances often change and clients change their mind about whether to pursue reablement.
- to know whether a service they recommend for clients has commenced and been completed – which is important for time-limited reablement periods.

This highlights the need for all parts of the aged care system to align in order to optimise reablement opportunities, with the ultimate objective of achieving reablement success.

3.4.2 Website and contact centre misaligned with reablement

First impressions are often influential in shaping or reinforcing expectations and views formed at the outset can become difficult to change. Managers and assessors at trial and non-trial RAS organisations reported that even clients undergoing their first assessment had service expectations as a result of what they had read on the website or been told by contact centre staff at the time of registration in My Aged Care. There were several challenges posed to reablement at these initial points of contact.

My Aged Care website continues to focus on service rather than support. One non-trial assessor reported that *'the new webpage is no good, saying … you (the client) can see what services are available.'*

For example the opening statement on the home page of the My Aged Care website reads – *'Find and access the government-funded services you need.'* (Department of Health 2020a)

The non-trial assessor also reported that the website does not mention, or provide arguments supporting, a W&R approach. One RAS manager highlighted the lack of this information, saying, *'search the website – there is absolutely no reference to reablement and the value of such an approach.'* Similar to the draft communication resources, there is no mention of the key argument for a W&R approach – that emerging evidence shows that an over-reliance on services has been linked to accelerated functional decline.

My Aged Care contact centre often sets client expectations of service provision from the outset and assessors expressed frustration with the contact centre, observing that they felt it *'undermines a reablement focus and is still very service oriented.'*

RAS staff reported that the scripts that contact centre staff commonly used were misaligned with a reablement approach – contact centre staff often focused on a client's physical deficits rather than what they could achieve. Assessors stated that as a result, they were often required to have difficult conversations with clients, their carers and family members – to explain that there were better approaches, that not all clients are eligible for services and, in the words of one assessor, '*that a service is not an end in itself but the means to maximise a client's independence.'*

3.4.3 IT system not optimised for reablement

The My Aged Care IT system is used by RAS organisations and CHSP providers to record information about assessment and CHSP services each client receives. RAS assessors and providers reported that this system requires significant improvement to fully support a wellness and reablement approach to aged care.

Trial and non-trial RAS staff consistently reported My Aged Care IT system limitations that collectively make it more difficult to optimise reablement opportunities and success.

Capturing more reablement opportunities

There are several points at which it would be possible to support and encourage clients to undertake reablement opportunities, including:

- when documenting an assessment, assessors cannot go back to the appropriate screen to select a period of reablement, even if the client agreed to try it. A minor change to the system functionality could allow accurate recording to reflect the client's preference.
- after an assessment is completed, assessors cannot select a period of reablement, even if the client, on reflection, changes their mind. Assessors, particularly in the trial regions, reported that clients think about matters and may decide to try reablement after the initial assessment. In

these cases, assessors are required to do an unnecessary reassessment – a poor use of resources. Ideally, assessors would be able to simply complete a support plan review and change a client's reablement status.

- a client's circumstances often change, and assessors require greater flexibility in starting and pausing a reablement period. As one assessor stated, '*clients have changing circumstances that impact on their reablement prospects*' and the IT system could be more agile in reflecting these changes.
- ACAT assessors cannot select reablement within the IT system, despite international literature indicating that those with more complex needs can benefit from a reablement period. Allowing ACAT assessors to select reablement would also be consistent with the Interim Report of The Royal Commission into Aged Care Quality and Safety.

Monitoring status of reablement services

The IT system could also further support the monitoring of reablement services. RAS organisations cannot determine if a service has commenced or been provided, despite their service recommendation being accepted by a CHSP provider.

This means that it is difficult for the assessor to know whether reablement strategies that include a service are in place or if reablement is on track for their clients.

On the other hand, some smaller CHSP providers do not know how to navigate the My Aged Care IT system and some providers have no access at all. This indicates the need for some additional oversight of a client's progress, including considerations of who has access to the IT system throughout the client's reablement journey. This is explored further in Section 8 about coordination between RAS organisations and CHSP providers.

3.5 RAS operational environment

Interviews were conducted individually with trial managers, mentors and assessor focus groups and an assessor survey conducted to reflect on the trial experience. AHA also held a second round of consultations to seek further feedback and discuss emerging findings.

3.5.1 Lessons

The trial model represents substantial change for RAS organisations and their environment. Based on the trial model, national implementation would require a phased and structured approach to be effective. Three phases are suggested, as follows:

1. Preparation

In the first phase, RAS organisations will require up to 6 months to prepare their staff to deliver the trial model. This includes recruiting and training mentors, training assessors and changing their operating environment to fully support the trial model of assessment and follow-up of reablement clients.

2. Transition

In the second phase RAS organisations would transition to full implementation – which the trial has shown can take around 12 months, from commencement of mentor training through to assessor training and demonstrated, consistent practice.

This will be an on-the-job learning phase, where assessors progressively embed the trial model into practice. A key lesson from the trial is that the active assessment approach requires significantly better analytical and problem-solving skills, as well as soft skills like active listening and client motivational techniques. Assessors are unlikely to be fully effective immediately, as the changeover for some will be significant.

These changes will increase the time required to conduct an assessment, reflecting the additional time needed to conduct and document active assessments during the transitional phase.

3. Ongoing monitoring

These revised arrangements should be finalised in the transition period and an ongoing operational model developed to adequately support RAS organisations to deliver the trial model on an ongoing basis.

3.5.2 Greater prior consultation with RAS organisations

The trial showed that substantial time is needed to prepare RAS organisations for the significant changes that the trial model brings to their core business, yet RAS organisations reported that there was limited time to prepare for the trial.

From the RAS organisation's perspective, the introduction of the trial model had an adverse effect on their business model. RAS managers underestimated the impact the trial would have on their KPIs, which measure timeliness of service delivery. One manager commented that *'timeframes have blown out of the water since the pilot and we haven't been able to get back to pre-trial numbers.'*

There was a consensus across the RAS organisations that the trial model, in comparison to the traditional model, resulted in a more appropriate and effective assessment of the client. However, the trial model required several months to embed, and during this transitional period, assessment and follow-up was more time consuming, averaging an hour or more per assessment.

Managers and assessors reported that they went from an average of 3 assessments per day down to 2 per day. Other parts of a RAS organisation, often hidden from view, were impacted. For instance, intake staff needed to also be aware of the trial model and its implications, to ensure they communicate to clients to wear loose clothing, so that clients can show assessors what they can do around the house.

The assessor survey results indicate that RAS organisations attempted to compensate for funding and resource shortfalls by compromising on essential components of the trial, such as follow up and coaching support. Coaching support for clients is essential, both in resolving any subsequent difficulties after the assessment and maintaining the morale of that client. This is particularly the case where the services provided to clients are complex. While RAS managers endorsed the value of coaching support, the survey revealed that 45% of assessors did not undertake this component.

We suggest that in any national rollout of the trial model, the department communicates with RAS organisations about the transition challenges and any changes to expected targets. Our suggested approach to these transition challenges is outlined in the following section.

3.5.3 Transition phase important

We suggest that the extent of change for RAS organisations – in moving from a traditional model to the trial model – should be acknowledged through a 12 month transition period to help monitor, guide and embed implementation.

Key elements that should ideally be in place to drive effective implementation of the trial model include:

- **Detailed trial guidance** to assist RAS organisations and CHSP providers to understand the trial model and to implement it to a consistent standard. This should involve both high and an operation level approaches:
  - High level – with a clear definition of reablement, which outlines key principles, benefits and intended outcomes.
  - Operational level – to build consistency of practice. This is important, as the trial showed that RAS organisations operate differently and with varying approaches to reablement.

  An operational guide could specify typical practices and documentation. For example, the trial revealed varied practices between organisations in the follow-up of clients. The extent and also the recording of follow-up differed across organisation. Some organisations added qualitative comments that were date stamped in the client's support plan while others did not record follow-up consistently in the client's record.
- **Assessor training** was an essential part of equipping RAS organisations to deliver the trial model.
- **Mentors as reablement champions** were an important component as trial RAS organisations transitioned to the trial model. They strengthened training and helped build consistency of practice, and their importance was acknowledged by both managers and assessors.

3.6 CHSP providers

CHSP services can assist clients to optimise their independence at home and in the community, and thereby enhance their wellbeing and quality of life.

The *2020-22 CHSP program manual* (Department of Health 2020b) makes it clear from the outset that CHSP providers should deliver services with '*a strong focus on wellness and reablement*' (page 6). These services can serve as reablement strategies, delivered on a short-term basis to assist clients achieve their goals.

3.6.1 Lessons

Some of the key challenges identified in the department's W&R survey match those identified by the RAS organisations we consulted with, including:

- some CHSP providers were not convinced of the benefits of wellness and reablement approaches
- reablement-focussed CHSP services were unavailable, particularly allied health services and AT
- clients', their carers' and their families' service expectations needed to be managed and changed
- communication and coordination between RAS and CHSP provider organisations were poor.

Interviews with CHSP providers also found that there were disincentives to provide shorter-term services compared with ongoing services. They reported that additional unfunded, time was needed for:

- care coordination with RAS assessors and other CHSP providers
- on-boarding reablement clients for short-term service delivery.

CHSP providers highlighted that while on-boarding costs are not specifically funded for any clients, these costs are more easily defrayed for clients with longer-term service needs.

3.6.2 Varying belief in wellness and reablement

The department's W&R survey found that a majority (79%) of CHSP providers believe that they have embedded W&R approaches, with metropolitan areas and WA having the most positive response to this question.

However, analysis of results by key organisational characteristics reveal that smaller organisations, non-metropolitan organisations and organisations without a strong relationship with RAS organisations are less likely to believe that W&R is embedded. This highlights the importance of good relationships and coordination between RAS organisations and CHSP providers, which is discussed in greater detail in Section 3.7 of this report.

The survey also found that just under a half (44%) of all CHSP providers – regardless of number of clients served, rurality or jurisdiction – reported that W&R approaches were successfully increasing clients' independence and reducing reliance on ongoing services. A large proportion of the remaining CHSP providers were unsure of client outcome, with 36% responding that they 'neither agree nor disagree' that W&R approaches are successfully increasing clients' independence.

It is unclear whether CHSP providers do not understand how W&R principles apply to services they deliver, or whether they do understand but do not agree with the approach. However, staff at all levels of trial and non-trial RAS organisations consistently expressed the view that a significant proportion of CHSP providers have not embraced a W&R approach.

This indicates that CHSP providers vary substantially in their understanding of and support for W&R approaches to providing services and that practice of W&R approaches vary across the sector. An indicator of the need to improve consistency in the sector is the common request from CHSP providers in upskilling and training staff.

Taken together, this indicates that training and other CHSP provider supports should particularly target smaller organisations, as well as those that work with regional and rural clients. The department's training program targeting regional CHSP providers – particularly its Instructor-led training initiative – should be of benefit once released.

3.6.3 Short-term services

Short-term services, particularly those offered by allied health professionals such as Occupational Therapists, are critical to empower and equip a client to increase their independence and achieve their reablement goals. However, it appears that insufficient short-term services are available. The department's W&R survey found that nearly 40% of CHSP providers do not regularly accept referrals to deliver short-term services.

The proportion of CHSP providers accepting short-term services was higher for large organisations compared to smaller organisations (defined by the number of clients). The size of the organisation also

appeared to influence the duration of service delivery for domestic assistance and personal care service types, with smaller organisations less likely to provide these services on a short-term basis.

Interviews with CHSP providers and discussions with members of the department's Reablement Working Group, revealed that there is a disincentive for CHSP providers to accept short-term referrals. The cost of on-boarding long-term clients are spread over a longer period, which is not feasible for clients over a 12-week reablement period. This means that, even for those CHSP providers who believe in reablement, the costs can be prohibitive for short-term service provision.

3.6.4 Service availability

The unavailability of CHSP services was identified as a major impediment to reablement by 78% of assessors who responded to our survey. It was also a major factor identified through interviews with non-trial RAS managers and assessors. CHSP providers also concurred, reporting in the department's W&R survey that their second greatest barrier to implementing a W&R approach was funding limitations.

These views are supported by our analysis of CHSP service utilisation data. As reported in *Part 3: Reablement trial outcomes*, data indicates that when a service was recommended, about one-fifth of the clients did not actually receive that service.

Some particular CHSP services are reportedly consistently not available to respond to reablement service recommendations. For example, allied health (OT and Physiotherapy) and AT service types were commonly cited as not available. During the trial an assessor commented that, *'In some areas people may be waiting 2 years for an appointment with a physiotherapist. We still class these clients as reablement, but they don't get any service within that time period so goals are unmet because a service is not available.'*

If a national rollout occurred in areas where there were severe service shortages, this would compromise the effectiveness of reablement initiatives, which depends on timely access to services. Prior to any national rollout, there would be considerable potential benefit if the areas of reablement focused service gaps were identified, such as for allied health within the trial Aged Care Planning Regions.

3.6.5 PIL complementary support strategies

Two PIL complementary support strategies target CHSP providers:

- change management strategy
- workforce training strategy.

These strategies have not yet been released, due to development delays including those associated with the impact of COVID-19, so it was not possible to assess their effectiveness, cost effectiveness or implementation.

The department had intended to release these during the trial period, so that they would complement the trial by providing information and training for providers. In the event of a national roll out of the trial model, we believe it will be important to release these supporting strategies well before implementation commences, to allow for uptake.

The department provided draft resources for each strategy and we assessed their appropriateness, as follows.

CHSP provider change management resources

The draft change management resources include:

- Practical guide for embedding wellness and reablement into service delivery
- Wellness and reablement service delivery toolkit
- Toolkit for Embedding Wellness and Reablement into your Organisation
- 7 other toolkits, aimed at different roles in CHSP providers such as client care planning.

We concluded that these draft resources are largely appropriate. The content they cover is seen by CHSP providers and RAS organisations as important and valuable to assist CHSP providers to embed a W&R approach. Some minor improvements are suggested in Table 3-1, which would enhance their usability.

CHSP provider workforce training resources

The training resources are designed to be available in the following 4 delivery methods, each with similar content:

- 3 online eLearning modules in *My Aged Care Learning Environment*
- Workplace Trainer's Toolkit for provider trainers
- *Instructor Led Training* Program for regional locations
- 11 'Joining the Dots' podcasts.

We have not reviewed the other training resource – a *Community of Practice* – as it has not yet commenced.

We concluded that the above training resources are appropriate and well targeted to respond to the needs of CHSP providers. The department's W&R survey indicates that around half (47%) of all CHSP providers require more information about, and support for, embedding W&R approaches into CHSP service delivery. Lack of training for both paid staff and volunteers was commonly cited as a barrier to implementing W&R approaches.

Given the diversity of size, location and structure of CHSP providers, it is appropriate that the department has made content available in different formats. Suggested improvements are outlined in Table 3-1 below.

Table 3-1: Suggested improvements to the draft change management and training resources

Issue	Suggested improvements
Signposting – positioning each resource within the training strategy	In finalising the products, each would benefit from an introductory section (this could simply be an overarching user guide or webpage) that: • outlines the purpose of the product (e.g., document or module) about to be read • identifies who the target audience is for each product (see Defining target audiences below), including the level of assumed knowledge • illustrates, through a diagram, how the product being read relates to and fits into the overall suite of products • outlines the intended sequence, where applicable, in which products should be read or completed • includes the time commitment required for each module and the series of podcasts • specifies the technical requirements for accessing the online training (e.g. can it be watched on a smartphone or tablet, as not all support workers may have access to computers).
Defining target audiences	We suggest using consistent names for key roles performed within provider organisations across all resources. This will provide greater clarity in messaging. The key roles include the following: • Support workers: Using the care plan as a guide, they work with the client to achieve their wellness and reablement goals. We suggest the term support worker includes any worker, paid or volunteer, who deliver services to clients, such as domestic assistance, personal care, meals, transport, nursing, allied health, home maintenance, social support or other front-line services. • Care coordinators: They often have direct responsibility for support workers. We use the term to include care facilitators and team leaders, and it may well include care planners. • Managers and the executive: We use the term to include all provider senior managers and board members.
Differentiating the concepts of wellness and reablement	We believe that greater consistency is needed to clearly define the small but important differences between wellness and a reablement approach, and how this translates to supporting clients. This includes differences in responding to a reablement client when undertaking care planning, providing support and reviewing the care plan. Wellness is defined across the resources consistently, however, what is often missing is that wellness approaches apply to all clients, whereas reablement does not. More emphasis could be placed on the hallmarks of reablement that distinguish it from wellness (e.g. time-limited, intensive and goal oriented).
Positioning providers within the broader aged care system	We believe there is value in providing a diagram and a description of entry-level aged care, highlighting the relationship between the RAS organisation (support plan) and the provider (care plan). Inconsistencies exist in explaining the process and respective roles of the RAS and providers, particularly in client goal setting.

3.7 Coordination

Good care and support are based on coordinated assessment and support – where necessary services are part of a client's ageing journey. This is particularly important for time-limited interventions, such as reablement.

3.7.1 Lessons

There is common agreement among RAS organisations and CHSP providers that their communication is at times poor and coordination is often ineffective.

Our observations during this evaluation, as well as feedback from RAS organisations and CHSP providers and input from the department's Reablement Working Group, point to RAS organisations and CHSP providers often operating as disconnected entities. This was not how the system was intended to operate and undermines the aim of the CHSP program and RAS organisations.

Previous reports (such as the *Nous and Tune review* (Department of Health 2017a) confirm that this is a long-standing and significant issue. While there may not be a need for extensive coordination for clients who require simple care or a one-off solution, poor coordination can significantly compromise care for complex clients and those undergoing reablement.

The training developed by the department will reinforce with CHSP provider staff the importance of the support plan and the need to work closely with assessors to provide the right support.

Improvements to the My Aged Care IT system could also facilitate closer assessor-provider coordination by:

- clearly defining a handover point between assessor and CHSP provider
- providing more timely information about when a recommended CHSP service commences, rather than when a CHSP provider accepts a referral for that service
- providing a mechanism to trigger care coordination, for those more complex clients that require it.

We also suggest that RAS organisations and CHSP providers would benefit from more departmental guidance about care coordination. This could include a protocol for sharing feedback and observations, and even functionality through the My Aged Care IT system to record and manage care coordination activity.

