



Options for the future of Veterans' Home Care (VHC)

Volume Two: Appendices to the Final Report

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Appendix 1

Comparison of VHC and other Australian Government funded programs

Table 16 Comparison of HACC and VHC Services

HACC Services	VHC	Other DVA	Comments
Domestic Assistance.	Yes		In HACC, domestic assistance is to provide assistance for people in the target population and their carers, it is normally provided in the home, and includes services such as support to those who need help in performing household tasks. Services may include: house cleaning; washing and ironing; help with shopping; transport to and from banks, appointments, etc; and general household support, such as paying bills and accounts, helping with telephone calls, etc. <i>VHC Domestic Assistance (DA) does not provide accompanied shopping.</i>
Social Support	No	DVA Day clubs Grant programs	In HACC, Social Support is normally provided in the client's home but may include accompanying the client on an excursion or trip. The support is provided to them as an individual and helps them to participate in society. It includes keeping them company, helping them do paper work, taking them shopping, assisting with bill paying or banking or to attend an appointment.
Personal care	Yes	Community Nursing	In HACC, Personal Care is normally provided in the home, and includes helping the client with daily self-care tasks (eg bathing, toileting, dressing, eating and personal grooming etc.). It may include medication monitoring. <i>VHC Personal Care (PC) provides up to 1.5 hrs per week through VHC, then referral to Community Nursing is made.</i>
Nursing care	No	Yes	In HACC, Nursing care is defined as health care provided to a client by a registered or enrolled nurse. <i>Provided by DVA through the Community Nursing program.</i>
Meals	No	No equivalent	In HACC, this refers to the receipt of a prepared and delivered meal to clients who are unable to prepare their own meals or maintain adequate nutritional intake. It doesn't include meals prepared at home (This is available under <i>Other Food Services</i> .) DVA has a Memorandum of Understanding with each State/Territory government for veterans to access these services
Other food services	No	No equivalent	In HACC, this service refers to assistance with preparation and cooking and the provision of advice on storage or food preparation.
Centre based day care	No		In HACC Centre-based day care refers to assistance provided to the client to attend/participate in group activities and is conducted in a centre-based setting. It includes group excursions/activities conducted by centre staff but held away from the centre. <i>Note: DVA contributes financially towards the running costs of Day clubs in NSW, Vic and WA.</i>
Respite care	Yes		In HACC, Respite Care is assistance provided to Carers so they may have relief from their caring role and pursue other activities or interests. The motivation underlying the assistance to the Carer is essential: a substitute carer is being provided so the carer gains time out. An ACAT assessment is required for residential respite. <i>VHC offers 3 types of respite care, In-home, Emergency Short Term Home Respite and approval for residential respite care.</i>
Allied health care	No	Yes *	In HACC, these services include podiatry, occupational therapy, physiotherapy, speech pathology and advice from a dietician or nutritionist.

HACC Services	VHC	Other DVA	Comments
			<i>DVA pays for these services for Gold card holders. For White card holders DVA pays for services related to their accepted war caused disabilities</i>
Assessment	Yes		In HACC –this service refers to all assessment and reassessment activities that are directly attributable to clients.
Case management	No	No equivalent	In HACC, Case management refers to the assistance received by a client with complex care needs from a formally identified agency worker. This person will coordinate planning and delivery of services from more than one agency.
Case planning / review and coordination	No	No equivalent	In HACC, Case Planning refers to activities that relate to the coordination, planning and delivery of services which are directly attributable to an individual client. It includes monitoring and reviewing of individual case/service plans as well as organisational and case coordination activities associated with service delivery to the client. <i>VHC assessment agencies provide some elements of case management</i>
Home maintenance	Yes	Yes	In HACC, Home Maintenance refers to general repair and care of a Client's home or yard provided by an agency. This helps the client to live comfortably and safely in their home. It may include handyman work, repairs, lawn mowing, rubbish removal, wood chopping and repairs to roof or guttering. <i>VHC Home and Garden Maintenance (HGM) service is targeted to safety related and for one off hazard cleanups, not for routine or cosmetic gardening. It has a limit of 15 hours per year.</i> <i>Other related DVA services include HomeFront and Veterans' Home Maintenance Line.</i> <i>HomeFront - is designed to prevent falls and accidents in the home. The HomeFront assessor will look for potential hazards in and around the home, recommend and, if appropriate, organise tradespeople to carry out minor modifications and/or repairs. Home Front –provides free annual assessment and currently up to \$193 p.a towards the cost of recommended aids and minor modifications. This amount is indexed annually each January from 2007 onwards.</i> <i>Veterans' Home Maintenance Line –provides home property maintenance advice and referral to reliable and efficient tradespeople. The advice service is free but veterans must pay for all work done by tradespeople, including call-out fees. This service may include may include handyman work, repairs, lawn mowing, rubbish removal, wood chopping and repairs to roof or guttering.</i>
Home modification	No	Yes	In HACC, Home Modification refers to structural changes to the Client's home so they can continue to live and move safely about the house. It will often include the fitting of rails, ramps, alarms or other safety and mobility aids. <i>DVA services: Home Front and Home Maintenance Line, offers some similar features as does RAP</i>
Provision of goods and equipment	No	Yes	In HACC, Provision of goods and equipment may be provided by an agency by lending or purchasing an item to help their Client. These goods and equipment items will help the Client's mobility, communication, reading, personal care or health care <i>DVA's Rehabilitation Appliances Program (RAP) provides eligible veterans, war widows, widowers and dependants to assist their independence and self- reliance. Where they are assessed as having a clinical need for such items, certain home modifications and appliance.</i>
Formal Linen service	No	No equivalent	In HACC, a Formal Linen service means that both the linen and the laundry services are provided to the client, and the cleaning of the linen is done elsewhere.