3.7.2 Assessments inaccessible to CHSP providers

There are concerns that CHSP providers delivering support do not always have access to detailed assessment information, possibly resulting in compromised care and wasted assessment effort.

RAS organisations reported that some smaller CHSP providers did not know how to navigate the My Aged Care IT system and therefore could not access the most relevant parts of the client's assessment.

They also reported that some providers of a referred service had no access at all to the My Aged Care IT system. In other instances, assessors reported that only intake staff of the provider (who did not deliver services) had access to client information in the assessment. In these latter cases, intake staff did not readily share this information with the person providing support to the client.

3.7.3 CHSP providers not using assessments

There were differing views by assessors and CHSP providers about the reasons why assessments were not used by providers, but there was broad agreement that this issue is of concern. The primacy of the assessment or support plan, as the foundation upon which reablement strategies are developed and agreed upon with the client, should be reinforced.

Assessors stated that some CHSP providers did not read the client's support plan and there was limited communication between parties during the reablement process.

On the other hand, some CHSP providers argued that assessments were at times too broad to be meaningful. Despite this view, the trial clearly improved the standard of the assessment by delivering more useful information to providers.

Whatever the cause of these concerns, if CHSP providers consider the plan is inadequate, they should confer with assessors in order to understand the reasons behind assessment decisions. It is important that assessors and providers work together more effectively to achieve the reablement goals of the client, which can be facilitated through implementation of the client support plan.

3.7.4 No handover point of client

Currently there is no defined point at which an assessor formally transfers a client to a CHSP provider. Around 90% of clients receive at least one service recommendation and a significant proportion receive multiple service recommendations. For clients who receive one or more service recommendations, we believe there would be value in a handover – including a discussion between the assessor and the CHSP provider/s – before the commencement of services.

This could resolve a number of issues identified in the trial, such as delays in clients gaining access to services and hindering reablement if a CHSP provider is unaware of, or unwilling to, take a W&R approach. A discussion before any service commences could help to shift attitudes and in time convince the CHSP provider on the benefits of reablement.

An effective handover would also allow for timely adjustments to the support plan in consultation with the client and, if necessary, it would identify and recommend another provider in order to deliver more timely care. Any concerns the provider may have with the client's support plan strategies and recommendations could be discussed and resolved at the handover stage.

It could also assist in coordinating the sequencing of services. Many reablement clients are engaged with more than one provider, and sometimes one service needs to start before the other.

A significant proportion of CHSP providers reported significant concerns with the handover period from their perspective. These concerns included:

- almost half (45%) of CHSP providers indicated that information sharing between their organisation and RAS is inadequate.
- the most common additional comments provided in the department's W&R survey related to the lack of communication with RAS organisations.
- smaller CHSP providers, defined by number of clients, were less likely to agree that they had a good relationship with RAS organisations, as compared with larger CHSP providers.
- on the other hand, CHSP providers who reported that W&R is embedded in their practices, typically also reported that they have a good relationship with RAS organisations.

3.7.5 Better oversight of reablement needed

Monitoring a client's reablement progress has several potential roadblocks. On one hand there is no mechanism to confirm when, or if, a recommended CHSP service has been delivered during the reablement period. This inhibits the ability of the RAS organisations to monitor client progress efficiently and effectively.

On the other hand, CHSP providers are also able to accept referrals, placing clients on their own waiting list (which is not available to RAS assessors) after accepting a referral in My Aged Care. In sum, the complete picture of the client's reablement journey is not available to the RAS assessor. This results in a less efficient follow-up process for the assessor and a lower chance of reablement success for the client.

This lack of clarity of the client's reablement process, similar to other concerns, weakens the prominence of the client's assessment process and reablement strategies contained in the support plan, which set the foundation for services provided to clients.

3.7.6 No care coordination mechanism

The need for care coordination varies from case to case. In some straightforward cases, such as providing transport support, no coordination of care may be required. Once the transport support is provided, the client need is met.

In other instances, where the complexity of care is significant, a different approach is needed. The client can have a range of complex needs, potentially involving multiple providers whose interventions occur over different time frames.

Currently there is no mechanism for care coordination for complex clients needing greater follow-up. This follow-up could include encouragement and support to meet what can be challenging goals. The support plan prepared by assessors and the care plan developed by providers tend to be separately prepared documents and do not have in-built coordination mechanisms, such as key points where the care provided is commonly discussed or reviewed. These points of coordination are important for more complex cases and are vital for supporting clients to remain independent.

3.8 Reablement reimagined

This section extends the reach of the evaluation to suggest what reablement could look like in the context of entry-level aged care.

3.8.1 Reablement model

The evaluation showed that the trial model is largely cost-neutral (Part 2: Outcomes, Section 2.6), and yields significant benefits, including improvement in personal wellbeing for reablement clients (Part 2: Outcomes).

If the department decided to implement the trial model nationally, it might wish to position **reablement as the default client pathway** for those entering My Aged Care and having a RAS assessment. This would prioritise a reablement approach, as unless reablement was assessed as not necessary or inappropriate, all clients would 'give reablement a go'.

Figure 3-4 outlines this approach, which is drawn from features of existing models in other jurisdictions including the United Kingdom, and our evaluation activities over the last two years, including post-trial feedback from RAS managers.

This approach provides new client pathways which the department might wish to consider. It is developed taking into consideration current aged care reforms and could be used to inform ongoing work on a streamlined assessment model and a unified home care model.

The approach illustrated in Figure 3-4 provides 3 client pathways:

- **Reablement not necessary**. Those who only require a minor intervention and no motivation to resume independence. Reablement and ongoing CHSP services are not necessary for these clients and reablement represents a poor use of resources.
- **Reablement inappropriate**. Those who have poorer reablement prospects and need either CHSP ongoing services or an ACAT assessment. For these clients, reablement is inappropriate.
- **Reablement period**. For all other clients having a RAS assessment, a third pathway involves a period of reablement with short-term CHSP services where appropriate and/or non-CHSP general recommendations (Part 2: Outcomes). This means that recommendations for ongoing services would not be routinely made at assessment for these clients.

Clients undergoing reablement would be categorised as either low or high risk, depending on the number of time-limited CHSP service recommendations and the number of CHSP providers accepting these recommendations.

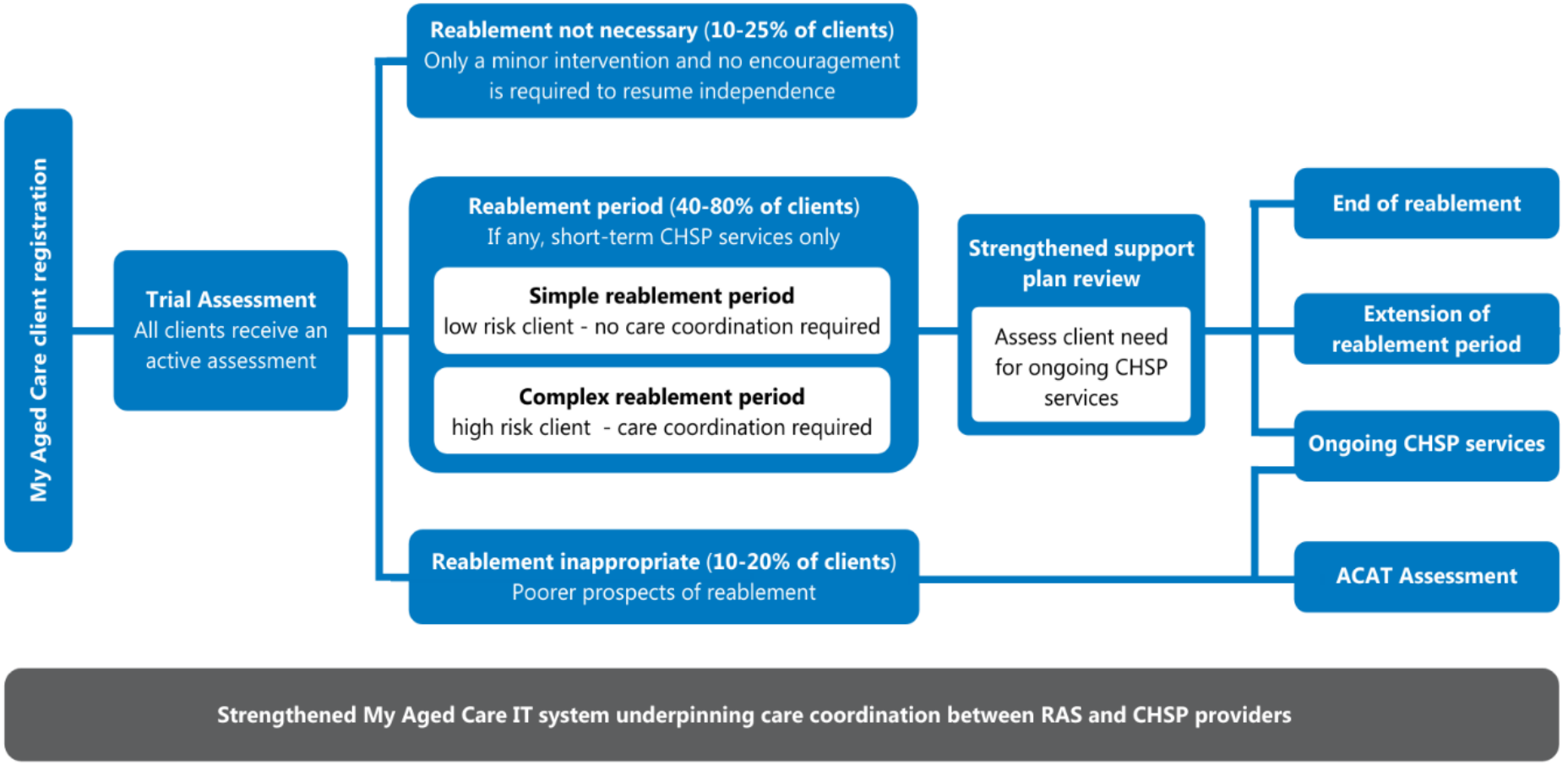
Low-risk clients are those who have a simple reablement period, requiring no client handover or care coordination between assessors and CHSP providers. An example is a client with a single CHSP service recommendation that has been accepted and has commenced in the reablement period.

Another example would be a client who has a general recommendation requiring no CHSP service or provider during the reablement period. This category of reablement is relatively straightforward, although client follow-up by the assessor is still important to ensure goals are appropriate and client needs are being met.

High-risk clients have a more complex reablement period, defined by several CHSP service recommendations that require sequencing and may often be delivered by different CHSP providers.

For example, a high-risk client could be a person who has come out of hospital and received several service recommendations, including recommendations for allied health, AT, domestic assistance and personal care. Ideally, for these clients, communication – between the assessor and CHSP providers – at the outset of the reablement period is required, as is ongoing care coordination. This ensures the client's needs are met, services are appropriately sequenced and reablement has every chance of success.

Figure 3-4: Flow chart of potential new client pathways and the reablement journey



3.8.2 Support plan review

The importance of a support plan review, at the conclusion of every reablement period, would increase as a result of this new model of care.

The support plan review would become the starting point for recommendations of ongoing CHSP services for clients. This would shift the decision-point for ongoing services to later in the client journey, allowing reablement every chance of success before ongoing services were put in place.

This would change the proportions of time-limited and ongoing CHSP services. Analysis of DEX data (Part 2: Outcomes) found that the current proportion of time-limited and ongoing services are similar for reablement and non-reablement clients across the country. This trial finding goes against a key principle of reablement, which is intended to consist of time-limited interventions. Reablement clients should ideally have more time-limited interventions including CHSP services where appropriate.

3.8.3 CHSP service provision

As reablement becomes embedded, there will be increased demand for some time-limited CHSP services.

New time-limited, reablement services could be delivered by CHSP providers that are aligned closely with RAS organisations, even sub-contracted by them, ensuring client handover and care coordination are more effective.

This would strengthen the important collaboration between RAS and CHSP providers that is not present under the traditional model of assessment (Section 3.7). The department may wish to consider funding new CHSP services that are dedicated to reablement clients and these services could be made available only on a time-limited basis.

3.8.4 My Aged Care

Improvements to the My Aged Care IT system – such as new functionality – could facilitate more effective collaboration and coordination between assessors and CHSP providers. These improvements could identify whether clients are low or high risk, prompting communication between the assessor and CHSP providers before the commencement of services, and ongoing care coordination.

This could encourage greater CHSP provider buy-in to W&R approaches by:

- confirming reablement goals
- establishing the intensity and frequency of recommended service delivery
- identifying delays to services (assessors need to be aware of delays as soon as possible, however often assessors only discover services have not been delivered late in the reablement period – if delays are known early, this may prompt a revisiting of the goals and recommendations)
- requiring CHSP providers to agree and sign-up to deliver the recommended services within a specified timeframe or, if there is disagreement, to discuss with assessors and reach agreement on adjusting the plan to better meet the needs of clients.

4 Technical supplement

This Part 4 of the report presents additional technical information and data that supplements Parts 2 and 3 of the report. It provides:

1. Data analysis methods, including a summary of client outcome measures, data preparation and linkage of assessment and service utilisation data tables, and cost effectiveness methodology
2. Supplementary client outcome data, including additional data for sample characteristics, personal wellbeing index, and health-related quality of life
3. Supplementary assessment outcome data
4. Supplementary service utilisation data
5. Supplementary cost effectiveness data.

In addition, there are 3 appendices related to the preparation and conduct of this evaluation:

A. PIL trial protocol – submitted and approved by the Bellberry Human Research Ethics Committee
B. Survey and interview schedules
C. Participant information sheets.

4.1 Data analysis methods

This section explains the supplementary data analysis methods used to provide the information presented in Part 2 of this report.

4.1.1 Outcome measures

Three outcome measures were applied:

- the Personal Wellbeing Index (PWI)
- the 5-level EQ-5D (EQ-5D-5L), a measure of health-related quality of life
- a measure of self-reported independence.

Personal Wellbeing Index overview

The Personal Wellbeing Index (PWI) is a measure of subjective wellbeing that evaluates an individual's average level of satisfaction, on a scale of 0 to 100 points, across 7 life domains:

- standard of living
- health
- achievements in life
- relationships
- safety
- community connectedness
- future security (International Well Being Group 2013).

The PWI has been refined with input from 150 researchers in over 50 countries (International Well Being Group 2013) and with age-specific normative data for Australia.

For this study, raw scores were converted to an average PWI score ranging between zero and 10. A higher score indicates more positive wellbeing reported by the client.

EQ-5D-5L overview

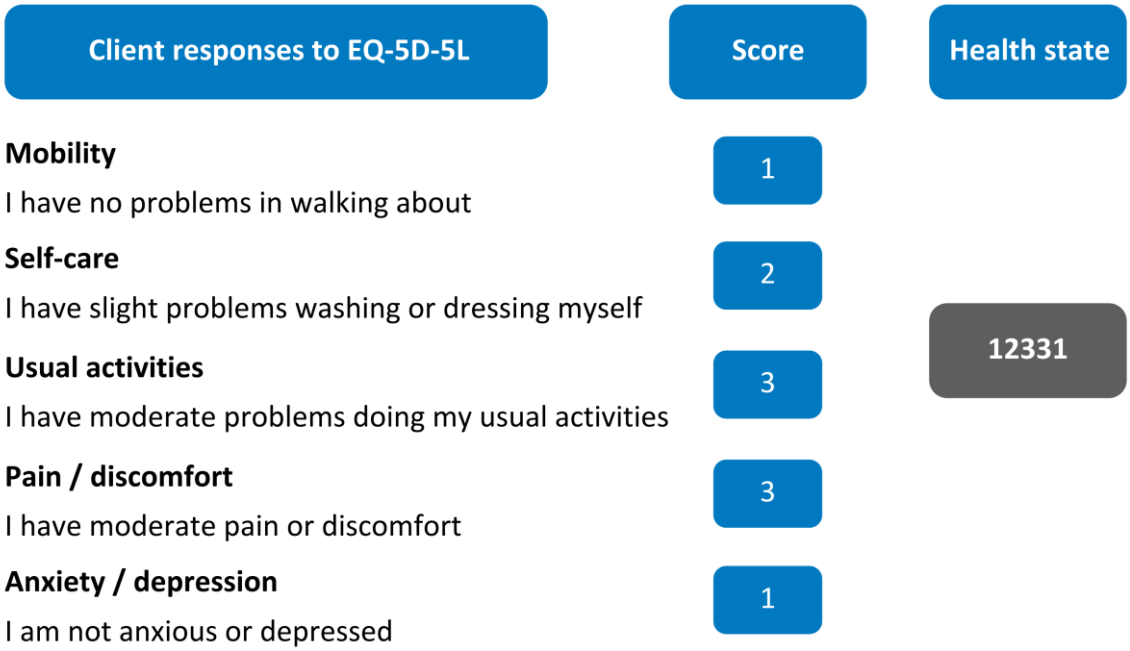
The 5-level EQ-5D (EQ-5D-5L) was summarised in two ways:

- mean score of individual responses
- conversion of all responses to a utility score.

Conversion to a utility score that lies between zero (worst health)[3] and 1 (full health) required mapping each client's responses to a 'health state'.

There are 3,125 possible health states in the EQ-5D-5L – an example is provided in Figure 4-1.

Figure 4-1: Example of EQ-5D-5L health state



Health states were then converted to a utility score by using a reference 'value set'. Value sets are developed in different geographic regions to determine how different representative samples 'value' each health domain of the EQ-5D-5L.

For example, a sample in the United States may feel lower pain and discomfort is more important to their quality of life than increased mobility. Weightings for each dimension are then used to calculate a person's EQ-5D-5L utility score.

The utility score for the current study was calculated using the UK general population value set, as an Australian value set for the EQ-5D-5L has not, at the time of writing, been developed.

This approach is consistent with recent EQ-5D-5L research undertaken with a general population sample in South Australia (McCaffrey et al. 2016).

A mixed factorial, repeated measure analysis of variance (ANOVA) was conducted to investigate differences observed on quality of life measures between:

- trial and control cohorts at baseline and follow-up (between groups analysis)
- trial baseline and trial follow-up, and control baseline and control follow-up (within groups analysis)

[3] Note that scores below zero are possible. Scores below zero equate to a health state that is 'worse than death'.

- reablement sub-groups across trial and control clients (between groups analysis).

Independence

Independence was measured at follow-up 6 months after a client's assessment, using a single-item measure: how satisfied are you with your level of independence?

This was asked to see whether there were differences in self-reported independence between trial and control cohorts after their respective reablement periods had concluded.

4.1.2 Assessment and service utilisation data tables

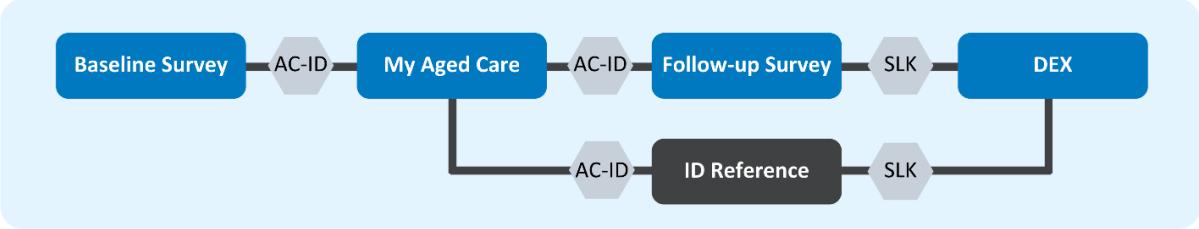
Data related to My Aged Care assessments and CHSP service utilisation were extracted from My Aged Care and the Department of Social Services Data Exchange (DEX) system.

This data includes information about client demographics, their assessments, services that they were recommended, whether the client was recommended a period of reablement and the types of services the client may have received.

Data was compiled in Microsoft PowerBI as a relational data model, with My Aged Care tables joined by unique Assessment IDs (AX-ID) and Client IDs (AC-ID), and DEX data tables joined as prescribed by the data administrators within the Department of Health.

My Aged Care and DEX datasets were joined using the client's Statistical Linkage Key (SLK). A high-level view of the data linkage model is illustrated in Figure 4-2.

Figure 4-2: Data linkage model



4.1.3 Cost-effectiveness methodology

Quantitative and qualitative data were collected to inform the costing model. These include:

- information about assessment hours prior to the trial, provided by the department
- trial assessment hours reported by RAS organisations in trial regions
- CHSP service utilisation data extracted from the DEX
- service unit costs obtained via a draft CHSP data report (Deloitte Access Economics 2019).

Details of these data sources and their contribution to the costing models are presented below.

Pre-trial assessment hours

To assign cost to a RAS assessment, it was necessary to estimate the amount of time taken to complete an assessment prior to the reablement trial.

Information supplied by the department indicated that prior to the trial, assessments took on average 2.5 hours to complete. This value was used to cost all assessments conducted in control ACPRs. Based on consultation with trial RAS**,** it was determined that **this 2.5 hours included time taken to write-up the assessment and all associated travel.**

Trial assessment hours

RAS organisations in trial ACPRs were required to report the time taken to complete assessments. This included the number of hours to conduct and write up the assessment. These values were used to calculate the cost of assessment in trial ACPRs, compared to a traditional RAS assessment.

CHSP service utilisation data

CHSP service utilisation data for the trial period was supplied by the department and was used to determine service utilisation for all cohorts.

These data are submitted by service providers on a 6-month schedule and recorded in the department's Data Exchange (DEX) system.

Costs for assessment and CHSP services

This section details the costing values utilised in the analysis, including values for assessment and CHSP services.

Assessment costs

Assessment costs used for the analysis are identified in Table 4-1. RAS organisations currently receive $400 to provide a 2.5 hour assessment, and to cover their travel and overhead costs.

For the trial model assessment group, a top up assessment time of 1.1 hours was added, costing $55. This includes the additional time identified for reablement client follow-up, delivered under the trial model.

Table 4-1: Assessment cost summary

RAS Assessment	Cost per hour	Hours	Total cost
Control assessment	$160	2.5	$400
Trial assessment	$160	2.5	$400
Top-up payments (trial only)	$50	1.1	$55

CHSP service costs

CHSP service utilisation data recorded in DEX varies depending on the type of service.

Table 4-2 displays the data type collected for each service type. For each service type, their unit cost (see Table 4-3) was applied to their service units, as follows:

- **Category 1 – Time:** The total number of hours per client per service category was calculated. For example, if a client received 2 hours of nursing, this was costed at $261.24.
- **Category 2** – **Quantity:** The total number of items received per client per service category was calculated. For example, if a client received 17 meals over the course of the trial period, this was costed at $208.42.
- **Category 3** – **Cost:** The total cost of items per client per service category was calculated. For example, if a client received $450 worth of home modifications, this was recorded as $450 against the client record.

Table 4-2: Data type collected, by CHSP service type

CHSP service type	Category for analysis	Time (minutes)	Quantity	Cost ($)
Assistance with Care and Housing	1	Yes		
Centre-based Respite	1	Yes		
Cottage Respite	1	Yes		
Flexible Respite	1	Yes		
Domestic assistance	1	Yes		
Personal care	1	Yes		
Social support – Individual	1	Yes		
Other food services	1	Yes		
Nursing	1	Yes		
Allied health and therapy services	1	Yes		
Social support – Group	1	Yes		
Home modifications	3			Yes
Home maintenance	1	Yes		Yes
Goods, equipment and assistive technology	2		Yes	Yes
Meals	2		Yes	
Transport	2		Yes	
Specialised support services	1	Yes		
Category		**1**	**2**	**3**

Table 4-3 identifies CHSP service unit costs used, as reported by Deloitte Access Economics Draft CHSP Data Report (Deloitte Access Economics 2019).

Table 4-3: CHSP services unit costs

Service type	Service unit price[1]	Inflated to 2019-20
Allied Health and Therapy Services	$131.90	$133.66
Assistance with Care and Housing	$113.10	$114.61
Centre-based Respite	$51.40	$52.09
Cottage Respite	$49.70	$50.36
Domestic Assistance	$56.50	$57.25
Flexible Respite	$74.40	$75.39
Goods, Equipment and Assistive Technology	$250.80	$254.15
Home Maintenance	$73.40	$74.38
Home Modifications[2]	At cost	At cost
Meals	$12.10	$12.26
Nursing	$128.90	$130.62
Other Food Services	$61.60	$62.42
Personal Care	$67.00	$67.90
Social Support Group	$28.80	$29.18
Social Support Individual	$53.90	$54.62
Specialised Support Services	$157.60	$159.71
Transport	$36.80	$37.29

[1] Deloitte Access Economics Draft CHSP Data Report defines unit cost as 'the expenditure claimed by providers for the services delivered by the volume of output delivered' (Deloitte Access Economics 2019).
[2] Home Modifications service type is category 3 (see Table A-2) and the reported cost amount was used for modelling purposes.

4.2 Supplementary data – client outcomes

Sections 4.2 to 4.5 contain supplementary data tables associated with Part 2: Outcomes.

4.2.1 Sample characteristics

Demographics varied between trial and control cohorts. As shown in Table 4-4:

- the trial cohort had more 65 to 74-year-olds (32.5%) than the control cohort (25.9%)
- there were fewer female clients in the trial cohort (62.0%) than the control cohort (64.5%).

Table 4-4: Demographic information, by trial and control cohorts

Demographic	Trial n (%)	Control n (%)	Total n (%)
Age			
50-64	6 (0.5%)	3 (0.7%)	**9 (0.6%)**
65-74	366 (32.5%)	114 (25.9%)	**480 (30.6%)**
75-84	500 (44.4%)	224 (50.9%)	**724 (46.2%)**
85-94	231 (20.5%)	85 (19.3%)	**316 (20.2%)**
95 and above	6 (0.5%)	3 (0.7%)	**9 (0.6%)**
Missing	18 (1.6%)	11 (2.5%)	**29 (1.9%)**
Sex			
Female	699 (62.0%)	284 (64.5%)	**983 (62.7%)**
Male	410 (36.4%)	144 (32.7%)	**554 (35.4%)**
Not stated		1 (0.2%)	**1 (0.1%)**
Missing	18 (1.6%)	11 (2.5%)	**29 (1.9%)**
Total	**1,127 (100.0%)**	**440 (100.0%)**	**1,567 (100.0%)**

4.2.2 Personal Wellbeing Index

Figure 4-3 illustrates the change over time in subjective wellbeing for trial and control clients. A higher score indicates more positive wellbeing reported by the client. As shown, subjective wellbeing remained constant for trial clients, but reduced for control clients (from 7.87 to 7.65), between baseline and follow-up.

Mean and standard deviation values for the 7 PWI items and the composite score are provided in Table 4-5.

Figure 4-3: PWI scores, by cohort at baseline and follow-up

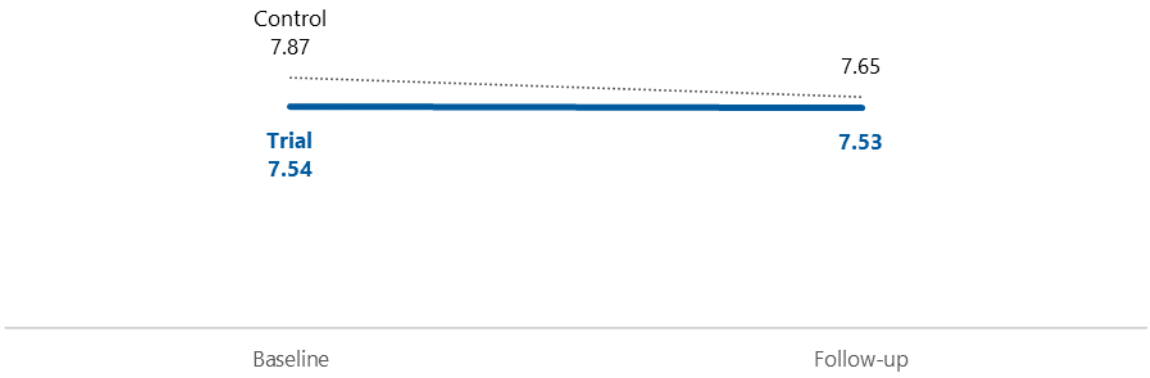


Table 4-5: Mean and standard deviation values for the PWI

PWI	Trial baseline	Trial follow-up	Control baseline	Control follow-up
Standard of living	8.06 (1.84)	8.01 (1.81)	8.34 (1.79)	8.10 (1.83)
Personal health	6.08 (2.27)	6.58 (2.09)	6.28 (2.28)	6.52 (2.16)
Achieving in life	7.00 (2.29)	6.98 (2.02)	7.37 (2.20)	7.03 (2.01)
Personal relationships	8.61 (1.80)	8.40 (1.81)	8.80 (1.52)	8.57 (1.64)
Personal safety	8.17 (1.93)	8.22 (1.65)	8.60 (1.81)	8.50 (1.54)
Community-connectedness	7.39 (2.37)	7.11 (2.14)	7.77 (2.42)	7.33 (2.01)
Future security	7.50 (2.20)	7.40 (1.84)	7.93 (2.04)	7.54 (1.84)
Total PWI	**7.54 (1.50)**	**7.53 (1.38)**	**7.86 (1.45)**	**7.65 (1.32)**

Note: The first number is the mean and the second number (in parentheses) is the standard deviation.

PWI scores varied between RAS organisations. As shown in Table 4-6:

- Trial clients' PWI scores improved at 3 RAS organisations over time – Trial RAS A, B and E
- Trial RAS C and D both had decreased PWI scores over time for their trial clients
- the 3 control cohorts all had decreased PWI scores from baseline to follow-up – the largest of which was at Trial RAS C, which decreased from 7.95 to 7.65.

Table 4-6: Overall PWI, by cohort and RAS organisation

RAS organisation	Trial baseline	Trial follow-up	Control baseline	Control follow-up
A	7.49 (1.57)	7.59 (1.30)	No control cohort	No control cohort
B	7.44 (1.50)	7.52 (1.38)	7.76 (1.35)	7.51 (1.41)
C	7.63 (1.36)	7.44 (1.37)	7.95 (1.43)	7.65 (1.32)
D	7.86 (1.44)	7.60 (1.41)	7.99 (1.25)	7.86 (1.14)
E	7.45 (1.56)	7.49 (1.51)	No control cohort	No control cohort
Total PWI	**7.54 (1.50)**	**7.53 (1.38)**	**7.86 (1.45)**	**7.65 (1.32)**

Note: The first number is the mean and the second number (in parentheses) is the standard deviation.

4.2.3 Health-related Quality of Life

Mean and standard deviation values for the 5 EQ-5D-5L dimensions and the composite utility score are provided in Table 4-7. For the individual dimensions, a lower score indicates more positive health-related quality of life. For the utility score, zero equates to worst health and 1 to full health. As shown:

- both control and trial clients had the same utility score at baseline (0.68)
- trial client utility scores improved between baseline (0.68) and follow-up (0.74), with similar increases observed in control clients (from 0.68 to 0.73)
- all domains of the EQ-5D-5L improved between baseline and follow-up for trial and control clients, however trial clients show greater improvements in mobility and self-care as well as greater reductions in anxiety and depression.

Utility scores increased for trial and control clients at a similar rate over the 6-month period. Figure 4-4 illustrates the change over time in utility scores for trial and control clients.[4]

Figure 4-4: Utility scores, by cohort at baseline and follow-up

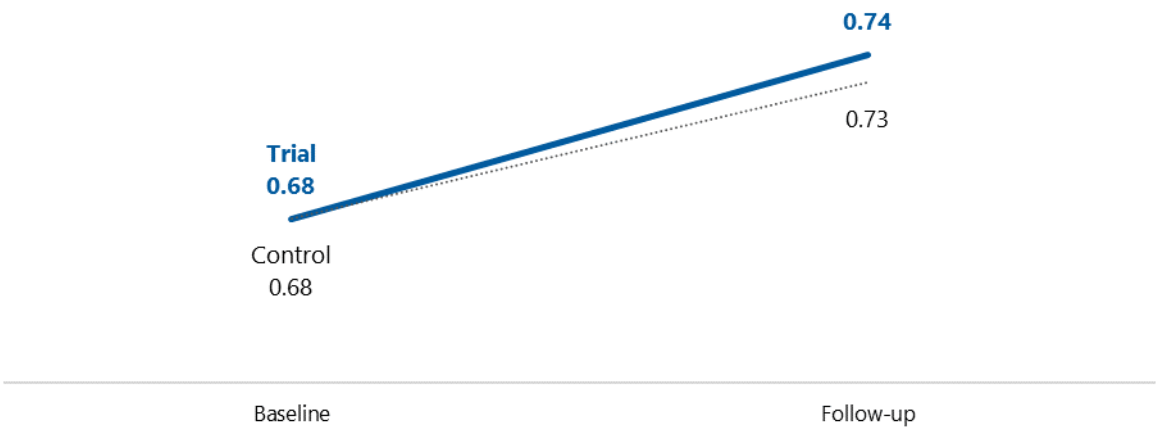


Table 4-7: Mean, standard deviation and utility values for the EQ-5D-5L

EQ-5D-5L	Trial baseline	Control baseline	Trial follow-up	Control follow-up
Mobility	2.41 (0.97)	2.35 (1.02)	2.27 (1.02)	2.32 (1.06)
Self-care	1.49 (0.77)	1.40 (0.74)	1.28 (0.65)	1.27 (0.68)
Usual activities	2.37 (1.00)	2.38 (1.01)	1.91 (1.00)	1.93 (1.03)
Pain/Discomfort	2.73 (1.00)	2.79 (1.00)	2.57 (1.01)	2.54 (0.97)
Anxiety/Depression	1.89 (0.95)	1.85 (0.94)	1.74 (0.93)	1.77 (0.92)
Utility score	**0.68 (0.21)**	**0.68 (0.20)**	**0.74 (0.20)**	**0.73 (0.19)**

Note: The first number is the mean and the second number (in parentheses) is the standard deviation.

[4] Statistical analysis was not conducted on the EQ-5D-5L to determine the effects of time, cohort or any interaction effects on health-related quality of life, as 3 of the 5 assumptions of the statistical procedure were not met.

Table 4-8 indicates that most RAS trial cohorts had similar baseline health-related quality of life scores. As shown:

- all RAS showed increases in health-related quality of life between baseline and follow-up
- Trial RAS A trial clients had a 0.09 increase (from 0.67 to 0.76) in health-related quality of life, while Trial RAS D control clients increased by 0.02 (from 0.73 to 0.75) between baseline and follow-up.

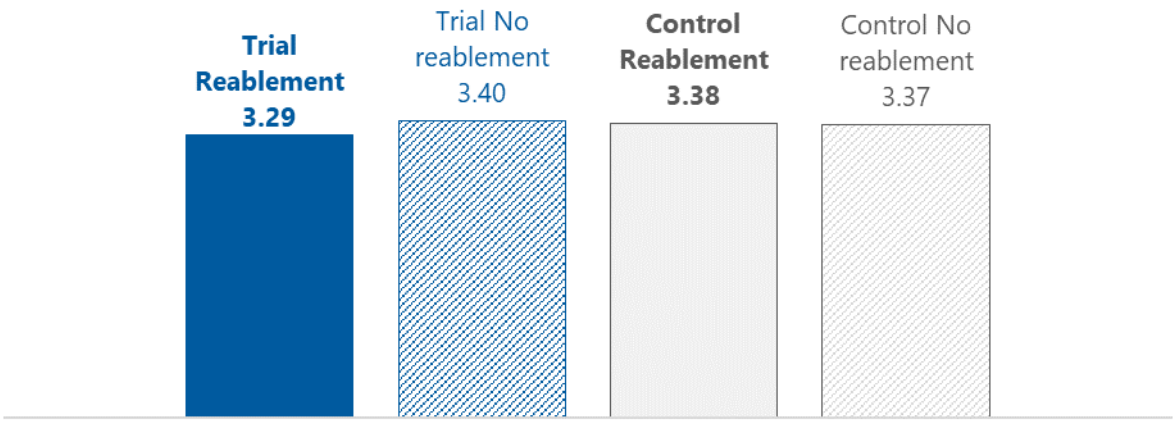
Table 4-8: Utility scores, by cohort and RAS organisation

RAS organisation	Trial baseline	Trial follow-up	Control baseline	Control follow-up
A	0.67 (0.20)	No control cohort	0.76 (0.20)	No control cohort
B	0.66 (0.24)	0.67 (0.23)	0.73 (0.20)	0.71 (0.19)
C	0.68 (0.19)	0.68 (0.20)	0.72 (0.23)	0.74 (0.20)
D	0.68 (0.21)	0.68 (0.18)	0.73 (0.20)	0.75 (0.15)
E	0.69 (0.20)	No control cohort	0.73 (0.20)	No control cohort
Total	**0.68 (0.21)**	**0.68 (0.21)**	**0.74 (0.20)**	**0.73 (0.20)**

Note: The first number is the mean and the second number (in parentheses) is the standard deviation.