HACC Services	VHC	Other DVA	Comments
Transport	No	* Partial	In HACC, Transport is assistance provided so that the client may get out of their house and do chores, attend other activities or community centres, and participate in the community. <i>DVA's service: Booked Car With Driver (BCWD) – for medical appointments only, partly matches this service.</i>
Counselling/ support, information and advocacy	No	Yes	In HACC, this assistance type covers a number of supportive services to help clients and carers deal with their situation. It includes one-on-one counselling, advice, and information. <i>DVA offers the Veterans' and Veterans' Families Counselling Service is a specialised, free, confidential Australia-wide service for Australian veterans and their families.</i>
HACC Other services	No	* Different	In HACC, this includes Commonwealth Carelink centres for information on health ageing, disability and community services. 1800 052 222 and also Internet information via the Department of Health and Ageing's (DOHA) web site as well as: <ul style="list-style-type: none"> ▪ Group activities where individual records are not kept ▪ Education Information training ▪ Advice or information provided by telephone advice or referral services ▪ Advocacy on behalf of groups <i>DVA Fact sheets and Web site</i> <i>Veteran Affairs Network offices assistance with services available.</i>
Other Dept of Health and Ageing Services including Community Aged Care Packages (CACPs), Extended Ageing in Place (EACH), Transition Care	No	No equivalent	In Department of Health and Ageing, CACPs offer a higher level of support including cases management and higher levels of service approvals. Eligibility is determined by an Assessment by Aged Care Assessment Team (ACAT) and they are allocated subject to availability of funding. Some HACC providers are also CACP service providers. <i>Veterans are covered under the Aged Care Act as a special needs group for these services</i>

Table 17 VHC versus HACC Services

VHC Services	HACC Services and CACPs	Comments
Domestic Assistance (DA) Guide ('benchmark') of 1.5 hours per fortnight per client.	Domestic Assistance (DA) – Domestic assistance is normally provided in the home, and includes services such as dishwashing, house cleaning, clothes washing, shopping and bill paying.	In VHC, DA may include unaccompanied shopping for the client. VHC has a guide (previously called a 'benchmark') of 1.5 hrs per fortnight. In HACC shopping - may include accompanied shopping with the client. HACC has no limits on services that can be approved per client.
Personal Care (PC) – Trigger at 1.5 hrs per week to community nursing.	Personal Care (PC) – No limit	In VHC, when PC requirements are above 1.5 hours per week and/or where there is a clinical need, then a referral is made to DVA Community Nursing. In HACC there is no limit in the approval levels per client, however when there is a clinical need then referral is made to community nursing.
Home and Garden Maintenance (HGM) Limit of 15 hours per year.	Home Maintenance	<i>VHC HGM is for safety related and one off hazard cleanups, not for routine or cosmetic gardening. It has a limit of 15 hours per year.</i> HACC HM may include routine tasks like lawn mowing, weeding and cosmetic gardening.
Respite Care Refer to comments	<i>Respite Care</i> Respite types as per VHC	<i>DVA VHC respite is available to eligible veterans who are carers or being cared for subject to VHC assessment and VHC guidelines. DVA VHC respite</i>

VHC Services	HACC Services and CACPs	Comments
Limit of 196 hours per year for eligible veterans.		<i>includes In-home, Emergency Short Term Home Relief (ESTHR) and approval for residential respite. There is a limit of 196 hours per year paid for by DVA (although Prisoners of War may access more). Veterans must contact either HACC, the National Respite for Care Program, Commonwealth Carelink Centre or Commonwealth Carer Respite Centre (CCRC) for further respite care. Respite is available to all Australian citizens with residential respite subject to an ACAT assessment.</i>

Table 18 Other DVA services available to Veterans eligible for VHC

Other DVA Services	Comparable HACC services	Comments
Community Nursing where clinical assistance is needed and /or where PC levels are more than 1.5 hours per week	Community Nursing	Very similar.
Rehabilitation Appliances Program (RAP) provides safe and appropriate equipment, according to assessed clinical need.	Provision of goods and equipment	
Home Front – modifications up to \$193 p.a. covers assessment, aids and minor modifications. This amount is indexed annually.	Home Modification	
Veterans' Home Maintenance Line – for referrals to qualified tradespeople.	Home maintenance	DVA refers veterans to qualified tradespeople, where as HACC provides qualified tradespeople.
Booked Car With Driver (BCWD) – for transport to and from medical appointments.	Community Transport	DVA BCWD provides transport to medical appointments only. HACC Community Transport provides transport for social outings and shopping and participation in community activities.
Veterans' and Veterans' Families Counselling Service (VVCS) – services for Vietnam Veterans and their families.	Counselling support Information and advocacy	VVCS is also available to all Australian veterans and their families as well as some current and ex-serving members.
Veteran Affairs Network Offices – information providers for services available to veterans.		
DVA Gold card covers payments of many allied health services , including podiatry, occupational therapy, physiotherapy, speech pathology and advice from a dietician or nutritionist.	Allied Health	
DVA Internet – including Fact sheets and other information about services available.	HACC Internet	

Appendix 2

Results from an international review of the literature, including existing program documentation and previous reviews

This attachment documents the review of the international and practice literature for this project. This literature synthesis was designed to highlight the overall policy and practice context for the Review of the Veterans' Home Care program. As outlined in the methodology paper for the Review, particular emphasis has been placed on "maintaining the independence of older people within their home environment" for as long as possible (CHSD 2007). Further details about the search strategy and culling process are outlined in the methods section of the main report.

The first part of the literature review focuses on the Australian policy context of community care, starting with the Home and Community Care (HACC) program, on the assumption that VHC shares the same broad policy objectives, intended health outcomes and economic rationale. Changes in the demographic and social policy context since the 1980s are noted, as are recent policy developments.

The academic / scientific / experimental literature is then examined with the aim of finding high quality interventions in the area of home care that are directly relevant to veterans in the Australian context. For the purposes of this Review, an intervention is defined as a health care or social intervention. Practice models and interventions in home care are reviewed from both the academic literature and practice settings (including internet searches and other reviews). Relevant models of service organisation in home care are covered, reviewed with a view to identifying key practices and innovations suitable for the Australian veteran population.

The specific aims of the first sections of the literature review are to describe and highlight the current views of consumer needs, and best practice interventions published in the academic literature that are relevant to the service types of the VHC program. The aim was to examine the evidence for the components of the program based on the highest quality evidence that is available, in order to inform the overall VHC Review and to set the project findings, data analysis and options for the future in context. The key results are described below in this attachment and highlighted in the body of the report.

The collection of selected relevant papers is presented in tables based around the service types and issues most relevant to the VHC program. Not all those references cited are included in the table format as they do not all refer to evidence for interventions. Tables mostly describe interventions where the relevant papers are listed alphabetically according to the target group and outcome, as well as providing a brief description and an evidence ranking. This ranking is based on the level of scientific evidence for the intervention. That is, whether the intervention is a well supported practice, a supported practice or promising practice requiring further evidence. Further information on the evidence rankings that have been used can be found in the methods section of the main report.

Changes in the demographic and policy context

The starting point for a community care policy and service response in Australia was in the 1970's with the advent of community health services, developed in the context of providing alternatives to the dominance of institutional forms of care based in acute hospitals, mental health and nursing homes. The response was embodied in the Community Health Program established in 1973 by the Hospitals and Health Services Commission (HHSC) with service components delivered to defined regions or localities. The components were: preventive programs of information and counselling; direct preventive action; early detection of disease; health promotion programs; diagnostic and treatment services; rehabilitation and supportive services for those with continuing disease and disability; and help to adapt for those with chronic disability (HHSC 1973 p.4).