Trial reablement clients reported slightly lower ratings of independence (3.29) at follow-up (Figure 4-5) compared to other cohorts. However the difference in self-reported independence between cohort and sub-groups was not statistically significant.[5]

Figure 4-5: Self-reported independence at follow-up, by cohort and sub-group



[5] There was no significant difference in self-reported independence scores, F (3, 1,563) = -1.031, p = 0.38.

4.3 Supplementary data – assessment outcomes

Sections 4.2 to 4.5 contain supplementary data tables associated with Part 2: Outcomes. This Section 4.3 provides data about the types of services recommended at assessment.

Table 4-9 displays the services recommended at assessment, by service type and cohort. Compared to control clients, a smaller proportion of trial clients received domestic assistance (33% vs 44%) and home maintenance (23% vs 30%) recommendations.

Table 4-9: Services recommended, by service type and cohort

Service type	Trial	Control	ROC	WA	Vic
Sample size	**15,304**	**12,283**	**74,390**	**13,073**	**36,965**
Allied Health and Therapy Services	34%	32%	36%	19%	54%
Domestic Assistance	33%	44%	43%	42%	43%
Transport	28%	34%	33%	22%	11%
Home Maintenance	23%	30%	32%	20%	35%
Home Modifications	20%	20%	22%	14%	22%
Social Support Individual	10%	13%	14%	9%	9%
Meals	7%	9%	9%	5%	9%
Social Support Group	7%	7%	8%	7%	10%
Nursing	6%	7%	8%	2%	6%
Goods, Equipment and Assistive Technology	6%	6%	6%	14%	<1%
Personal Care	5%	7%	7%	7%	8%
Flexible Respite	5%	6%	8%	2%	5%
Specialised Support Services	4%	3%	5%	1%	7%
Assistance with Care and Housing	1%	1%	1%	1%	<1%
Centre-based Respite	<1%	<1%	1%	<1%	<1%
Other Food Services	<1%	<1%	<1%	<1%	<1%
Cottage Respite	<1%	<1%	1%	<1%	<1%

The types of general recommendations also varied between cohorts, as shown in Table 4-10. It was more common for trial clients (vs control clients) to receive general recommendations for low-risk AT products (42% vs 30%), non-CHSP services (35% vs 33%) and strategies for independence (10% vs 3%) that were tailored to the client's circumstances and goals.

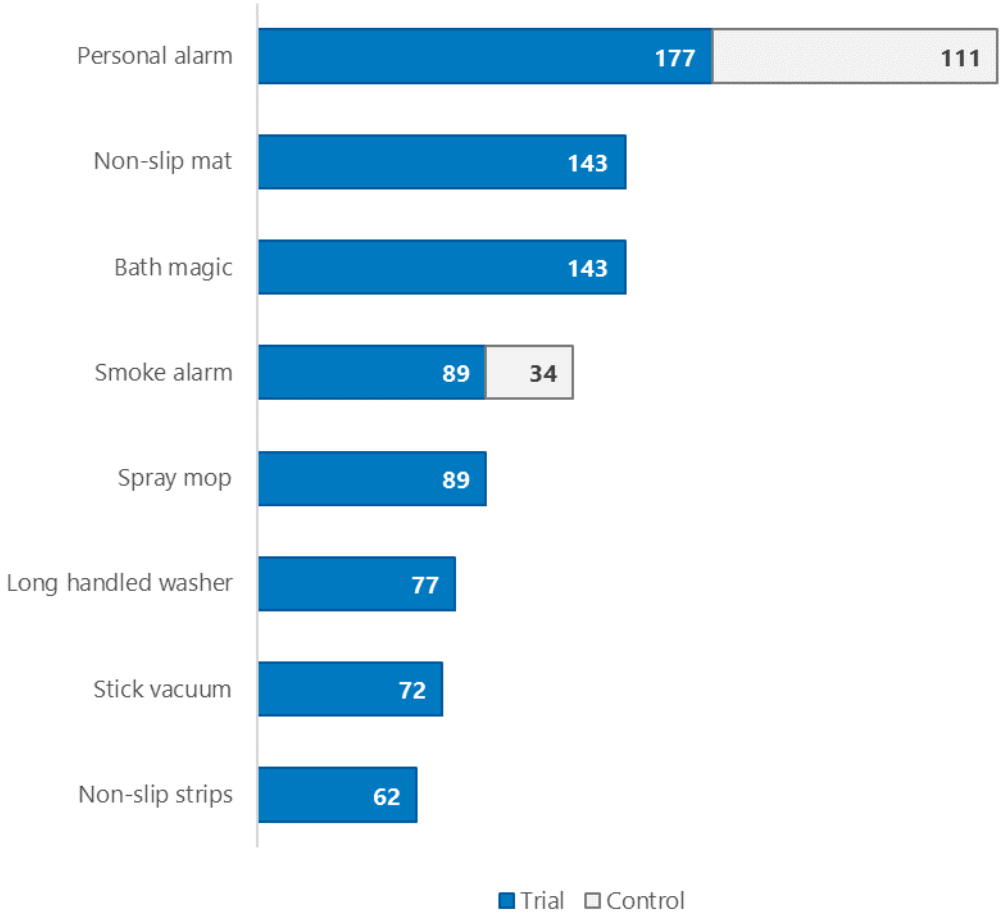
Control clients on the other hand, more often received general recommendations for emergency (25% vs 9%) and advance care planning (8% vs 3%) support that were generic in nature, and not tailored to the circumstances and goals of the client. However, control clients were recommended carers support at a higher rate than trial clients (9% vs 3%), which may indicate that control assessors focussed on recommendations that drew upon the availability of carers.

Table 4-10: General recommendations made, by cohort and type

Category	Trial (1,382)	Control (380)
AT products	**42%**	**30%**
Non-CHSP services	**35%**	**33%**
Health promotion	14%	12%
ADL support	10%	8%
Allied health referrals	5%	2%
Carers support	3%	9%
Social support	3%	3%
Strategy for independence	**10%**	**3%**
Continuation of client led activity	4%	2%
Strategy for independence	6%	1%
Emergency care support	**9%**	**25%**
Emergency care support	5%	18%
Fire safety	4%	7%
Advance care planning	**3%**	**8%**
Total	**100%**	**100%**

For AT products recommended, Figure 4-6 shows that control assessors only recommended personal alarms and smoke alarms, whereas trial assessors recommended a much greater diversity of AT products.

Figure 4-6: Top 8 AT products recommended, by product type

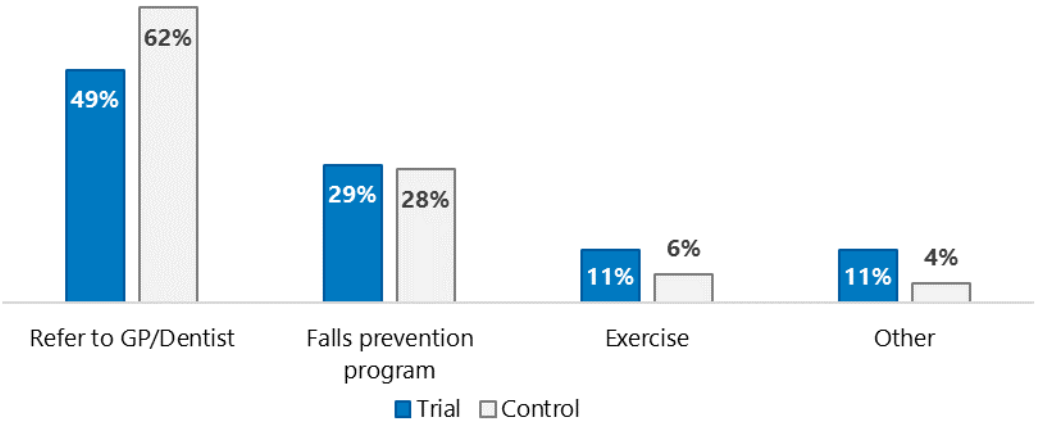


Another non-CHSP service general recommendation group identified during our analysis was recommendations relating to the promotion of clients' health and wellbeing (Figure 4-7).

Although control clients had a higher proportion of recommendations referring them to a GP or dentist (62% vs 49%) compared to trial clients, the intent of these control client recommendations appeared to be more generic than for trial clients.

For example, 6% of trial clients had a referral to a GP or dentist which related to the assessor suggesting the client discuss the possibility of accessing an Allied Health Care plan or Mental Health Care plan – whereas only 2% of control clients had such recommendation.

Figure 4-7: Health promotion general recommendations, by category and cohort



4.4 Supplementary data – service utilisation

Sections 4.2 to 4.5 contain supplementary data tables associated with Part 2: Outcomes. This Section 4.4 contains supplementary service utilisation data.

Analysis of allied health and therapy services found that:

- For the trial cohort, like the control and rest of country cohorts, by far the most common service types provided were occupational therapy services (e.g. 27% for trial reablement cohort) and physiotherapy services (9%).
- In contrast, occupational therapy and physiotherapy were received in almost identical proportions for Western Australia (e.g. both 8% for reablement cohort) and Victoria (e.g. 37% and 36%).
- For Western Australia, other allied health and therapy services (e.g. 6% for reablement cohort) and restorative care services (4%) also featured, with many service sub-types not represented.
- In comparison to all other cohorts, Victorian clients were more likely to receive podiatry services (e.g. 11% for reablement cohort).

To explore the non-concordance between the services recommended and the services received, we matched client service recommendations with client service records in the DEX dataset.

For the purposes of this analysis, service non-concordance was defined as **a service that was not recommended but was received.**

The rate of non-concordant service delivery is identified in Table 4-12. As shown, the rates were similar across client cohorts.

A challenge for clients who received reablement was receiving the recommended services within the 12-week reablement period following assessment. Across cohorts and reablement sub-groups we analysed the proportion of clients who received a service within 90 days of their assessment completion date (Table 4-13).

This data is based on clients assessed in the first 6 months of the 2019-20 financial year, who had received at least one service recommendation. This approach was taken to remove the influence of clients assessed in the latter half of the year whose services would not be recorded until the following financial year.

As shown in Table 4-13, 15% of trial clients and 18% of control clients did not receive their first service within 90 days of assessment. This cohort was smaller for rest of country (13%), WA (10%) and Victoria (8%).

Table 4-11: Allied health and therapy services received by service type, by cohort and reablement sub-group

Service sub-type	Trial R	Trial N-R	Control R	Control N-R	ROC R	ROC N-R	WA R	WA N-R	Vic R	Vic N-R
Sample size	**1,914**	**2,101**	**603**	**1,689**	**6,175**	**13,153**	**886**	**1,144**	**2,883**	**13,854**
Allied Health and Therapy Services	**37%**	**18%**	**34%**	**15%**	**45%**	**20%**	**23%**	**10%**	**64%**	**39%**
Occupational Therapy	27%	13%	23%	10%	34%	13%	8%	3%	37%	20%
Physiotherapy	9%	3%	6%	3%	13%	5%	8%	4%	36%	17%
Ongoing Allied Health and Therapy Services	4%	2%	3%	1%	2%	1%	<1%		1%	1%
Other Allied Health and Therapy Services	3%	1%	2%	1%	3%	2%	6%	2%	4%	2%
Exercise Physiologist	2%	1%	2%	1%	2%	1%	<1%	<1%	4%	2%
Podiatry	2%	2%	2%	2%	3%	3%	<1%	<1%	11%	10%
Restorative Care Services	2%	1%	2%	0%	<1%	<1%	4%	1%	<1%	<1%
Dietitian or Nutritionist	1%	1%	1%	0%	2%	1%	<1%		5%	3%
Social Work	1%	1%	1%	1%	2%	1%		<1%	1%	1%
Speech Pathology	1%	<1%	0%	<1%	1%	<1%		<1%	1%	1%
ATSI Health Worker	<1%	<1%		<1%	<1%	-				<1%
Diversional Therapy	<1%	<1%		<1%	<1%	<1%				<1%
Hydrotherapy	<1%	<1%	<1%	<1%	<1%	<1%				<1%
Psychologist	<1%	<1%	<1%	<1%	<1%	<1%				1%

Table 4-12: Non-concordance of services received with services recommended, by cohort and reablement sub-group

Service type	Trial R	Trial N-R	Control R	Control N-R	ROC R	ROC N-R	WA R	WA N-R	Vic R	Vic N-R
Sample size	**5,139**	**11,979**	**1,788**	**11,449**	**13,625**	**66,114**	**3,810**	**11,811**	**4,506**	**35,409**
Social Support Individual	6%	5%	6%	5%	5%	5%	6%	7%	5%	5%
Allied Health and Therapy Services	3%	2%	1%	2%	1%	2%	1%	1%	1%	3%
Domestic Assistance	2%	3%	2%	2%	2%	2%	2%	2%	1%	2%
Home Maintenance	2%	1%	2%	1%	2%	2%	1%	1%	3%	2%
Home Modifications	2%	2%	<1%	1%	1%	1%	<1%	<1%	1%	1%
Transport	2%	2%	1%	2%	1%	2%	2%	3%	1%	1%
Nursing	2%	2%	3%	3%	3%	2%	<1%	<1%	7%	6%
Meals	2%	2%	1%	1%	1%	1%	1%	1%	1%	1%
Specialised Support Services	2%	2%	1%	1%	2%	1%	1%	1%	4%	5%
Personal Care	1%	1%	<1%	1%	1%	1%	1%	1%	7%	6%
Social Support Group	1%	1%	<1%	1%	1%	1%	1%	1%	2%	1%
Flexible Respite	<1%	1%	<1%	<1%	1%	1%	<1%	1%	2%	2%
Goods, Equipment and Assistive Technology	1%	1%	1%	1%	1%	1%	2%	1%	<1%	<1%
Assistance with Care and Housing	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%
Centre-based Respite	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%
Other Food Services	<1%	<1%	1%	1%	<1%	<1%	<1%	<1%	<1%	<1%
Cottage Respite	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%

Table 4-13: Proportion of clients receiving a service within 90 days of assessment, by cohort and sub-group

Cohort and sub-group	% of clients who received first service within 90 days of assessment	% of clients who received first service beyond 90 days of assessment
Trial	**85%**	**15%**
Reablement	89%	11%
Non-reablement	83%	17%
Control	**82%**	**18%**
Reablement	84%	16%
Non-reablement	82%	18%
Rest of country	**87%**	**13%**
Reablement	92%	8%
Non-reablement	86%	14%
Western Australia	**90%**	**10%**
Reablement	91%	9%
Non-reablement	90%	10%
Victoria	**92%**	**8%**
Reablement	95%	5%
Non-reablement	91%	9%

Includes only clients assessed during the first half of financial year 2019-2020

4.5 Supplementary data – cost effectiveness

Sections 4.2 to 4.5 contain supplementary data tables associated with Part 2: Outcomes. This Section 4.5 contains supplementary cost-effectiveness data.

4.5.1 Effect of assessment

Effect data was examined for the PWI and health-related quality of life (EQ-5D-5L), for the traditional assessment and the trial assessment groups – at baseline and at 6 month follow up. For each of these groups, data was also examined for reablement and non-reablement subgroups.

For the PWI score, data is presented in Table 4-14, Table 4-15 and Table 4-16. As shown in Table 4-16, there was a statistically significant difference in personal wellbeing between baseline and 6 month follow-up measurements (0.25) when comparing trial and control groups. This means that personal wellbeing was maintained for trial clients between baseline and 6 month follow-up, while for control clients it declined.

For the health related quality of life change score, there was no significant difference between trial and control groups, neither for the overall cohort nor for the reablement/non-reablement sub-groups.

Cost-effectiveness analysis was only performed for the PWI outcome, which showed a significant difference between trial and traditional assessment for the PWI change score. The quality of life outcome was excluded from the cost-effectiveness analysis due to non-significant results.

While statistically significant changes in personal wellbeing were observed, in practical terms the clinical impact of these changes is likely small.

Table 4-14: Personal Wellbeing Index – Comparison of trial and traditional approaches – Baseline

Sub-group	Traditional	Trial	Mean difference
Total sample	7.94 (1.43)	7.59 (1.51)	**-0.35** (95% CI -0.53 to -0.17) p<0.000
Reablement sub-group (Traditional n=109; Trial n=330)	7.88 (1.44)	7.39 (1.53)	**-0.49** (95% CI -0.82 to -0.17) p=0.003
No reablement sub-group (Traditional n=271; Trial n=523)	7.96 (1.43)	7.72 (1.49)	**-0.25** 95% CI -0.46 to -0.03) p=0.026

Note: Numbers in brackets are Standard Deviation from the mean (e.g. 1.43 SD from 7.94 mean)

Table 4-15: Personal Wellbeing Index – Comparison of trial and traditional approaches – 6-month follow-up

Sub-group	Traditional	Trial	Mean difference
Total sample	7.70 (1.35)	7.60 (1.35)	**-0.09** (95%CI -0.26 to 0.07) p=0.265
Reablement sub-group (Traditional n=109; Trial n=330)	7.72 (1.21)	7.53 (1.34)	**-0.18** (95%CI -0.47 to 0.10) p=0.205
No reablement sub-group (Traditional n=271; Trial n=523)	7.69 (1.40)	7.65 (1.43)	**-0.04** (95%CI -0.25 to 0.16) p=0.682

Note: Numbers in brackets are Standard Deviation from the mean (e.g. 1.43 SD from 7.94 mean)

Table 4-16: Personal Wellbeing Index – Comparison of trial and traditional approaches – Change

Sub-group	Traditional	Trial	Mean difference
Total sample	-0.24 (1.32)	0.01 (1.40)	**0.25** (95%CI 0.09 to 0.42) p=0.003
Reablement sub-group (Traditional n=109; Trial n=330)	-0.16 (1.26)	0.14 (1.47)	**0.31** (95%CI 0.00 0.07 to 0.62) p=0.050
No reablement sub-group (Traditional n=271; Trial n=523)	-0.27 (1.34)	-0.07 (1.34)	**0.20** (95%CI 0.01 to -0.40) p=0.044

Note: Numbers in brackets are Standard Deviation from the mean (e.g. 1.43 SD from 7.94 mean)

4.5.2 Cost-effectiveness of the trial

ICER (incremental cost-effectiveness ratio) values were calculated under each scenario (trial and traditional) to determine whether the trial model was a cost-effective approach.