Building on the community health principles and lessons of the previous decade, the HACC program began in 1985 after a series of reports on the inadequacies of home-based care for the frail aged. The rationale for HACC embodied a mixture of policy, health and economic aims; increasing choice for consumers by changing the balance of care (between institutional and community models), preventing, avoiding or delaying inappropriate residential aged care placement, and reducing costs by promoting efficient home-based support alternatives (Home and Community Care Review Working Group 1988).

As a result of the growth of services in the community that are substitutable for lower levels of residential care (the various programs for case management and care packages), the health status of frail older people living in the community and the service context of contemporary community care is very different now to the 1980s. Larger numbers of older people with higher levels of functional dependency are being managed at home, and the growth of a large number of programs including support for carers, has raised community expectations that this direction will continue. There is now increased activity through the Australian Government's community care reform agenda, and the broader community care service context is expected to change to accommodate the reality of these higher levels of dependency in the community, and to come to terms with the most recent evidence on effective interventions to address the higher levels of need of care recipients and their carers.

The policy direction behind the growth of home and community based services have been a mixture of social, health and economic goals. The rationale is to delay or prevent functional impairment and subsequent nursing home admissions by primary prevention (e.g. immunisation and exercise), secondary prevention (e.g. detection of untreated problems), and tertiary prevention (e.g. improvement of medication use). "However, the value of home visitation programs is controversial" (Stuck et. al. 2002, p.1022), and the question of whether basic-level services are preventive of institutional placement is one of the questions considered in this review of the evidence.

At the time of starting the HACC program an important idea was promoted through work on the now well known 'compression of morbidity' hypothesis (Fries 1980). This theory promoted the value of preventive interventions for older people and raised the possibility of reducing cumulative lifetime morbidity. Since chronic illness and disability usually occur in late life, the theory suggested that cumulative lifetime disability could be reduced if primary prevention measures postponed the onset of chronic illness, while decreases in health risks may also increase the average age at death.

"The hypothesis predicts that the age at the time of initial disability will increase more than the gain in longevity, resulting in fewer years of disability and a lower level of cumulative lifetime disability. There is some controversy in this hypothesis with some contending that healthier lifestyles may actually increase morbidity (and health expenditures) late in life by increasing the numbers of years with chronic illness and disability." (Binns 2007) <http://www.medicineau.net.au/clinical/obesity/obesit1404.html>

This is confirmed in the recent publication of the AIHW on the burden of disease and injury in Australia in 2003, which stated:

"The rate of disability will actually decline in most age groups, except for those 80 years and over, where it is expected to increase and thereby offset some of the gains for younger age groups. The growing rate of disability in the oldest age group mostly comes from expected increases in diabetes and neurological conditions." (Begg et. al. 2007, p. 8)

The most relevant example of the increased burdens of disease from increased longevity is associated with dementia, as described by AIHW (2006).

"Because Australia's population is ageing, there has been growing recognition that dementia represents a significant challenge to health, aged care and social policy. This report estimates that the number of people with dementia will grow from over 175,000 in 2003 to almost 465,000 in 2031, assuming the continuation of current dementia age-specific prevalence rates." (page xii)

In terms of the social impact these changes are likely to make, Access Economics (2003) for Alzheimer's Australia estimated that growth of 6% per annum in the HACC program would be required to keep up with increasing demand (even after a 20% top up for current unmet need), plus additional respite services will be needed to better support informal caregivers (p. 6).

So the increase in lifespan has not been matched by an extension of health, and the extra years are spent with disability, disease and dementia, suggesting that the idea of the compression of morbidity has turned out to be a mirage. The prevalence of degenerative disease with age has led to an expansion of morbidity, not a compression.

The AIHW burden of disease study drew out the obvious implications for services:

“Ageing of Australia’s population will result in increasing numbers of people with disability from diseases more common in older ages such as dementia, Parkinson’s disease, hearing and vision loss, and osteoarthritis. This will increase demand for services in the home, community care, residential aged care and palliative care sectors.” (Begg et. al. 2007, p. 8)

There are also expected to be changes to the profile of carers in the future. The AIHW published a study on the future supply of informal care from 2003-1013 (Jenkins et al. 2003) where they estimated that the informal carer sector provides the equivalent of one million full time positions, and informal carers provide 77% of all the care that enables people with disabilities to stay at home. The study points out that structural and numerical ageing of the population signals higher demand for primary carers and heightens concern about the circumstances of a growing number of older carers. Becoming unable to care can cause significant anxiety and practical difficulties for older carers in particular.

Over 50% of partner and parent carers said that they could offer the best available care for their family member, confirming the widespread preference for care in the community. Overall, 79% of primary carers in 1998 lived with their care recipient. Future provision of informal care to people aged 45 to 64 years, could prove vulnerable to higher rates of relationship breakdown than has been evident in previous generations. In particular this could make an impact on the veterans in the post-1975 cohort.

Assuming all other factors are held constant, in 2013 the ratio of primary carers to the population in need of assistance from a primary carer will have declined from the ratio observed in 1998 from 43 primary carers per 100 persons with a severe or profound restriction to around 40. This projection is driven by high growth in the age groups from which large numbers of primary carers are traditionally sourced, counteracting the effect of a moderate reduction in the proportion of working-age women who are willing to reduce paid work to care compared to 1998. (Jenkins et al. 2003)

It is apparent that in social policy terms, the combination of changing the balance of care and the rising levels of dependency and disability in the community, and expected changes in the patterns of informal care, means that demand for higher levels of home-based support is increasing.

It is fair to say that community care services are becoming victims of their own success, and maintaining a philosophy of meeting ‘basic’ needs is creating a policy conundrum. In a capped funding environment, with significant and growing levels of unmet need, an allocation system based on need should dedicate more resources to higher levels of need or else risk increasing inequity. The work on targeting of community care interventions discussed elsewhere in this attachment is relevant to this argument.

In summary, the combination of demographic changes with their associated changes in the morbidity profile and of burden of disease, increased levels of dependency in older people maintained in the community, and the relative success of aged care assessment and more complex community care alternatives, have created a very different context for community care in 2007, from that existing in the 1980s. The notion of “prevention” is now more complex than

expecting maintenance level services to prevent residential care admission or to minimise the impact of chronic diseases. The effectiveness of 'basic' care services as promoted by policy in the 1980s needs to be tested by more recent evidence. It is against this policy and demographic backdrop that the review of effective interventions will now be considered.

Best practice interventions in home care

The results presented below are divided into the following program types or headings: Domestic Assistance, Personal Care, Home and Garden Maintenance, Respite Care; as well as other DVA services including community nursing and allied health. An overall view of developments in the literature is also presented in order to put these results into a wider perspective.

Domestic Assistance

An important finding of this literature search was the lack of any specific evidence based on reliable data on domestic assistance provided in isolation or as part of a "basic" level of service provision that does not include associated nursing or allied health care components. It is clear that these types of services are generally subsumed into larger care components for frail older people that include a mix of domestic, social and health-related activities. Further findings on care packages are presented in the section on the overall view of the literature and the question of the effectiveness of 'basic' level services in isolation from other components of service interventions is covered in the section on the policy and practice literature.

Personal Care

As with domestic assistance services, a finding of this literature search was the lack of any specific findings on personal care services provided in isolation from other services particularly nursing care, and these types of services are most commonly subsumed into larger care packages or a set of nursing interventions for frail older people.

While there is a paucity of information on the effectiveness of personal care services *per se* in the scientific and medical literature, there is evidence on the benefits of the more generalised intervention of home visiting. This finding is not unexpected given the biases in the scientific and medical literature towards more professionalised and technical interventions, leaving these community care service types to be treated as being subsumed within a range of broader social support interventions. These papers are now reviewed.

Home Visiting

The literature search process found a number of relevant scientific literature papers for home visiting (see table below). The two systematic reviews of Stuck et al. 2002 and Elkan et al. 2001 provide good evidence for the benefits of preventative home visiting (conducted by a nurse or health visitor) on older people 65 years and over. Effective components of this intervention include: multidimensional geriatric assessment, multiple follow-up visits and targeting of those at lower risk of death and are relatively young (Stuck et al. 2002).

In a more recent review than that conducted by Elkan et al. (2001), Stuck et al. (2002) found beneficial effects of preventative home visits on nursing home admissions, functional decline and mortality. The systematic review into nursing-based interventions for chronic conditions by Frich (2003) supports these findings.

"Best outcome in older populations is reached if target population are 'the younger-old', or if intervention is tailored to elders, who have stated health problems. The effect seems to depend on the duration of the study and multiple follow-up home visits. The effect also depends on the nurse as a person. The interventions that are most effective often consist of a multidimensional assessment followed by a form of active care coordination and 'empowering' rather than maintenance approach in terms of advising, recommending and negotiating, where the aim is often to support the patient in taking an active part in health related issues." (page 143)

Frich (2003) also makes another pertinent point here that is related to the characteristics of less professionalised community care service types where there is a lack of clear definitions of the activities being undertaken in terms of intensity or duration. Frich (2003) points out that a characteristic of this literature is that “Interventions are seldom described in detail.” (p.143)

Two important, veteran-related interventions were found in the search process. One study by Meyer et al. (2002) reports on an innovative program that uses a technology in the US Veterans’ Health Administration to monitor patients in order to enhance case coordination and management. The program uses technologies like instamatic cameras operated by patients or carers to monitor diabetic wounds, and a set of computerised questions and messaging service about disease symptoms administered via the telephone with the results sent to a secure internet site to manage complex medical / chronic disease populations.

This ‘telehealth’ approach was found to improve efficiency and decrease resource utilisation (including emergency department visits, hospital and nursing home admissions) as self-reported improvements in functioning and health (Meyer et al. 2002).

The other study by Hughes et al. (2000) reports on another veterans’ program in the US, which is a team managed primary care service for chronic patients post discharge. Patients were eligible if they had 2 or more ADL impairments, a terminal illness, or were homebound with chronic heart failure or homebound with chronic obstructive pulmonary disease. The intervention involved a care manager, 24 hour on call contact, prior approval for readmissions and discharge planning processes as well as nurse, physician and social worker visits per month for an average of 5-6 months. In terms of outcomes of this intervention, health related quality of life (HRQoL) was improved for terminal patients and service satisfaction was high for non-terminal patients.

Hughes et al. (2000) found caregiver quality of life, burden and stress were reduced and readmissions were down at 6 months, although these readmission results were not sustained at 12 months and other utilisation variables were not changed (e.g. bed days). Therefore overall program costs were up for the period of study.

It should be noted that this approach reported by Hughes et al. (2000) is based on chronic patients in a post hospital discharge phase, and technically this is not a “basic-level” home-care service in the sense that it is more related to a discharge planning service, a step down facility or hospital in the home, where personal care and domestic assistance is subsumed inside nursing and other services.

Table 19 Description and evidence rating for the references relevant to home visiting

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Elkan R, Kendrick D, Dewey M, Hewitt M, Robinson J, Blair M, Williams D and Brummel K (2001) Effectiveness of home based support for older people: systematic review and meta-analysis. British Medical Journal. Vol. 323, No. 7315, pp. 719-725.	Reduced mortality, improved functioning, improved quality of life, delayed admission to hospital and to residential care.	Older people 65 years and over - general and high risk	Well-supported practice	Systematic review - effectiveness of home visits (involving health education, assessment/problem identification, and referral to social support) to people aged 65 or older living at home, including frail older people at risk of adverse outcomes. Evidence that home visiting can reduce mortality and admissions to long term institutional care in the general elderly population.
Frich L (2003) Nursing interventions for patients with chronic conditions. Journal of Advanced Nursing. Vol. 44, No. 2, pp. 137-153.	Reduced mortality; improved quality of life, cost-effectiveness. Clinical outcomes: improved	Older people living at home suffering from a range of chronic conditions, including diabetes and rheumatoid	Well-supported practice	Descriptive literature review of the effect of home visit nursing interventions on people suffering a range of chronic conditions. Intervention included a full physical review plus assessment of cognitive, emotional and social functioning, and support for active engagement of patient in the health care. Interventions tailored to ‘younger old’