The ICER value is plotted within one of 4 quadrants according to the overall costs and effects of the model. The location (quadrant) of an ICER value (point estimate) is interpreted as follows:

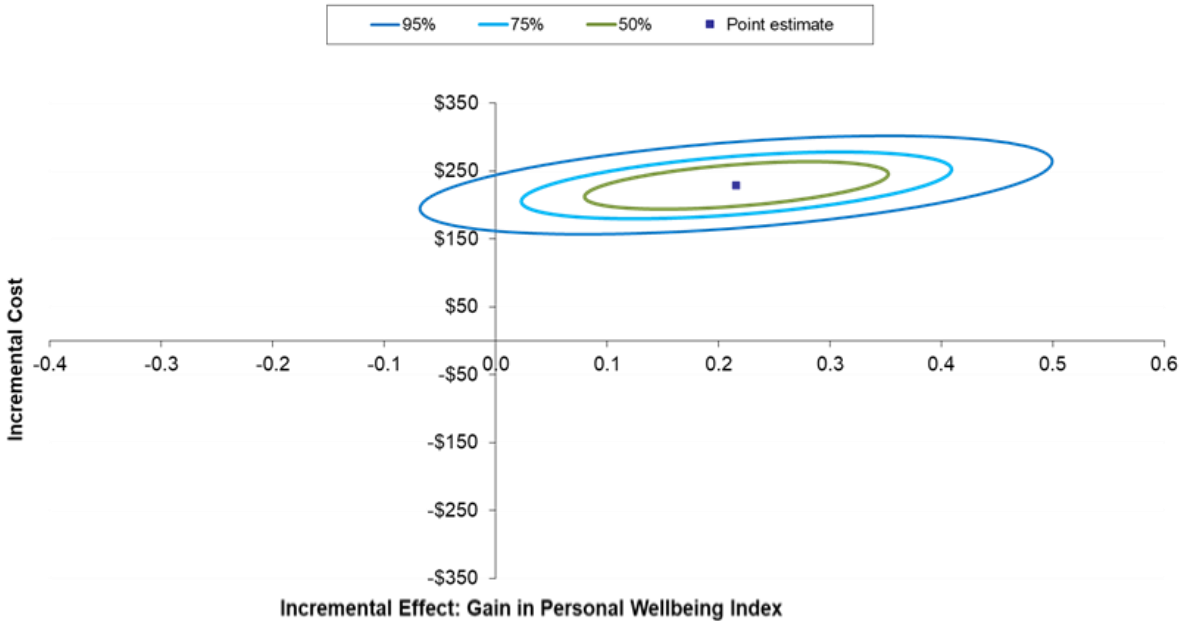
- Top left quadrant – the intervention was more costly, and less effective
- Bottom left quadrant – the intervention was less costly, but less effective
- Bottom right quadrant – the intervention was less costly, and more effective
- Top right quadrant – the intervention was more costly, but more effective.

As indicated by the point estimate in the top right quadrant of Figure 4-8, the additional cost of the trial model including transition costs was $238 per assessment ($237.66 rounded), and the PWI incremental effect difference was 0.25. This shows that both the cost and the effect are greater for the trial assessment group.

The ICER for PWI was therefore $934 (95%CI $525 to $22,489). This indicated that for each 1-point gain on the PWI observed for trial assessment clients, compared to traditional assessment clients, the additional cost was $934.

The confidence ellipses for trial model versus traditional model are also illustrated in Figure 4-8. The confidence ellipses show significance at the 50% and 75% levels, but not the 95% level.

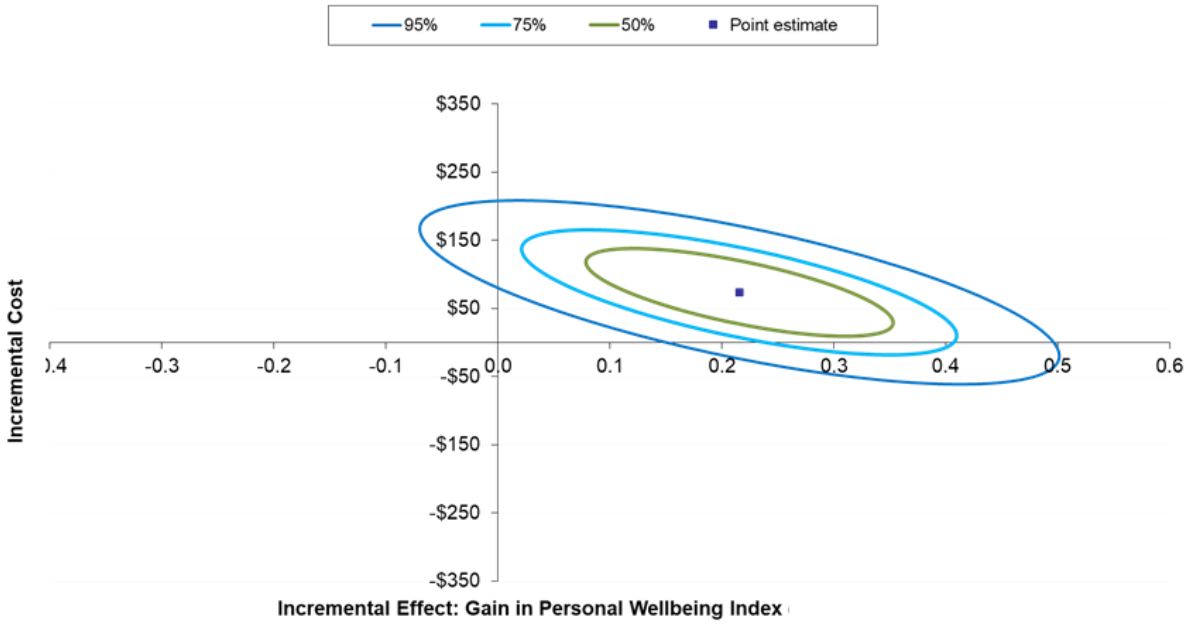
Figure 4-8: Primary analysis point estimate, trial assessment versus traditional assessment



As detailed in Table 4-14, an adjusted analysis was calculated to reflect the assessment costs once the trial model is embedded. This yielded an incremental cost difference of $51 ($51.31 rounded) and an incremental effect difference of 0.25 on the PWI, and therefore the ICER for PWI was $202 (95%CI $178 to $22,489).

This indicated that for each 1-point gain on the PWI observed for trial assessment clients, compared to traditional assessment clients, the additional cost was $202. This is presented in Figure 4-9, where it can be seen by the point estimate placement in the top right quadrant, that both the cost and the effect remain greater for the trial assessment group.

Figure 4-9: Sensitivity analysis, trial assessment versus traditional assessment



Appendices

Appendix A PIL trial protocol

This appendix sets out the trial protocols that were submitted to and approved by Bellberry Human Research Ethics Committee. It includes minor formatting changes made to the original version.

PIL trial protocol relates to the evaluation of the reablement trial as part of the *Promoting Independent Living* (PIL) budget measure. This protocol outlines how the evaluation was conducted and delivered, and includes the following sections:

- Background Information.
- Project objectives and purpose.
- Study design, including:
  - participant population
  - data sources
  - study procedures
  - participant recruitment
  - data handling and recording
  - data analysis
  - direct access to source data/documents
  - ethics.
- Financing and insurances.
- Publication policy.

This protocol was prepared in accordance with Section 5.2.5 of the *NHMRC National Statement of Ethical Conduct in Human Research (2007 incorporating all updates)*, hereafter referred to as the National Statement.

AHA adheres to the values, principles and themes that inform the design, ethical review and conduct of human research participants (Sections 1 and 2) of the National Statement (National Health and Medical Research Council 2018).

For questions regarding the evaluation of the reablement trial or this protocol, please contact:

Principal Investigator: Jill Waddell

Co-investigators: Mike Herbert
Dr Tim Dyer
Dr Alex Stretton
Jessica Small

Phone: 1300 242 111 (local call cost)

Email: PIL@ahaconsulting.com.au

Address: Level 6, 140 Bourke St, Melbourne VIC 3000
Locked Bag 32005, Collins Street East, VIC 8006

Website: www.ahaconsulting.com.au

In February 2019, the Department of Health (the department) engaged Australian Healthcare Associates (AHA) to undertake an evaluation of a reablement trial as part of the PIL budget measure. This protocol outlines AHA's evaluation approach for the purposes of applying for ethical approval to gather information from clients participating in the reablement trial.

A.1 PIL trial protocol

A.1.1 Background Information

Australian Government spending on aged care was estimated at $20 billion in 2017–18 (National Health and Medical Research Council 2018) (AIHW 2019). As the Australian population ages, and the number of people needing aged care increases, there is a concurrent policy shift to providing care that 'better supports the wellbeing of older people and the delivery of care in ways that respect their dignity and support their independence' (Department of Health 2017b).

The Commonwealth Home Support Programme

Launched in 2015, the Commonwealth Home Support Programme (CHSP) is the primary entry-level home care program for older Australians. The key CHSP objective is to enable clients to remain living independently at home and in their community for as long as they can, and wish, to do so (Department of Health 2017c).

The CHSP is designed to provide support services to eligible clients who have difficulty performing activities of daily living due to functional limitations. As outlined by the Department of Health (2017b), services funded under the CHSP include:

- community and home support services, such as domestic assistance, transport, meals, personal care, home maintenance, social support, nursing and allied health
- aids and equipment, such as mobility aids or modifications to the home environment
- respite care, allowing carers to take a break from their usual caring responsibilities, in recognition of the vital role that they play.

Regional Assessment Services

Regional Assessment Services (RAS) are responsible for determining eligibility for potential CHSP clients. Currently, the RAS assessment process involves:

- conducting home support assessments, usually face-to-face in the client's home
- developing support plans
- referring clients for CHSP services or further assessment by an Aged Care Assessment Team (ACAT) if the client's needs are greater than can be met through the CHSP.

The RAS assessment process is designed to be conducted independently of CHSP providers, to ensure clients are referred only to the services that will fulfil their needs and goals (Department of Health 2018b).

The wellness and reablement approach

Traditional models, which offer many home support services, have often focused on clients' difficulties and what they are unable to do. This approach has arguably led to a task-oriented, dependency model of service delivery. Over the past decade, emerging research and the successful implementation of independence-focused home care programs within Australia and overseas has led to an increasing emphasis on a wellness and reablement (W&R) approach.

Wellness is a broad term encompassing elements of reablement and restorative care. It aims to promote independence and autonomy through assessments, support planning and service delivery that build on a client's strengths and capability (Tessier et al. 2016). Emerging evidence (Tessier et al. 2016) suggests that implementing a wellness approach at the earliest opportunity can have significant long-term benefits for clients, including:

- improved sense of purpose, autonomy and self-worth
- improved physical and emotional health and wellbeing
- improved social and psychological functioning
- increased ability to remain living independently and safely in their own homes for longer
- reduced service delivery needs.

Like wellness, reablement aims to promote clients' independence and autonomy, but through a time-limited intervention that is targeted towards regaining a client's confidence and capacity to resume daily activities. Reablement encourages clients to identify their own strengths and capabilities, including setting their own functional goals (Department of Health 2018b).

Promoting Independent Living budget measure

The 2017 *Legislated Review of Aged Care* recommended that the Government and service providers work to improve access to W&R in order to provide greater choice and better support for clients to live independently (Department of Health 2017b). Suggested means to help clients live independently included: increasing access to time-limited supports, improving integration with other services, assisting the sector and the community to better understand W&R approaches, and providing W&R training for aged care assessors.

The department allocated $29.2 million (from July 2018 to June 2020) to the *Promoting Independent Living* (PIL) budget measure to trial a reablement approach with RAS organisations. The assessment model trialled is based on the well-established Western Australian 'show me' assessment model, which implements a short reablement period before any ongoing services are provided. Assessors undertook active assessments, which included asking clients to demonstrate how they performed certain tasks in order to better understand their limitations. Under this model, the RASs played a more significant care coordination role for clients and provided more direction to service providers on the frequency and volume of services to be delivered.

Following a tender process, 5 organisations were contracted by the department to be part of the reablement trial across 20 ACPRs in Australia. These organisations had the following clauses in their contracts relating to the evaluation of the PIL budget measure:

1. The Contractor must cooperate with the Department and the Evaluator in the establishment phase of the Trial to identify sources of baseline data and develop agreed data collection methods and outcome measures (both qualitative and quantitative) for measuring the impact of the Trial.
3. The Contractor must collect data using agreed data collection methods and provide it to the Evaluator within the agreed timeframes as required to support the evaluation of the Trial.
4. The Contractor must support engagement between the Evaluator and the Contractor Personnel and Clients of the Contractor to facilitate collection of agreed data by the Evaluator.

The outcomes of the evaluation will inform the national implementation of a reablement-focused model that delivers greater consumer independence, mobility and autonomy, and reduces or delays the need for more complex aged care support services.

The two main elements of the trial included the following:

1. **An active assessment** that enabled identification of the client's degree of skill and functional decline and guided the choice of strategies to be introduced. The discrete elements included:
   a. the RAS assessor assessing the client, including asking the client to 'show me' a range of daily activities
   b. the development of a support plan that identified:
      i. areas of concern
      ii. reablement goals against each area of concern, identifying areas where new and existing skills could be developed
      iii. client motivation to achieve each goal(s)
      iv. reablement strategies to reach each goal, which addressed areas of concern and focused on building the physical, cognitive and emotional skills of the individual.
2. **A reablement period.** Time-limited CHSP services were provided during the 6 to 8-week reablement period, where relevant. Strategies to achieve reablement goals could have included CHSP services such as allied health and provision of aids and equipment.

Where a period of reablement was agreed upon in the support plan, the RAS assessor maintained contact with the client throughout the 6 to 8-week reablement phase to provide encouragement and to allow the individual time to practise and learn new skills and techniques. This support was provided over the telephone or in the home. Regular reviews throughout the reablement period (with the client and, where relevant, the CHSP provider/s) allowed for strategies to be refined and provided opportunities to reinforce and support achievement. At the conclusion of the reablement period, the client could continue to receive CHSP services on an ongoing basis, if these were required.

A.1.2 Project objectives and purpose

The purpose of the evaluation of the reablement trial was to investigate the following questions:

1. Has the reablement trial been implemented as planned?
2. How are aids and equipment currently distributed in the trial sites?
3. Did the reablement focused assessment model increase demand for services, including aids, equipment and allied health services?
4. How appropriate is the reablement trial for addressing the needs of clients, families and carers, and for promoting greater independence and autonomy?
5. How appropriate is the reablement approach for all service types or organisations funded under CHSP to embed wellness and reablement strategies?
6. To what extent has the reablement trial achieved its intended outcomes?
7. How cost-effective is the reablement trial?
8. To what extent did differences in service delivery and funding models, workforce profiles, jurisdictional differences and service provider and client resources and supports affect the implementation, delivery and outcomes of the PIL?

9. How did the service provider and client resources and supports affect the implementation, delivery and outcomes of the measure?

AHA developed a methodology to gather evidence to address each of these 9 evaluation questions. Methods included:

- interviews with RAS and CHSP staff and management, departmental staff and peak bodies
- evaluation of reablement training delivered to all participating RAS
- review of departmental program documentation and master contract with RAS and CHSP service providers
- analysis of de-identified client data routinely collected during RAS assessment and CHSP service delivery
- collection and analysis of self-reported Quality of Life (QoL) data.

Evaluation components requiring ethical approval

The reablement trial evaluation methods were reviewed as part of AHA's internal ethics process and identified as either 'Quality Assurance and Evaluation Activities' (National Health and Medical Research Council 2014) or requiring external, independent ethical approval (see Section 2.8 for further details).

The elements of the reablement trial evaluation that were identified as requiring external, independent ethical approval related to where clients, their carers or their family were:

- asked to provide information beyond what is routinely collected as part of a home assessment
- contacted directly by AHA
- asked to supply information which was not de-identified.

A.1.3 Study design

The reablement trial evaluation was conducted from February 2019 to November 2020. The evaluation team were based in Melbourne but conducted activities across trial and control sites throughout Australia's states and territories.

Trial and control sites

The trial involved 5 RAS organisations conducting trial assessments across 20 sites and traditional assessments across 13 sites. Control sites were chosen with input from the department and were matched with trial sites based on client through-put and location. A list of participating trial and control sites is presented in Table A-1.

Table A-1: Trial and control site locations

Aged care planning region	State	RAS E	RAS B	RAS C	RAS A	RAS D
Far North Coast	NSW		Control	Trial		
Illawarra	NSW		Trial	Trial		
Mid North Coast	NSW		Trial	Control		
New England	NSW		Trial	Control		
South East Sydney	NSW		Control	Trial		
Southern Highlands	NSW		Trial	Control		
Darling Downs	QLD		Control			Trial
Fitzroy	QLD					Trial
Mackay	QLD					Trial
Northern	QLD					Trial
Wide Bay	QLD		Control			
Metropolitan East	SA				Trial	Control
Metropolitan North	SA				Trial	Control
Metropolitan South	SA				Trial	
Riverland	SA				Trial	Control
South East	SA				Trial	
North Western	TAS	Trial				Control
Northern	TAS	Trial				Control
Southern	TAS	Trial				Control
Darwin	NT					Trial
Total trial sites		**3**	**4**	**3**	**5**	**5**
Total control sites		**0**	**4**	**3**	**0**	**6**

Participant Population

The population from which reablement trial evaluation participants were recruited encompassed:

- clients requiring home assessments from either trial or control sites
- carers or family members of a person who was either participating in the reablement trial or was recruited from a control site.

Eligibility requirements for assessment services stipulate that clients must be:

- aged 65 years and over
- aged 50 years and over for Aboriginal and Torres Strait Islander people
- prematurely aged on a low income who are 50 years or over (45 years or over for Aboriginal and Torres Strait Islander people) and are homeless or at risk of homelessness.

Exclusion criteria for the reablement trial evaluation included clients who would not be suitable for reablement services. Specifically, excluded clients were those:

- receiving palliative care
- referred for further assessment by an Aged Care Assessment Team (ACAT) due to client's needs being greater than can be met through the CHSP
- not requiring reablement.