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
	vaccination frequency, and delayed development of disability and significant mortality rates.	arthritis.		people, or to elders with stated health problems had the best outcomes. Multiple follow-up nursing visits, extended over a long term, and based on individualised interventions for patients with chronic conditions recommended.
Hughes SL, Weaver FM, Giobbie-Hurder A, Manheim L, Henderson W, Kubal JD, Ulasevich A and Cummings J (2000) Effectiveness of Team Managed Home-Based Primary Care: A Randomized Multicenter Trial. <i>Journal of the American Medical Association</i> . Vol. 284, No. 22, pp. 2877-2885.	Functional status and quality of life for patients and for caregivers; hospital admissions and cost.	Patients with a mean age of 70 years who had 2 or more ADL impairments or a terminal illness, congestive heart failure (CHF), or chronic obstructive pulmonary disease (COPD).	Well-supported practice	<p>RCT – assessment of impact of team-managed home-based primary care (TM/HBPC) in Veterans' Affairs (VA) settings on functional status, quality of life (QoL), satisfaction with care, and cost of care. Intervention comprised home-based primary care including a primary care manager, 24-hour contact for patients, prior approval of hospital readmissions, and HBPC team participation in discharge planning. Key features included integrated networks, systematic screening to identify high-risk patients, an emphasis on continuity of care, and the management of patients across organisational boundaries.</p> <p>The TM/HBPC intervention improved most QoL measures among terminally ill patients and satisfaction among non-terminally ill patients. It improved carer QoL, satisfaction with care, and carer burden and reduced hospital readmissions at 6 months, but it did not substitute for other forms of care. Benefits needed to be considered against the greater cost of TM/HBPC.</p>
Meyer M, Kobb R and Ryan P (2002) Virtually Healthy: Chronic Disease Management in the Home. <i>Disease Management</i> . Vol. 5, No. 2, pp. 87-94.	Number of clinic visits, ED visits, hospital admissions, hospital bed days, nursing home admissions. Also QoL was measured by SF-36.	High-risk, high-use, high-cost veterans were targeted - complex medical/chronic disease populations.	Supported practice	<p>Evaluation of an "aging in place" model that integrated the care coordinator role with technology to improve health status, increase program efficiency, and decrease resource utilisation. Evidence indicated reductions in emergency room visits, hospital admissions, hospital bed days of care, VHA nursing home admissions, and nursing home bed days of care. A functional assessment revealed five significant improvements out of 10 domains of the SF 36V.</p> <p>(Care coordination - disease management is conducted throughout the continuum of care. Care coordinators monitor patient problems and help resolve them whenever and wherever they arise.</p> <p>Technology - The technology serves as a tool to help the care coordinator stay efficient and productive in meeting the needs of many patients.)</p>
Stuck AE, Egger M, Hammer A, et al. (2002) Home visits to prevent Nursing Home admission and functional decline in elderly people. <i>JAMA</i> . Vol. 287, pp.1022 - 1028.	Nursing home admissions and functioning	Older people 65 years	Well-supported Practice	Systematic review on preventive home visiting - components comprehensive geriatric assessment, multiple visits, target persons at lower risk for death and the relatively young. Deals with primary prevention eg. immunization and exercise, secondary prevention eg. detection of untreated problems, and tertiary prevention eg. improvement of

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
				medication use. Shows different mechanisms are operating for function and mortality outcomes. “Preventive home visitation programs appear to be effective, provided the interventions are based on multidimensional geriatric assessment and include multiple follow-up home visits and target persons at lower risk for death. Benefits on survival were seen in young-old rather than old-old populations.” (Abstract)

Home and Garden Maintenance

As with domestic assistance services and personal care services, a finding of this literature search was the lack of any specific data on home and garden maintenance services provided in isolation. It seems these types of services are most often subsumed into larger care packages for frail elders or as part of a home modification intervention. (Further data on care packages is presented in the overall view of the literature section)

Because these are not health interventions, but are part of environmental services, there is little evidence on the benefits and practice of home and garden maintenance in the scientific and medical literature. However there is a clear trend in the literature examining home modification and its impact on functioning and quality of life. These papers are reviewed below.

Equipment and Home Modifications

The search process found the following relevant papers with implications for equipment and home modification programs as an effective set of interventions (see table below).

A systematic review of occupational therapy interventions (Steultjens et al. 2004) described assistive devices, training, comprehensive OT, home hazards assessment and counselling of the primary caregiver, and information on falls prevention and social participation. These interventions were found to be useful in promoting an independence model, rather than a dependence model, for home care services.

“Strong evidence is present for the efficacy of advising on assistive devices as part of a home hazards assessment on functional ability. There is some evidence for the efficacy of training of skills combined with a home hazard assessment in decreasing the incidence of falls in elderly people at high risk of falling. Some evidence is available for the efficacy of comprehensive occupational therapy on functional ability, social participation and quality of life. Insufficient evidence is present for the efficacy of counselling the primary caregiver of dementia patients about maintaining the patient's functional abilities.” (Steultjens et al. 2004 Abstract)

The paper by Gitlin et al (2006) in particular provides strong evidence from the results of a randomised controlled trial. It reports on a preventive, home based intervention program for the well elderly that is shown to be cost effective. It argues for the familiar dictum that ‘prevention is better than cure’, and much less costly e.g. the installation of one grab rail versus the cost of a hip replacement due to a fracture resulting from fall (\$16,300-18,700).

Gitlin et al (2006) also provide evidence for a wider eligibility spectrum and argue the ‘well elderly’ is a neglected population. While the majority of health funds are directed to the unwell, despite the majority of elderly being well, a preventive program that maintains IADLS and ADLS could be promoted in a way that maintains social participation and community engagement, and also promotes health and well being.

The other randomised controlled trial found in this search was Nikolaus and Bach (2003) where the home based intervention included comprehensive geriatric assessment, assessment of the home for environmental hazards (safety checklist), advice about possible changes, necessary home modifications and education in the use of technical and mobility aids. The intervention involved at least two home visits. Unlike Gitlin (2006), the Abstract suggested the focus should be on the less well.

“The intervention was most effective in a subgroup of participants who reported having had two or more falls during the year before recruitment into the study.”

Table 20 Description and evidence rating for the references relevant to home modification

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Fielo SB and Warren SA (2001) Home Adaptation: Helping Older People Age In Place. Geriatric Nursing. Vol. 22, No. 5, pp. 239-247.	Delayed admission to residential care; improved function; improved quality of life	Frail aged	Expert opinion	Describes common problems faced by older people who wish to remain in their own homes and provides information about products to assist them.
Gitlin LN, Winter L, Dennis, MP, Corcoran M, Schinfeld S and Hauck WW (2006) A randomised trial of a multicomponent home intervention to reduce functional difficulties in older adults. Journal of the American Geriatrics Society. Vol. 54, No. 5, pp. 809-16.	Improved functioning based on self-report (ADLs, mobility/transferring, and IADLs), self-efficacy, and fear of falling; adaptive strategy use and observed home hazards.	People aged 70 and older, cognitively intact (MMSE); not receiving home care; and reporting the need for help or difficulties with two IADLs or one or more ADLs.	Well-supported practice	RCT - multicomponent home intervention involving OT, physical therapy, home modifications (and training in use), instruction in problem-solving, energy conservation, safe performance, and fall recovery techniques; and balance and muscle strength training. At 6 months, intervention participants had less difficulty than controls with IADLs and ADLs, greater self-efficacy, less fear of falling, fewer home hazards, and greater use of adaptive strategies, with most benefits sustained at 12 months.
Lansley P, McCreddie C and Tinker A (2004) Can adapting the homes of older people and providing assistive technology pay its way? Age and Ageing. Vol. 33, No. 6, pp. 571-576.	Cost effectiveness	Frail aged	Expert opinion	The adaptability of properties varies according to many design factors and the needs of occupiers. Adaptations and assistive technology can substitute for and supplement formal care, and in most cases the initial investment is recouped through subsequently lower care costs within the average life expectancy of a user.
McKeever PD, Scott HM, et al. (2006) Hitting home: a survey of housing conditions of homes used for long-term care in Ontario. International Journal of Health Services. Vol. 36, No. 3, pp. 521-533.	n/a	Frail aged	Views of clients and/or carers	Telephone survey of a random sample of 811 long-term home care clients in Ontario, Canada. Many clients' homes required major and minor repairs, were not suitable in size, were not affordable, and lacked important household amenities. More than 30 percent required modifications to enable clients to live and be cared for comfortably and safely, and half the clients had not completed these because of exorbitant costs. Overall, many clients were living in homes less than optimal for domestic life and long-term care provision.
Nikolaus T and Bach M (2003) Preventing falls in community-dwelling frail older people using a Home Intervention Team (HIT): results from the Randomized Falls-	Number of falls at 12 month follow-up	Hospitalised frail elders with a history of falls	Well-supported practice	RCT – Home based intervention including comprehensive geriatric assessment, assessment of the home for environmental hazards (safety checklist), advice about possible changes,

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
HIT Trial. Journal of the American Geriatrics Society. Vol. 51, No. 3, pp. 300-305.				necessary home modifications and education in the use of technical and mobility aids. (The intervention involved at least two home visits) "The intervention was most effective in a subgroup of participants who reported having had two or more falls during the year before recruitment into the study" (Abstract)
Steultjens EMJ, Dekker J, Bouter LM, et al. (2004) Occupational therapy for community dwelling elderly people: a systematic review. Age & Ageing. Vol. 33, No. 5, pp. 453-60.	Functional ability, social participation and quality of life, as well as independent living	Community dwelling elderly people (age > or = 60 years)	Well-supported practice	Systematic review of occupational therapy interventions describes assistive devices, training of skills, comprehensive OT, home hazards assessment and counselling of primary caregiver. Useful in promoting an independence model, rather than a dependence model, for home care services. Also includes information on falls prevention and social participation. "Strong evidence is present for the efficacy of advising on assistive devices as part of a home hazards assessment on functional ability. There is some evidence for the efficacy of training of skills combined with a home hazard assessment in decreasing the incidence of falls in elderly people at high risk of falling. Some evidence is available for the efficacy of comprehensive occupational therapy on functional ability, social participation and quality of life. Insufficient evidence is present for the efficacy of counselling the primary caregiver of dementia patients about maintaining the patient's functional abilities." (Abstract)

Respite Care

The search process found the following relevant papers for respite care (see table below). These papers cover the range of evidence categories from descriptive studies to randomised controlled trials and systematic reviews. The key findings from this analysis are summarised in the systematic review of Mason et al. 2007 that assessed 12927 titles and abstracts, across 37 databases between 1980 and 2005. They found that there seems to be a small effect of respite care for carers in terms of their perceived burden, and mental and physical health, plus that carers report high levels of satisfaction with services. This is also supported by the paper into carer satisfaction with respite by Townsend & Kosloski 2002.

However, the:

"existing evidence base does not allow any firm conclusions about the effectiveness or cost-effectiveness to be drawn and is unable to inform current policy and practice" (Mason et al 2007, p. 297).

This major research gap has also been identified by Ingleton et al. 2003 in their review of respite in palliative care, where they reviewed 260 papers, of which 28 related directly to adult respite care in specialist palliative care. These were largely concerned with descriptive accounts of respite programs, guidance on referral criteria or evaluating effects on patients but not carers. They found no empirical studies evaluating the impact of respite care provided by specialist palliative care services on carer outcomes. Both these works are a call to action for greater quality research into

this important area, as the ageing of the population, and economic and workforce developments in western societies, increase pressures on families with frail older people.

Another key message from these papers is that researchers need to explore the active ingredients of respite (Mason et al 2007) to see what works and how outcomes are affected by contextual factors (e.g. financial barriers, eligibility criteria or informal supports). Townsend & Kosloski (2002) in their paper attempt to disentangle these ingredients with regard to carer satisfaction with respite services.

In a review of RCTs, Flint (2005) found that there is little evidence that respite care for a patient with dementia significantly affects carer burden or delays institutionalisation of the patient. However, many carers report 'high levels of satisfaction with respite services' p516

An earlier review by McNally et al. (1999) drew a similar conclusion finding that there was little evidence that respite intervention had either a consistent or enduring beneficial effect on carer well-being. They suggested that a more 'carer-centred' approach is required in both the provision and evaluation of respite care intervention. This approach would address the experiences of both carers and care-recipients during the respite period. As with other authors, they noted that the majority of the work conducted to date has been methodologically poor.

Gaugler and Zarit (2001) reported that an elderly client typically attends an adult day program for 2 or 3 days a week for about 5 hours a day. However, adult day care is not homogenous, nor does it serve a generic population. As such, they classified interventions as either 'medical' programs or 'social' programs. They found satisfaction with services and that family carers seem to benefit from utilising adult day services over time. However, adult day programs act more as a supplement to informal assistance than a substitute for nursing home care, and the functional status of clients is often not affected.

Lee and Cameron (2004) reviewed three RCTs which compared respite care with a control intervention for people with dementia. They concluded that "Analysis of the data showed no significant effects on caregiver outcomes and there was no evaluable data for people with dementia" (p7), but warned that 'these results should be treated with caution, however, as they may reflect the lack of high quality research in this area rather than an actual lack of benefit' (p1).

In terms of the intervention level analysis, two high quality studies of programs called "Seniors at Home" (Rassen 2003) and "Missouri Care Options" (Marek et al. 2005) looked into coordinated care (i.e. case management) by either a nurse or social worker, and these included respite support services for carers in their care packages. They found significant results with respect to health and functioning and/or cost savings.

A nation-wide intervention (USA) is also described by Bellome and Cummings (2005) in a paper on adult day care services - a form of respite care. Most centres are open five days a week, for 8-9.5 hours a day. Average attendance is 25 per day (with 42 people on the books). Many clients attend part-time and for half a day; services include "therapy activities, personal assistance, meals, social services, intergenerational programming, medication management, transportation, nursing services and caregiver support groups." (p.18)

An important and early RCT of respite care for carers of Alzheimer's patients was conducted by Lawton et al. (1989). Half of the 642 participants received subsidised respite care in the context of ongoing case management, counselling, informational and educational services and half received only counselling and information at enrolment. Over 12 months, families with respite care maintained their impaired relative significantly longer in the community (22 days). Although respite was ineffective for carer burden and mental health, satisfaction was very high. Although not a strong intervention, respite care can increase carers' quality of life.