A.2 Data sources

Quantitative and qualitative data collected for the evaluation included:

- client information routinely collected during home assessments, using the National Screening and Assessment Form (NSAF)
- wellbeing and health-related Quality of Life (QoL) measures
- interviews of aged care clients, their carers and families (CCF).

A.2.1 National Screening and Assessment Form

Review of the information gathered via RAS assessments identified that the majority of participant information relevant to the reablement trial evaluation was collected using the NSAF.

The NSAF is an online form designed to collect client information during RAS assessments. It is available via the My Aged Care assessor portal, via the myAssessor app or as a printed version.

When using the NSAF to record details of home assessments, RAS assessors are required to record:

- the assessment process
- client social and functional status
- client health condition(s)
- client psychological functioning
- client support considerations
- client goals and support plan recommendations.

AHA investigated obtaining access to NSAF data with the department. The department confirmed that all routinely collected assessment data would be de-identified prior to being delivered to AHA. Access

to de-identified client data was reviewed and approved by the department in accordance with their Data Access and Release Policy (DARP).

A.2.2 Wellbeing and health-related Quality of Life measures

Information beyond what is routinely collected during assessment was identified as necessary for the purposes of the evaluation. Specifically, it was identified that the NSAF did not contain items that measure clients' wellbeing and health-related Quality of Life (QoL). This was required to inform the investigation of evaluation question 6: 'To what extent has the reablement trial achieved its intended outcomes?'

Identification of appropriate tools to measure clients' subjective wellbeing and health-related QoL included the following steps:

- consultation with RAS providers to establish what information is routinely collected from clients outside of the NSAF
- consultation with WA researchers who had used QoL measures in previous evaluations of reablement services
- review of tools and literature, including a brief review of measures of QoL and social participation outcomes performed by AHA
- advice from AHA's expert evaluation advisor Professor David Dunt (founding Director of the Centre for Health Policy at the Melbourne School of Population and Global Health at the University of Melbourne) to determine the suitability of the tools proposed for this evaluation.

The outcome of the above steps was identification of the Personal Wellbeing Index (P{WI) and the 5-level EQ-5D (EQ-5D-5L), as suitable for evaluating client QoL and health-related QoL outcomes respectively. These tools measure related but different aspects of client QoL. The PWI is a measure of subjective wellbeing that calculates an individual's average level of satisfaction, and the EQ-5D-5L is a measure of health-related quality of life,

Further detail of the PWI and EQ-5D-5L are provided in Appendix B.

A.2.3 Client, carer and family interviews

AHA determined that semi-structured interviews with aged care clients, their carers and families (CCF) would enhance the quality of evaluation data by providing CCFs with greater opportunity to reflect upon their service experience in a more detailed and comprehensive way.

The purpose of the semi-structured interviews was to develop an in-depth understanding of clients' experiences of RAS assessments and their levels of satisfaction with assessments and subsequent reablement services.

Key evaluation questions targeted by these interviews were:

1. How appropriate is the RAS trial assessment model for:
   - addressing the needs of clients, families, and carers?
   - promoting greater independence and autonomy for clients?
2. To what extent has the PIL budget measure achieved its intended outcomes? Who benefited and in what context?

Clients were approached first to participate in interviews (further details are in Section 2.4.5, Participant recruitment). Carer and family interviews were only be performed in instances where the client was unable to participate. As discussed in the following section, CCF interviews were conducted at two time points:

- soon after the assessment in trial sites (active assessment) and control sites (business-as-usual assessment)
- following the period of reablement, 6 to 8 weeks after assessment.

The second interview investigated experiences of RAS assessment as well as the period of reablement. These were important to ensure that the outcome of service delivery (whether participants received the services they wanted or not) did not influence the participant's view of their experience of the assessment process. Consultation tools for CCF interviews are presented in Appendix B.

The AHA consultants who conducted client interviews had either undergraduate or postgraduate qualifications in social sciences or public health and had extensive experience, from similar evaluation projects, interviewing older adults and/or vulnerable people with complex needs.

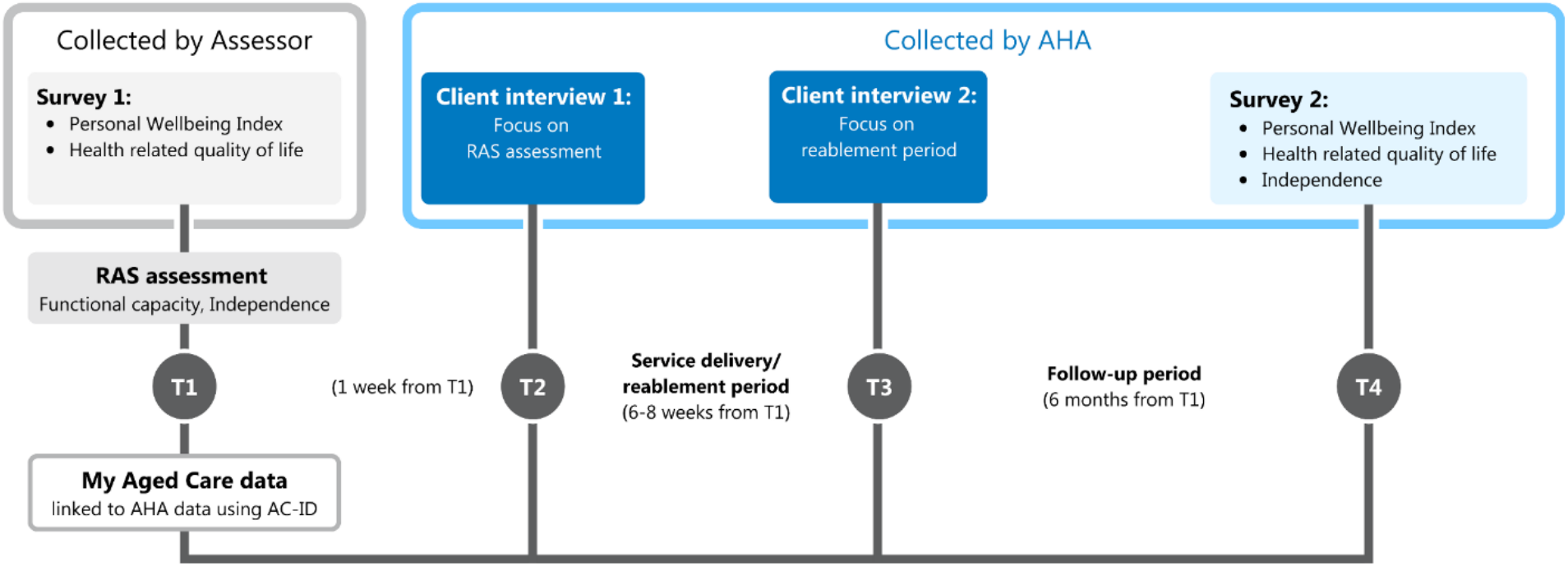
A.3 Study procedures

As shown in Figure A-1 and described in the subsequent sections, data were collected at 4 time points throughout the reablement evaluation:

- T1 – Baseline client QoL, function and independence
- T2 – Client, carer or family interview following assessment (focused on RAS assessment)
- T3 – Client, carer or family interview following service delivery (focused on services received)
- T4 – Follow-up client QoL, function and independence.

Procedures were identical at trial and control sites.

Figure A-1: Reablement trial and data collection points



T1 – Baseline client QoL, function and independence

Prior to conducting a home assessment, baseline QoL information was collected in the client's home by RAS assessors using the PWI and ED-5D-5L. Information was recorded via electronic survey which included an existing Aged Care ID (AC-ID), used in the My Aged Care system as a unique identifier for the purposes of linking to NSAF data. Assessors also reported which RAS they represent in the electronic survey, to identify service-specific response rates.

Assessors entered client demographics, baseline functional capacity and independence information into the My Aged Care system using the NSAF. This data was collected as part of the standard RAS process.

T2 – Client, carer or family interview following assessment

Approximately one week after assessment, AHA telephoned clients who had agreed to be contacted (see Section 2.2.5 Participant recruitment for further details) to investigate their experience during assessment. Carers and family members were invited to participate in instances where clients were unable. All interviews were conducted by telephone at a time suitable to the client.

T3 – Client, carer or family interview following the reablement period

Following a service provision period of 8 to 12 weeks, AHA contacted clients, carers or family members who had agreed to be contacted. All interviews were conducted by telephone at a time suitable to the client.

T4 – Follow-up client QoL, function and independence

AHA collected follow-up client QoL, functional capacity and independence data via a telephone phone call, 6 months after baseline assessment. Follow-up client QoL information was collected using the same tools as baseline, using the clients AC-ID to link to T1 data collection.

A.4 Participant recruitment

All clients who were referred to RAS at trial sites and control sites, and who met eligibility criteria within the evaluation period, were invited to participate. Recruitment for different time points occurred over three instances:

1. Recruitment for baseline QoL was performed by assessors during the initial visit prior to conducting the assessment. AHA developed a script for assessors to introduce the reablement trial and make clear to their clients that participation is voluntary, and that information collected as part of the trial is separate to the RAS assessment process. Participants were supplied with an information sheet and asked to complete a consent form if they agreed to participate. (See Appendix C for all related scripts and forms.) Completed consent forms were scanned by assessors and emailed to AHA.
2. At the end of the RAS assessment, clients or their carers and/or family members who agreed to participate in the trial were invited to be contacted by AHA to describe their experience with the assessment process. Clients or their carers and/or family members who agreed to be interviewed were asked by their assessor to provide their contact details. AHA developed a script for assessors to invite their clients to participate in a telephone interview (see Appendix C).
3. Signed consent forms were sent to a dedicated email address at AHA. AHA made potential participants aware that the evaluation was looking to sample a small number of individuals from each participating service and that participation was voluntary, would be performed by an independent evaluation team and would not influence the service that they received. trial and control sites invited all participants to opt-in to interviews. Contact details of all participants who consented to be interviewed were supplied to AHA, who then randomly selected 5 participants from each trial site and 8 from each control site. Interviews were spread across the evaluation period. Recruitment continued until 100 participants from trial sites and 100 participants from controls sites were interviewed. Consent forms were modified to remove details about the interview opt-in once an adequate sample from trial and control sites were reached.
4. Clients or their carers and/or family members who participated in the first interview were invited to be contacted to discuss their experience with services 6 to 8 weeks after assessment. Only clients or their carers and/or family members who participated in an interview relating to assessment were recruited for the second interview, and could opt out if they wished.

AHA recognises the pivotal importance of clients, carers and their family members throughout this evaluation and aimed to minimise the potential burden for participating in the evaluation. Participants who agreed to interviews were provided with a $30 voucher for each interview in recognition of the time taken to contribute. Participants could opt out of the reablement trial evaluation at any time.

A.5 Data handling and record keeping

AHA manages a range of projects which require rigorous participant confidentiality and data security measures, and understands its obligations in relation to privacy and the storage of sensitive information.

AHA has a highly secure IT infrastructure which, due to obligations set out in other government contracts, meets the security requirements of the *Defence Signals Directorate Information Security Manual*. This infrastructure includes high-speed and high-capacity servers located at our head office as well as at a secure off-site data centre, and enables us to send, receive and store highly sensitive and/or confidential information electronically. Records of consultations were stored in locked filing cabinets, whilst electronic data was stored on a secure, password protected hard drive. Information was aggregated and analysed to ensure that no individual person was identifiable.

When accessing and using data, AHA comply with the *Principles for Accessing and Using Publicly Funded Data for Health Research* (National Health and Medical Research Council 2016). AHA recognises its responsibilities and accountabilities when accessing and using publicly funded health and health-related datasets, including complying with all relevant legislation, such as the Privacy Act 1988.

AHA did not hold hard copies of any participant's records. Signed consent forms were scanned by RAS services and sent to AHA electronically. RAS services destroyed signed consent forms once they had been emailed to AHA.

All electronic data was stored and transmitted wholly within Australia. Backups were stored onsite on AHA premises in Melbourne and securely within ASD CCSL Datacentres (in Sydney). Data were encrypted at rest and in transit and access was only provided to members of the evaluation team through technical controls.

Security was managed through Active Directory and file share permissions. AHA's servers, firewall and anti-virus software were all kept up to date with all required firmware updates and software patches.

Data will be destroyed in accordance with their relevant classification and legal requirements. AHA has a strong understanding of, and adherence to, the *Australian Privacy Principles* (APPs) (Office of the Australian Information Commissioner 2019). These cover:

- open and transparent management of personal information (including having a privacy policy)
- capacity of an individual to conduct anonymous transactions or to use a pseudonym where practicable
- collection of solicited personal information and receipt of unsolicited personal information including giving notice about collection
- ways in which personal information can be used and disclosed (including overseas)
- maintenance of the quality of personal information
- retention of personal information secure
- right for individuals to access and correct their personal information.

AHA is also familiar with other guidelines that intersect with the APP entities and the Privacy Act, such as the *Guidelines on Data Matching in Australian Government* (Office of the Australian Information Commissioner 2014).

All client information received by AHA as part of the evaluation was in digital format. To ensure that client data was dealt with appropriately, the following data collection and transfer methods were used:

- Secure file transfer for information supplied by department.
- Secure online data collection.
- Forward scanned consent forms to a dedicated project inbox.

All client outcome data was linked with an AC ID, a unique identifier routinely used in the NSAF to link data. This ensured that all data was de-identified, but could be matched to different time-points accurately. If requested, participant information and/or data was deleted at any stage of the project and participants were informed that this would not influence the service that they received.

A.6 Data analysis

Data analysis occurred over several steps and was dependent on the quality of information from the My Aged Care system, supplied by the department. The data analysis steps were as follows:

1. Descriptive statistics were used to explore the demographic profile of clients who presented at trial and control sites.
2. Data was assessed to explore the assumptions of parametric statistics. Non-parametric statistics were used when the assumptions of parametric statistics were not met
3. Inferential statistical analysis was performed to assess whether there were statistically significant differences between control and trial sites with outcome measures at follow-up. Appropriate statistical adjustments were made to account for differences in trial and control sites with regards to demographic and baseline measures of outcome variables.

AHA consulted with a statistician throughout this process to ensure that appropriate methods and controls were followed.

A.7 Direct access to source data and documents

AHA affirms that direct access to source data was provided on request to Bellberry and other requisite authorities for the purposes of study-related monitoring, audits, HREC review and regulatory inspection(s). AHA complied with the monitoring and management requirements of National Statement (2007) Section 5.5.5 by providing an annual progress report to Bellberry no later than 12 months from commencement of the project (or within 3 months of completion of the project if sooner). A final report was submitted within 3 months of completion of participant involvement.

A.8 Ethics

The evaluation methodology was reviewed as part of AHA's routine Internal Ethics Review Policy and Procedure, which provides an effective, accountable and transparent framework for assessing and managing potential risks arising from AHA's evaluation engagements. The internal review process ensured compliance with the *NHMRC National Statement on Ethical Conduct in Human Research* (the National Statement) (National Health and Medical Research Council 2018), the *Ethical Considerations in Quality Assurance and Evaluation Activities* (National Health and Medical Research Council 2014), and *Australian Code for the Responsible Conduct of Research* (National Health and Medical Research Council 2007).

Consultations involving key organisational participants were identified as representing negligible risk and approved internally.

The internal review process determined that the proposed semi-structured interviews involving CCF participants and the collection of client QoL information, represented 'greater than low risk' from an ethical perspective (see paragraph 5.1.6 of the National Statement . Consequently, this component of the project was referred to Bellberry for ethics review.

The potential risks for participants, adverse or unintended, due to the involvement in the semi-structured interviews was outlined in the Participant Information Sheet (submitted as an attachment in eProtocol). There was a small but possible chance that participants experienced emotional discomfort or distress as a result of participation. In the event a CCF participant became distressed, AHA conducted the following actions:

- Offer the participant a break, ask if they would prefer a call back at another time or cease the interview if participant did not wish to continue.
- Discuss neutral topics until the participant regained composure.
- Refer the participant to resources they have in place to assist them (for example GP, private counsellor, family member or friend).
- Refer the participant to contact details for relevant support services if required (as listed in the Participant Information Sheet).
- With the participant's permission, AHA made a follow up call to ensure their safety and appropriate care.

At all times, the safety of, and care for, participants was prioritised. In the event a participant was deemed at imminent risk of harm to their self or others, AHA planned to enact the following procedure:

- Ask for permission to contact their next of kin (or another person).
- Notify another staff member of the situation.
- Call emergency first responders on 000.

AHA maintained records of such events and how they were handled. Where relevant, participant-related incidents were reported to Bellberry HREC and to the department.

A.9 Funding and insurances

This project received funding from the department. AHA insurances include:

- public liability insurance at $20,000,000 per claim
- professional indemnity insurance at $20,000,000 per claim and $40,000,000 in the aggregate for each policy period.

A.10 Publication policy

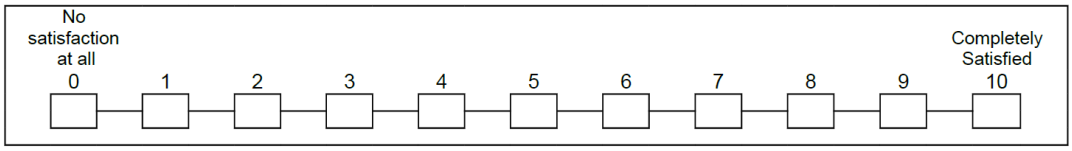
The findings from this project are presented to the department in a final report. As contracted, the publication of this report, or dissemination of the project findings to clients and/or participating organisations or to a broader audience, is at the discretion of the department. Individual clients will not be identified in any reporting or publications resulting from the project.