Gaugler et al (2003) reported on adult day service use and reductions in caring hours for dementia carers and concluded that adult day service use is potentially effective in reducing carers'

emotional and psychological distress. Grant et al (2003) reported on a two week respite intervention (random assigned) with follow-up testing one month post intervention using both psychological and physiological measures. They concluded that:

"the study provides preliminary evidence that a simple respite intervention may be useful in reducing sympatho-adrenal-medulatory arousal in a subgroup of carers who may be considered vulnerable to deleterious health outcomes by virtue of being placed under unusually burdensome caregiving circumstances in the context of inadequate social support." (p.70)

Holm and Ziguras (2003) reported on a small study of 18 care recipients who received host-home respite. The cost of providing host-home respite was almost 40% cheaper than in-home care, but both services cost more than centre-based care (day and overnight) because of the higher staff-client ratios.

"The model may be particularly suitable for people of non-English-speaking background and for Aboriginal groups . . . However, such models would need support from a larger organisation, perhaps an existing respite service, for staff support and training, financial management, central monitoring and accountability." (p.144)

In a study examining the effect of institutional respite care on sleep, Lee et al (2007) found that the carers sleep experiences benefited from respite. However:

"for caregivers...improved sleep quality during respite may come at the cost of personally disturbed sleep quality during the immediate post respite period...with improvements during respite period quickly returning to baseline in the immediate post respite period" (p.257) "..They conclude that institutional respite offers the potential to improve quality of sleep and quality of life for dementia caregivers..." (p.257)

Table 21 Description and evidence rating for the references relevant to respite care

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Bellome JA and Cummings S (2005) <i>Adult day services: the missing link in home care. Caring</i> . Vol. 24, No. 7, pp. 12-8.	n/a	n/a	Promising practice	Description of adult day care services in the United States and the development of a national quality measurement study
Flint A (2005) <i>Effects of respite care on patients with dementia and their caregivers International Psychogeriatrics</i> Vol.7, No.4, pp.505-517	rate of institutionalisation, carer burden	Review of original research, controlled trial, dementia population	Well-supported practice	Based on the results of controlled studies, there is little evidence that respite care for a patient with dementia significantly affects caregiver burden or delays institutionalisation of the patient. In fact there is some suggestion from uncontrolled trials that utilising respite services may increase the rate of institutionalization. Despite this, many caregivers report 'high levels of satisfaction with respite services' p516
Gaugler J and Zarit S (2001) <i>The effectiveness of adult day services for disabled older people. Journal of Aging and Social Policy</i> Vol.12, No.2, pp.23-47.	Admission to residential care, QOL, caregiver stress, client functioning, caregiver adaptation and timing of institutionalisation.	Disabled adults / older people, and their caregivers. Respite or day care.	Well-supported practice	"Experts should pay special attention to the program content, timing, and targeting of adult day programs in order to improve overall effectiveness."
Grant I, et al (2003) <i>In-home respite intervention reduces plasma epinephrine in stressed Alzheimer caregivers American Journal of Geriatric Psychiatry</i> Vol 11, No. 1	Psychological and biological markers of stress	US study of 55 spousal caregivers testing whether	Well-supported practice	".. The study provides preliminary evidence that a simple respite intervention may be useful in reducing sympatho-adrenal-medulatory arousal in a subgroup of caregivers who may be

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
pp62-72		providing in-home respite was associated with reduction in stress		considered vulnerable to deleterious health outcomes by virtue of being placed under unusually burdensome caregiving circumstances in the context of inadequate social support." p70
Holm S and Ziguras S (2003) <i>The host-homes program: an innovative model of respite for carers of people with dementia</i> . <u>Australasian Journal of Ageing</u> , Vol. 22, No.3, pp.140-145	Interviews, observation of the groups and, attendance records, care recipient demographic information and costs of the program.	7 carers for older people with dementia	Promising practice	The cost of providing host-home respite was almost 40% cheaper than in-home care, but both services cost more than centre-based care (day and overnight) because of the higher staff-client ratios. Both carers and care recipients appreciated the small-group setting and homelike environment, which allowed the formation of friendships with other regular attendees and some tailoring of activities to suit the care recipients' interests. Staff felt they were able to pay greater attention to the needs of individual care recipients and to monitor and respond to changes in their health or behaviour.
Ingleton C, Payne S, Nolan M, Carey I. (2003) <i>Respite in palliative care: a review and discussion of the literature</i> . <u>Palliative Medicine</u> . Vol. 17, No. 7, pp. 567-75.	Carer burden	Palliative patients	Supported practice	Systematic review of respite care found insufficient evidence to support its use for patients with advanced disease. Review also presents evidence for effectiveness of respite with chronic disease "There is insufficient evidence to draw conclusions about the efficacy of offering respite care to support carers of patients with advanced disease." (Abstract)
Lawton, M., E. Brody, et al. (1989). <i>A controlled study of respite service for caregivers of Alzheimer's patients</i> . <u>Gerontologist</u> Vol 29, No.1, pp 8-16.	Timing and rate of institutionalisation	642 caregivers of people with Alzheimer's	Well-supported practice	Over 12 months, families with respite care maintained their impaired relative significantly longer in the community (22 days). Although respite was ineffective for caregiver burden and mental health, satisfaction was very high. Although not a strong intervention, respite care can increase caregivers' quality of life.
Lee, D.; Morgan, K; Lindsay, J (2007) <i>Effect of institutional respite care on the sleep of people with dementia and their primary caregivers</i> <u>Journal of the American Geriatrics Society</u> Vol.55, No.2 pp.252-8	Sleep outcomes,	UK study of 33 dyads; 6 weeks monitoring sleep outcomes, including 2 week residential respite intervention for people with dementia.	Promising practice	"The benefits of respite were most evident for caregivers who did not share a bedroom with the patient" (p.252), however "for caregivers, .. Improved sleep quality during respite may come at the cost of personally disturbed sleep quality during the immediate post respite period ... with improvements during respite period quickly returning to baseline in the immediate post respite period" (p257). "Institutional respite offers the potential to improve quality of sleep and quality of life for dementia caregivers.." (p257)
Lee H & Cameron M (2004) <i>Respite care for people with dementia and their carers</i> <u>Cochrane Database of Systematic Reviews</u> Issue.1, Art No.:CD004396.	Rate of institutionalisation; burden, psychological stress and health, physical health,	3 RCTs which compared respite care with a control intervention for people with dementia.	Well-supported practice	"Analysis of the data showed no significant effects on caregiver outcomes and there was no evaluable data for people with dementia" p7 Number of methodological issues - interventions and outcomes were too dissimilar so data couldn't be pooled. "These results should be treated with caution, however, as they