Appendix B Surveys and interview schedules

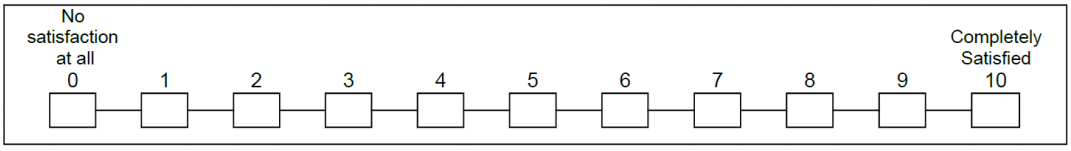
Figure B-1: The Personal Wellbeing Index – fifth edition

The following questions ask how satisfied you feel, on a scale from zero to 10. **Zero** means you feel no satisfaction at all and **10** means you feel completely satisfied. "

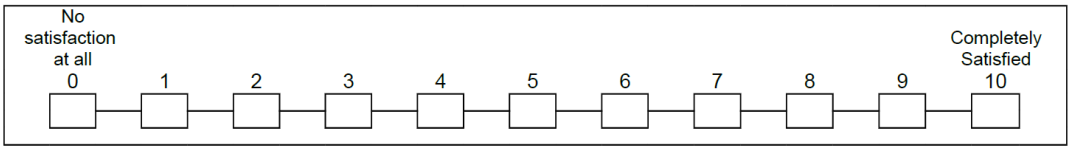
1. "How satisfied are you **with your standard of living ?"**



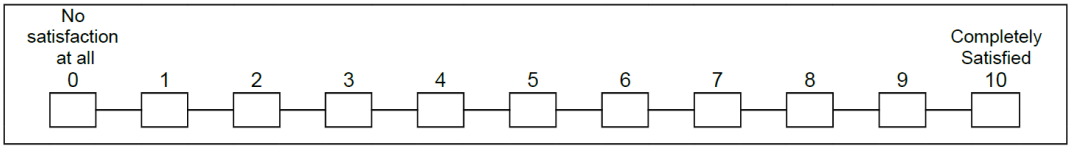
2. "How satisfied are you **with your health ?"**



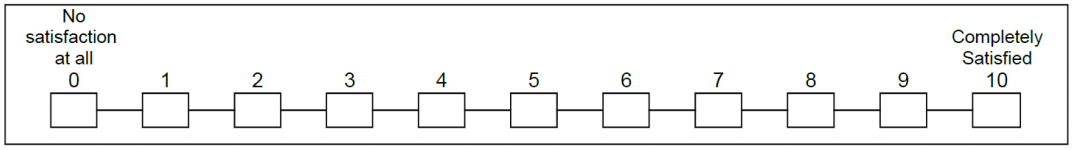
3. "How satisfied are you **with what you are achieving in life ?"**



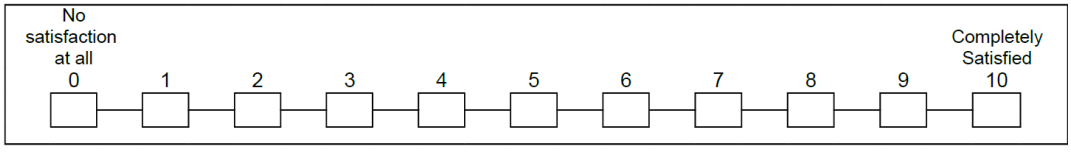
4. "How satisfied are you **with your personal relationships ?"**



5. "How satisfied are you **with how safe you feel ?"**



6. "How satisfied are you **with feeling part of your community ?"**



7. "How satisfied are you **with your future security ?"**

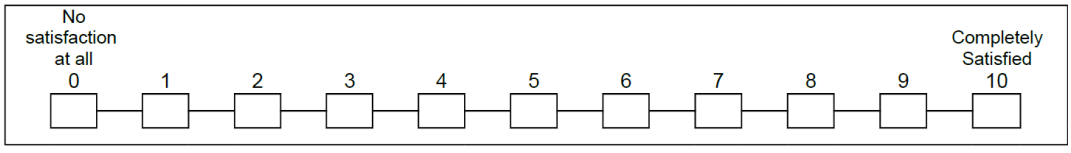


Figure B-2: EQ-5D-5L

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

I have no problems in walking about ❑
I have slight problems in walking about ❑
I have moderate problems in walking about ❑
I have severe problems in walking about ❑
I am unable to walk about ❑

SELF-CARE

I have no problems washing or dressing myself ❑
I have slight problems washing or dressing myself ❑
I have moderate problems washing or dressing myself ❑
I have severe problems washing or dressing myself ❑
I am unable to wash or dress myself ❑

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities ❑
I have slight problems doing my usual activities ❑
I have moderate problems doing my usual activities ❑
I have severe problems doing my usual activities ❑
I am unable to do my usual activities ❑

PAIN / DISCOMFORT

I have no pain or discomfort ❑
I have slight pain or discomfort ❑
I have moderate pain or discomfort ❑
I have severe pain or discomfort ❑
I have extreme pain or discomfort ❑

ANXIETY / DEPRESSION

I am not anxious or depressed ❑
I am slightly anxious or depressed ❑
I am moderately anxious or depressed ❑
I am severely anxious or depressed ❑
I am extremely anxious or depressed ❑

B.1 Client, carer or family interview following assessment

This semi-structured interview guide was used following the active assessment. It provided information on the client's perspective on the assessment and assisted in addressing the key evaluation questions:

- How appropriate is the RAS trial assessment model for:
  - addressing the needs of clients, families, and carers?
  - promoting greater independence and autonomy for clients?

4. **Can you please tell me about your experience with the assessor from [insert RAS organisation name]. Were you satisfied with your assessment? What you were asked to do during this assessment?**

   Prompts:

   - Did the assessment served your needs and if not, what didn't work so well?
   - If it did meet your needs, what did you especially like about it?
   - Probe trial sites around the Active, 'Show me' aspect of their assessment

5. **On a scale from 1 to 10, how would you rate your satisfaction with the assessment process?**

   Prompt:

   - With a 1 rating being not at all, and a 10 rating meaning 100%

6. **Were you satisfied with your support plan?**

   Prompts:

   - Were you provided with a plan outlining your goals and strategies to achieve them?
   - Do you think the goals and strategies to achieve them were appropriate?

7. **What happened after you were provided with your Support Plan?**

   Prompts:

   - Were you referred for any services? If referred for Services – did you receive them?
   - Were you provided with any aids/equipment?

8. **Did the assessor check in with you to review your progress against your Support Plan?**

   Prompt:

   - Did the assessor call or visit you after the assessment? How often? How did it go?

9. **On a scale from 1 to 10, how well do the services you receive meet your needs?**

   Prompt:

   - This does not include the assessment, only the support after the assessment, with a 1 rating being not at all, and a 10 rating meaning 100%

10. **Do you feel that the assessment and what happened afterwards [coaching, service provision, aids and equipment] has allowed you to be more independent at home?**

    Prompts:

    - If not, why?
    - If yes, how?

B.2 Client, carer or family interview following service delivery

This semi-structured interview guide was used to gather information of client, carer or family experiences with services following assessment. It sought to gain insights into the client's perspective on the reablement period, rather than the RAS assessment (which is covered by interview guide B1), and assisted in addressing the key evaluation questions:

- How appropriate is the RAS trial assessment model for:
  - addressing the needs of clients, families, and carers?
  - promoting greater independence and autonomy for clients?
- To what extent has the *Promoting Independent Living* budget measure (PIL) achieved its intended outcomes? Who benefited and in what context?

1. **You may recall that we spoke to you a while ago after you had your assessment. Can you tell us a bit about what has happened since then, that is, for the last six or eight weeks?**

   Prompts:

   - What has happened as a result of your assessment?
   - Were you referred for any services? If referred for services of any kind – did you receive them?
   - Were you provided with any aids/equipment?

2. **Over the last six to eight weeks, did your assessor or a provider of equipment or services, call or touch base to check on process?**

   Prompts:

   - Did the assessor call or visit you after the assessment? How did it go?
   - How many times were you followed up by the assessor?
   - Did anyone else—like a provider of equipment or services—contact you?

3. **Do you feel that the assessment and what happened afterwards [like coaching, or getting an aid or service] has allowed you to be more independent at home?**

   Prompts:

   - If not, why?
   - If yes, how?

4. **Did you receive the services that you expected?**

   Prompts:

   - Did you get the level of services you thought you would?
   - Were any of the services different to what you expected and if so, why?

5. **On a scale from 1 to 10, how well do the support and any services you receive meet your needs?**

   Prompt:

   - This does not include the assessment, only the support after the assessment, with a 1 rating being not at all, and a 10 rating meaning 100%

6. **What has been the influence of the services that you have received on your carers and family?**

   Prompt:

   - Have your family members or any carer been impacted by the services, and if so, in what way?

Appendix C Participant information

The following documents were distributed to assessors or clients, carers and family who participated in the trial.

C.1 Assessor introduction script

The following script was distributed to assessors in control and trial sites to be used during participant recruitment.

Introduction

The Government is trialling a new approach to assessing the needs of older Australians, emphasising the idea of 'reablement'. Reablement helps people to maintain their independence and focuses on helping you regain confidence and the ability to manage your day-to-day activities.

We are inviting our clients from [TRAIL SITES/CONTROL SITES] to participate in a study about of this new approach to find out how well it is working, and if there are ways that it could be improved. This study is being conducted by an independent party called Australian Healthcare Associates.

If you do agree to participate, your participation:

- Is voluntary
- Won't influence the services that you receive
- Will involve:
  - Answering questions about your quality of life before we start your assessment, which will take around 5 minutes
  - Answering questions about your quality of life and your functioning via a phone call in six months' time from now, which will take around 5 minutes.

Please take some time to review the participant information sheet and ask me if you have any questions.

We also have consent forms which we would like you to complete if you agree to participate in the evaluation.

C.2 Invitation for interview – following assessment

The following script was distributed to assessors in control and trial sites to invite participants, who had agreed to be part of the evaluation, to opt-in to follow up interviews.

Introduction

The Government wants to know about the experiences of people who have undergone RAS assessments. Would you be interested in participating in a telephone interview with the independent evaluation team? If you give your contact details, the evaluation team will contact you to organise a brief interview at a time that suits you.

C.3 Participant Consent Form

Study Title: **Evaluation of the *Promoting Independent Living* budget measure**

Principal Investigator: **Jill Waddell**, Associate Director, Australian Healthcare Associates

Co-Investigators: **Michael Herbert**, Senior Consultant, Australian Healthcare Associates
Dr Alex Stretton, Consultant, Australian Healthcare Associates
Jessica Small, Senior Consultant, Australian Healthcare Associates

I, _____ the undersigned voluntarily consent to participate in the project titled **Evaluation of the *Promoting Independent Living* budget measure**.

I acknowledge that the nature, purpose and risks of the project and alternatives to participation have been fully explained to my satisfaction. Specifically, the details of information collected about me and the proposed interview, how long it will take, and an indication of any discomfort that may be expected have been explained to me.

1. I freely agree to participate in this project according to the conditions in the Participant Information Sheet which I confirm has been provided to me.
2. I understand that my involvement in this project may not be of any direct benefit to me.
3. I have been given the opportunity to have a member of my family or another person present while the project is explained to me.
4. I have been told that no information regarding my personal history will be divulged to unauthorised third parties and my identity will not be revealed in any reports or publications.
5. I understand that I am free to withdraw from the project at any stage. If I decide to withdraw from the project, I agree that the information collected about me up to the point when I withdraw may continue to be processed.
6. I am 18 years of age or older.
7. I declare that all my questions about the study have been answered to my satisfaction.
8. I have read, or have had read to me, and I understand the Participant Information Sheet, Version 1.3, dated 23 April 2020.
9. I have read and understand the reasons for and purpose of this information collection.

Name of participant: _____

Signature of participant: _____ Date: _____

Carer or family input

Please indicate below if you are giving feedback on behalf of the person you provide care for.

I am giving feedback on behalf of the person I provide care for. Tick here: _____

Declaration by RAS assessor:

A verbal explanation of the project, its procedures and risks has been given to the participant and I believe that the participant has understood that explanation.

Name of Assessor:

Signature of Assessor: Date:

The RAS assessor must provide the explanation and provision of information concerning the research project on behalf of the Principal Investigator.

Follow-up interviews

AHA will be doing a small number of telephone interviews to talk to individuals about their experiences and satisfaction with the trial assessment process. This process is described in the Participant Information Sheet which you have received.

If you are happy to be contacted about the Evaluation of the *Promoting Independent Living* budget measure, please fill out the section below with your details:

Name:

Email address:

Phone number:

C.4 Participant Information Sheet – Evaluation of the *Promoting Independent Living* budget measure

You are invited to take part in the evaluation of the *Promoting Independent Living (PIL)* budget measure. You have been invited because you are receiving services in one of the areas that is participating in the Measure. This project is being conducted by Australian Healthcare Associates (AHA) on behalf of the Australian Government Department of Health.

Purpose of the project

The *Promoting Independent Living* budget measure (PIL project) aims to promote greater independence for older Australians. The PIL project will trial a different approach to assessing the needs of older Australians. This revised assessment approach is already in use in parts of Australia, such as Western Australia. As part of this project, it will be trialled by five Regional Assessment Services (RAS) and will emphasise the idea of 'reablement'. The aim of this evaluation is to find out how well this revised assessment is working, and if there are ways that it could be improved. To do this, we need to talk to clients who are participating in the new assessment approach, and those who are receiving standard assessments.

Your involvement

If you choose to participate in this project, information will be collected from you in two ways:

1. **A questionnaire that will be administered by your RAS assessor before your assessment and by an AHA staff member 6 months after this assessment.**

Your RAS assessor will ask you some questions about how you feel you're getting on with various aspects of your life, such as your health, mobility, social connections and your daily living. The assessor will then ask you some similar questions via telephone about 6 months after your assessment to see if anything has changed for you. It will take about 5 minutes in total on each occasion.

2. **Telephone interviews with an AHA staff member.**

About a week after your assessment, an AHA staff member will arrange a time to telephone you and talk to you about your experiences and satisfaction with the trial assessment.

About 6-8 weeks after your assessment, an AHA staff member will arrange a time to talk to you about what happened after the assessment and any services you received. These telephone conversations should take no longer than 15 minutes.

In order for an AHA staff member to call you, your assessor will need to provide AHA with your telephone number. You may choose to have a carer or family member present during the telephone calls if you wish. An interpreter will be organised if required.

Participation in this evaluation is voluntary. If you don't want to take part, you don't have to. Knowing what is involved will help you decide if you want to take part in the project. **Ask questions about anything that you don't understand or want to know more about.** Before deciding whether or not to take part, you might want to talk about it with a relative or friend.

If you decide you want to take part in the trial, you will be asked to sign the Consent Form.

Risks and discomforts

The possible risks and discomforts from participating in this project might include feeling upset or confused while (or after) speaking about your experiences with the trial and the aged care system broadly. You do not have to share your personal or private experiences if you do not want to.

What is 'reablement'?

In the past, home support services have often focused on a client's limitations – what they are *un*able to do. Typically, clients become more dependent on services and their functional capacity can decline.

More recently, home care programs in Australia (and overseas) have focused more on a client's strengths – on what they *can* do. This approach encourages a client's autonomy while providing the ongoing support they need to continue living independently and safely in their own home.

Reablement also promotes a client's independence and autonomy by providing services for a limited time *when they are needed*, and helping the client to regain confidence and capacity to manage some or all of their day-to-day activities again.

Reablement does *not* mean that clients won't receive ongoing services if they need them. Rather, it helps a client to regain independence where they can, and to transition to ongoing services if required.

The aim of this evaluation project is to find out how well the new model is working, and if there are ways that it could be improved. To do this, we need to talk to trial clients (i.e. people being assessed for aged care services, and their carers and family members).

We will also talk to representatives from the Regional Assessment Services (RAS) that are conducting the trials, other representatives from the aged care sector and the Australian Government. In addition, we will compare data from the RAS involved in the trial with data from other RAS who are not involved with the trial. This data is collected as a normal part of the assessment and follow-up, and does not require you to do anything extra.

See the sections below on *Confidentiality* and *Data Storage* for information about how we protect your data and your privacy.

If you experience distress as a result of your participation, the interview will be paused and you will be referred to support options to help you feel safe (e.g. AHA may advise you to speak with your GP, private counsellor, family member, or a friend). If you do not want to continue with the interview, you may withdraw at any time.

If you require additional or ongoing support after the interview, the following services are available:

Lifeline – 13 11 14 or www.lifeline.org.au

Suicide Call Back Service – 1300 659 467 or www.suicidecallbackservice.org.au

beyondblue Support Service – 1300 22 4636 or www.beyondblue.org.au/get-support/get-immediate-support

Other support options include:

Switchboard – 1800 184 527 or www.switchboard.org.au (for people who are LGBTI)

You may also wish to speak to a trusted service provider, family member, friend or carer.

Possible Benefits

A possible benefit from participating in the project is that you will be helping to shape the way aged care assessments and services are delivered to you and others in the future.

Voluntary Participation/Right to Refuse or Withdraw

Although we would like you to participate in the project, there is no obligation for you to be involved. If you decide to participate in the project and later feel that you no longer wish to be part of it, you may withdraw your consent at any time without impact on any current or future care or services.

Confidentiality

The project will gather certain personal information about you, such as your views and experiences of the reablement trial activities. This information will be held by AHA and its authorised representatives. AHA will hold on file:

- Your signed consent form
- Data from the questionnaires
- Notes taken during interviews.

Your records and any other information relating to this project will be kept strictly confidential. Your confidentiality will be protected in any reviews or reports which may be published. Information will be aggregated and analysed to ensure that no individual person is identifiable.

No information regarding your personal history will be divulged to unauthorised third parties. Agencies authorised by law may inspect the records related to the project, but your identity will not be revealed.

By signing the attached consent form, you authorise the release of your information to the project team and authorised agencies as noted above.

Data Storage

Your data will be stored at AHA's secure premises in a locked filing cabinet or on a password-protected hard drive. Data will only be accessed by the team working on the project.

Data will be kept for a period of five years after we submit our final report. At the end of the storage period, your data will be destroyed.

Funding

The project is being funded by the Australian Government Department of Health.

Project Team Benefits

The project team is being paid by the Australian Government Department of Health to conduct this project.

Results of Project

The Australian Government Department of Health owns the data and reports generated from this project. The Department is responsible for deciding whether or not to disseminate the results.

Consent

The project team is required to provide you with all information regarding the nature and purpose of the project, including the risks and benefits, and you will be given the opportunity to discuss these.

You are free to choose not to participate or to withdraw from the project at any time and you will not suffer any prejudice as a result.

Advice and Information

If you have any further questions regarding this project, please do not hesitate to contact:

Principal Investigator: Jill Waddell

Co-investigator: Michael Herbert
Dr Alex Stretton
Jessica Small

Phone: 1300 242 111 (local call cost)

Email: pil@ahaconsulting.com.au

The Bellberry Human Research Ethics Committee has reviewed and approved this study in accordance with the *National Statement on Ethical Conduct in Human Research (2007), including all updates*. This Statement has been developed to protect the interests of people who agree to participate in human research projects.

Should you wish to discuss the project or view a copy of the complaint procedure with someone not directly involved, particularly in relation to matters concerning policies, information or complaints about the conduct of the project or your rights as a participant, you may contact the Operations Manager, Bellberry Human Research Ethics Committee on 08 8361 3222.

All study participants will be provided with a signed and dated copy of this Participant Information Sheet and Consent Form for their personal records.

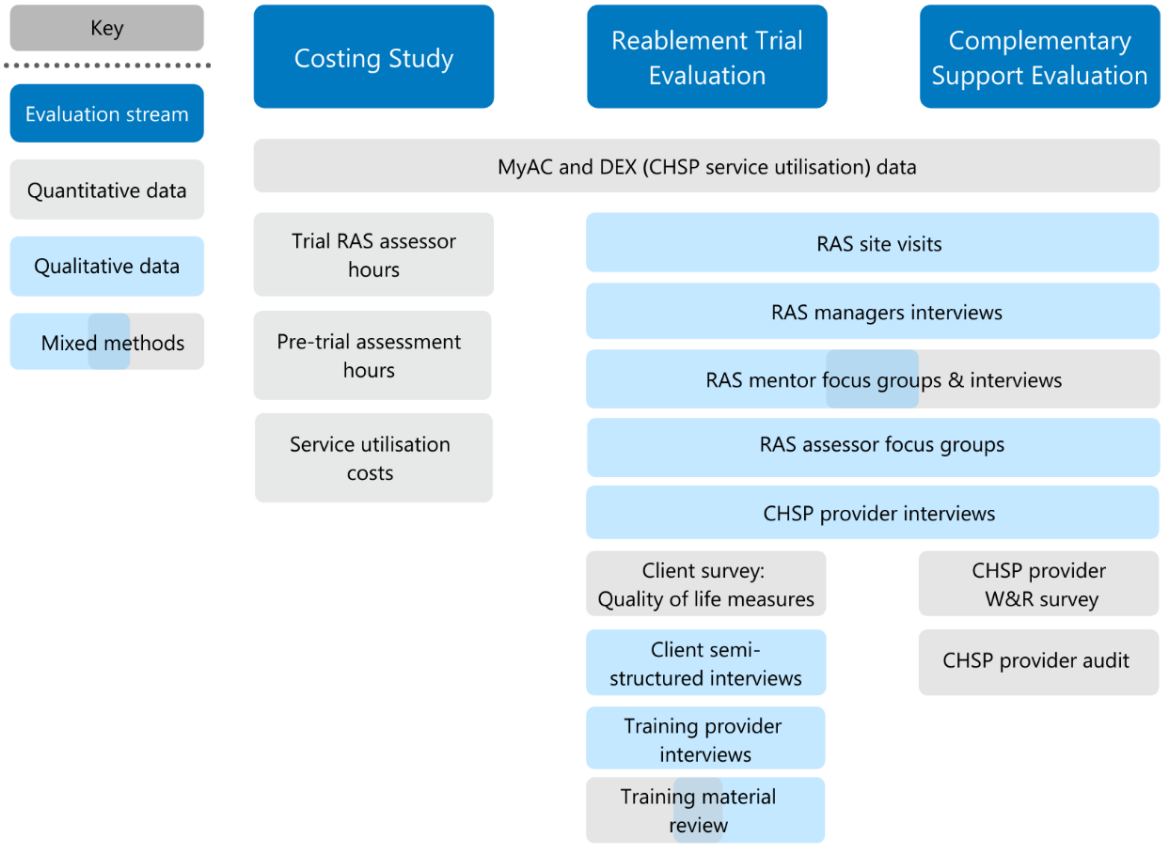
Costs

If you choose to participate in the telephone interviews, you will be given a $30 Coles Myer gift card for each interview in recognition of the costs (including time) incurred in contributing to the project.

Appendix D Long text alternatives

This document is designed to be as easily readable by a sighted reader as a low vision or non-sighted reader. This appendix provides long text alternatives for four figures, where this text cannot be fully encapsulated in the alt text provided with the figures. Each figure is reproduced below for reference.

Figure 1-1: Data sources for each evaluation stream



The three evaluation streams are:

- costing study
- reablement trial evaluation
- complementary support evaluation.

Quantitative data sources are:

- My Aged Care and DEX (CHSP service utilisation) data – used in all 3 streams
- Trial RAS assessor hours – used in the costing study
- Pre-trial assessment hours – used in the costing study
- Service utilisation costs – used in the costing study
- Client survey: quality of life measures – used in the reablement trial evaluation
- CHSP provider W&R survey – used in the complementary support evaluation
- CHSP provider audit – used in the complementary support evaluation

Qualitative data sources are:

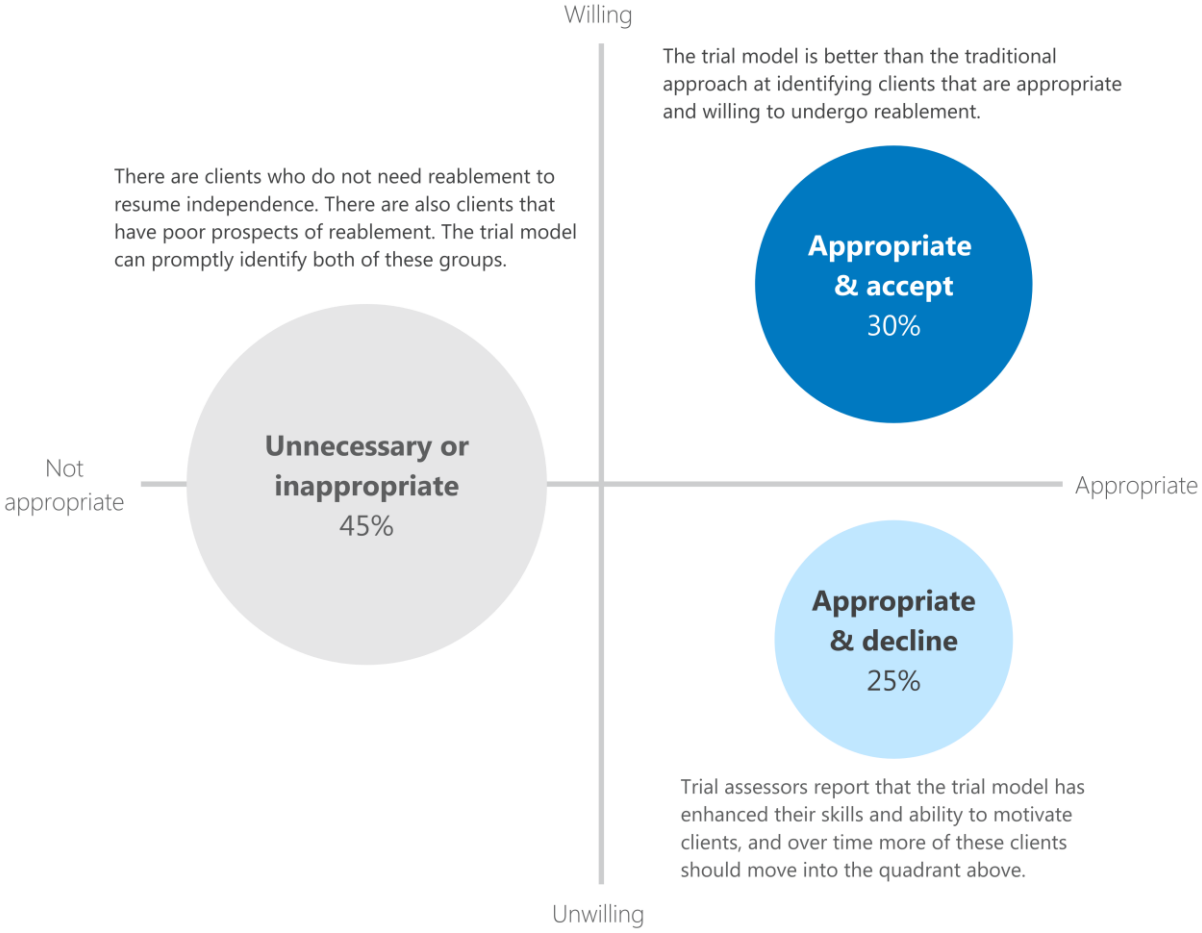
- RAS site visits – used in the reablement trial evaluation and complementary support evaluation
- RAS manager interviews – used in the reablement trial evaluation and complementary support evaluation

- RAS assessor focus groups – used in the reablement trial evaluation and complementary support evaluation
- CHSP provider interviews – used in the reablement trial evaluation and complementary support evaluation
- Client semi-structured interviews – used in the reablement trial evaluation
- Training provider interviews – used in the reablement trial evaluation

Mixed-methods data sources are:

- RAS mentor focus groups and interviews – used in the reablement trial evaluation and complementary support evaluation
- Training material review – used in the reablement trial evaluation

Figure 2-1: Reablement rate range under the trial model



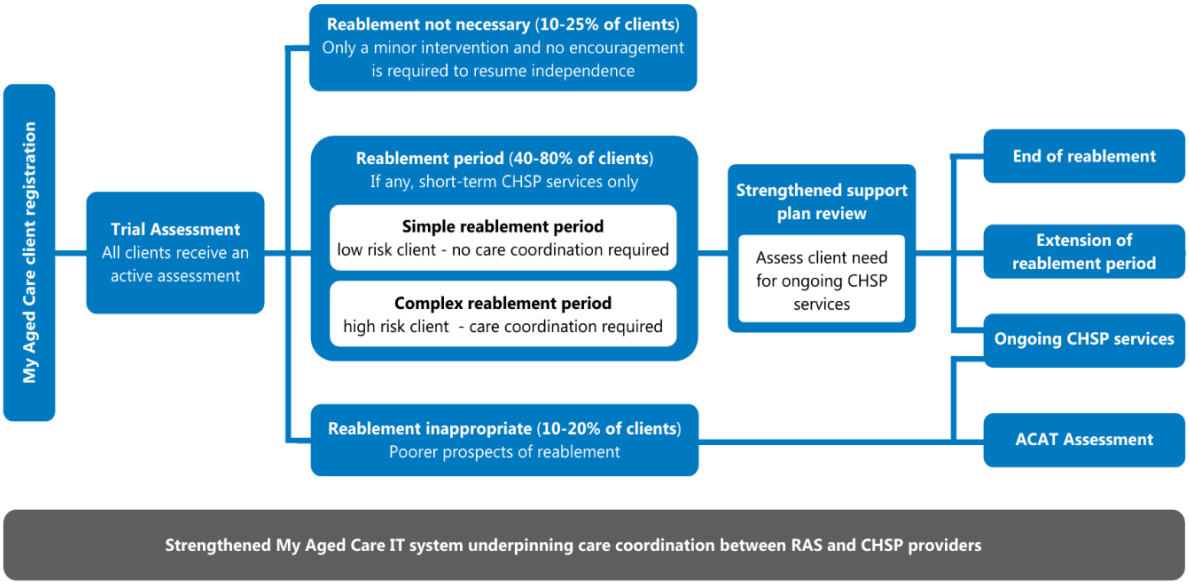
Quadrant chart showing reablement suitability for reablement along two axes: willing-not willing and appropriate-not appropriate.

The largest group (45%) is 'Unnecessary or inappropriate'. This includes clients that do not need reablement to resume independence, and clients that have poor prospects of reablement. The trial model can promptly identify both of these cohorts. This group sits in the 'not appropriate' side of the figure and is neutral in relation to willingness.

The second-largest group (30%) is 'Appropriate and accept', which sits in the 'willing and appropriate' quadrant. The trial model is better than the traditional approach at identifying clients that are appropriate and willing to undergo reablement.

The smallest group (25%) is 'Appropriate and decline', which sits in the 'unwilling and appropriate' quadrant. Trial assessors reported that the trial model has enhanced their skills and ability to motivate clients, and therefore over time more of these clients should move into the 'willing and appropriate' quadrant.

Figure 3-4: Flow chart of potential new client pathways and the reablement journey



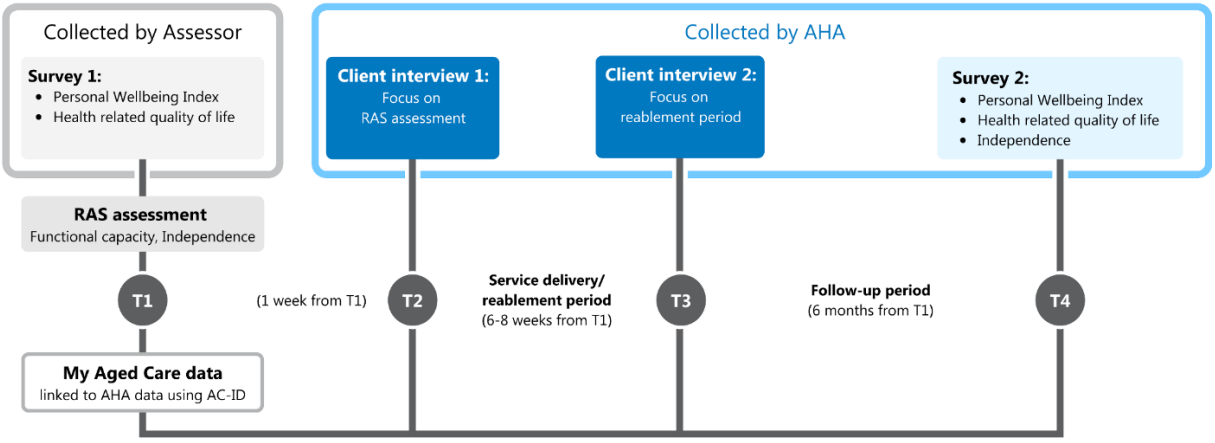
The first step is My Aged Care client registration, after which all clients receive an active assessment. Assessments have 3 potential outcomes:

- Reablement not necessary (10-25% of clients). Only a minor intervention and no encouragement is required to resume independence. End of pathway.
- Reablement period (40-80% of clients). Only short-term CHSP services, if any. There are 2 sub-groups:
  - Simple reablement period (low risk client – no care coordination required)
  - Complex reablement period (high risk client – care coordination required)

  The reablement period leads into a strengthened support plan review to assess client needs for ongoing CHSP services, with 3 potential outcomes: end of reablement, extension of reablement period, or ongoing CHSP services. End of pathway.
- Reablement inappropriate (10-2% of clients). Poorer prospects of reablement. This leads to 2 potential outcomes: ongoing CHSP services or ACAT assessment. End of pathway.

These pathways are supported by a strengthened My Aged Care IT system underpinning care coordination between RAS and CHSP providers.

Figure A-1: Reablement trial and data collection points



There are 4 data collection points (T1, T2, T3, and T4).

T1 data comprises:

- Survey 1 (Personal Wellbeing Index and health-related quality of life), collected by an assessor
- RAS assessment (functional capacity, independence)
- My Aged Care data (linked to AHA data using AC-ID.

All other data was collected by AHA.

T2 is one week from T1 and comprises client interview 1 (focus on RAS assessment):

T3 comes at the end of the service delivery/reablement period (6 to 8 weeks from T1) and comprises client interview 2 (focus on reablement period).

T4 comes at the end of the follow-up period (6 months from T1) and comprises survey 2 (Personal Wellbeing Index, health-related quality of life and independence).

Appendix E References

AIHW 2019, Government spending on aged care.

Deloitte Access Economics 2019, *CHSP Data Study – Draft Report (Unpublished)*.

Department of Health 2017a, *Legislated Review of Aged Care*, Canberra.

Department of Health 2017b, Legislated review of aged care 2017, Commonwealth of Australia, Canberra.

Department of Health 2017c, *Commonwealth Home Support Programme: Program Manual 2017*, Commonwealth of Australia (Department of Health), Canberra.

Department of Health 2018a, My Aged Care Assessment Manual: For Regional Assessment Services and Aged Care Assessment Teams, Commonwealth of Australia, Canberra.

Department of Health 2018b, *Commonwealth Home Support Programme: Program Manual 2018*, Commonwealth of Australia, Canberra.

Department of Health 2020a, My Aged Care, viewed 9 October 2020, <https://www.myagedcare.gov.au/>.

Department of Health 2020b, *Commonwealth Home Support Programme: Program Manual 2020-22*.

GEN Aged Care 2020, Aged care data snapshot – 2020, viewed 7 December 2020, <https://www.gen-agedcaredata.gov.au/Resources/Access-data/2020/October/Aged-care-data-snapshot—2020>.

International Well Being Group 2013, Personal Wellbeing Index – Adult (English) 5th Edition, Deakin University, Melbourne, Victoria.

Khor, S, Cummins, R, Fuller-Tyszkeiwicz, M, Capic, T, Jona, C, & Olsson, C 2020, *Subjective Wellbeing during COVID-19*, Melbourne, Victoria.

McCaffrey, N, Kaambwa, B, Currow, DC, & Ratcliffe, J 2016, Health-related quality of life measured using the EQ-5D–5L: South Australian population norms, *Health and Quality of Life Outcomes*, vol. 14, no. 1, p. 133.

Metzelthin, SF, Rostgaard, T, Parsons, M, & Burton, E 2020, Development of an internationally accepted definition of reablement: a Delphi study, *Ageing and Society*, pp. 1–16.

National Health and Medical Research Council 2007, *Australian Code for the Responsible Conduct of Research*.

National Health and Medical Research Council 2014, *Ethical Considerations in Quality Assurance and Evaluation Activities*.

National Health and Medical Research Council 2016, Principles for accessing and using publicly funded data for health research, , <https://www.nhmrc.gov.au/principles-accessing-and-using-publicly-funded-data-health-research>.

National Health and Medical Research Council 2018, *National Statement on Ethical Conduct in Human Research*.

Nous Group 2017, *Evaluation of the Regional Assessment Service: Formative Evaluation Report Draft*.

Office of the Australian Information Commissioner 2014, *Guidelines on Data Matching in Australian Government Administration*, Canberra.

Office of the Australian Information Commissioner 2019, *Australian Privacy Principles*.

Silverchain 2017, *Measuring the Impact of Community Care (Unpublished)*, Perth.

Tessier, A, Beaulieu, MD, McGinn, CA, & Latulippe, R 2016, Effectiveness of reablement: A systematic review, *Healthcare Policy*, vol. 11, no. 4, pp. 49–59.