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
	economic impact and quality of life, QoL, abuse			may reflect the lack of high quality research in this area rather than an actual lack of benefit." p1
Marek KD, Popejoy L, et al. (2005) <i>Clinical outcomes of aging in place</i> . <u>Nursing Research</u> . Vol. 54, No. 3, pp. 202-211.	Client ADLs, cognitive function, depression, incontinence, and pressure ulcers	Frail aged	Promising practice	Case-control evaluation study of an aged care package delivered in the community and coordinated by nurses – care package may include respite
Mason A, Weatherly H, Spilsbury K, et al. (2007) <i>The effectiveness and cost-effectiveness of respite for caregivers of frail older people</i> . <u>Journal of the American Geriatrics Society</u> . Vol. 55, No. 2, pp. 290-9.	Carer burden, depression	Frail aged and carers	Well-supported practice	Systematic review of respite care (adult day care, respite packages, in-home respite, host family respite, institutional respite, multidimensional packages, video respite) "For all types of respite, the effects upon caregivers were generally small, with better-controlled studies finding modest benefits only for certain subgroups, although many studies reported high levels of caregiver satisfaction. No reliable evidence was found that respite care delays entry to residential care or adversely affects frail older people." (Abstract)
McNally, S., Y. Ben-Shlomo, et al. (1999). <i>The effects of respite care on informal carers' well-being: A systematic review</i> . <u>Disability and Rehabilitation: An International Multidisciplinary Journal</u> Vol. 21, No. 1, pp 1-14.	Variety of carer outcomes	Carers of people with a chronic illness or disability. 29 studies were found following a literature search	Well-supported practice	There was little evidence that respite intervention has either a consistent or enduring beneficial effect on carers' well-being. The majority of the work conducted has been methodologically poor.
Rassen AG (2003) <i>Seniors-at-Home: a case management program for frail elders</i> . <u>Journal of Clinical Outcomes Management</u> . Vol. 10, No. 11, pp. 603-607.	Reduced health care costs	Frail aged identified as 'at risk'	Well-supported practice	RCT – intervention consists of comprehensive geriatric assessment followed by tailored package case managed by a social worker – care package may include respite
Townsend D and Kosloski K (2002) <i>Factors related to client satisfaction with community-based respite services</i> . <u>Home Health Care Services Quarterly</u> . Vol. 21, No. 3/4, pp. 89-106.	Carers' satisfaction with care	Frail aged, dementia	Views of clients and carers	Data from interviews with 1183 carers were entered into regression analyses to predict satisfaction with respite care. "Factors related to satisfaction with adult day care included the caregiver's age and health, ethnicity, caregivers' expectations for what the respite worker would and would not do, and the amount of red tape." (Abstract)

Other DVA services including community nursing and allied health

The search process found a number of relevant papers that have implications for other DVA services including community nursing and allied health (see table below). These papers provide support for evidence based interventions and reviews for other DVA services used by clients of Veterans' Home Care. They are presented here briefly to guide the considerations for the future development of the program, and further examination of these issues, if required.

A paper by Allen et al. (2001) provides useful supporting evidence for the Rehabilitation Appliances Program, especially with regard to the use of canes and crutches. These are also described above in the section on Home Modification.

For community nursing, the paper by De Vlieghe et al. (2005) outlines a descriptive study of the core interventions for home nursing of older people in Belgium and how performance of the basic helping activities (bathing, clothing) is a pre-condition for the performance of the more technically complex (wound care) and higher order interventions (e.g. counselling, prevention). Markle-Reid et al. (2006) provides a review of effective health promotion activities performed by nurses in people's homes.

The papers by Steultjens et al. 2004 and Gitlin et al. 2006 outline best practice occupational therapy interventions for older people. Preliminary findings are that: preventive, home based intervention may reduce mortality risk; control-oriented strategies may have positive influence on survival focus on what keeps people well; rather than a focus on what causes people to be unwell, the papers highlight the positive health benefits of people being able to continue doing what they like and want to do.

The literature emphasises how multi-factorial issues can impact on functional ability and how this warrants a multidisciplinary response /approach that is more like integrated primary health care, rather than a 'basic' care approach with low levels of service provision.

The papers Hill and Brettle (2005) and Owens et al. (2005) provide useful supporting evidence for the Vietnam Veterans' Counselling Service, and finally, the paper by Pynoos et al. 2006 outlines the evidence base for falls prevention programs.

Table 22 Description and evidence rating for the references relevant to other DVA services including nursing and allied health

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Allen SM, Foster A and Berg K (2001) Receiving help at home: the interplay of human and technological assistance. The Journals of Gerontology Series B- Psychological Sciences & Social Sciences. Vol. 56, No. 6, pp. S374-S382.	Improved functional status, hours of care	Disabled population	Supported practice	This research investigated use of mobility equipment as a substitute for human assistance and evidence for out-of-pocket cost savings re formal home care services. Findings suggest that canes and crutches are effective and efficient home care resources that have the potential to increase the autonomy of adults with disabilities and to facilitate chronic condition self-management. Use of canes and crutches (but not walkers and wheelchairs) reduced hours of care per week (formal and informal) and therefore out-of-pocket costs for formal helping services.
De Vlieghe K, Paquay L, Grypdonck M, Wouters R, Debaillie R and Geys L (2005) A study of core interventions in home nursing. International Journal of Nursing Studies. Vol. 42, No. 5, pp. 513-520	NA	Home nurses (i.e. community nurses)	Views of home nurses	Descriptive study of 441 home nurses in Belgium into their views about what are the core interventions in home nursing. They found that "self-care assistance, (im)mobility and (psycho)social interventions are the most frequently performed interventions in home nursing, but they are performed and can only be interpreted in combination with other, more technical interventions." (Abstract) Average age of their patients was 73.8 years
Gitlin LN, Winter L, Dennis, MP, Corcoran M, Schinfeld S and	Improved functioning	People aged 70 and older,	Well-supported	RCT - multicomponent home intervention involving OT, physical therapy, home

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Hauck WW (2006) A randomised trial of a multicomponent home intervention to reduce functional difficulties in older adults. <i>Journal of the American Geriatrics Society</i> . Vol. 54, No. 5, pp. 809-816.	based on self-report measures difficulties (ADLs, mobility/transferring, and IADLs), self-efficacy, and fear of falling; adaptive strategy use and observed home hazards.	cognitively intact (MMSE) and English speaking; not receiving home care; and reporting the need for help or difficulties with two IADLs or one or more ADLs.	practice	modifications (and training in use), instruction in problem-solving, energy conservation, safe performance, and fall recovery techniques; and balance and muscle strength training. At 6 months, intervention participants had less difficulty than controls with IADLs and ADLs, greater self-efficacy, less fear of falling, fewer home hazards, and greater use of adaptive strategies, with most benefits sustained at 12 months.
Hill A and Brettle A (2005) The effectiveness of counselling with older people: results of a systematic review. <i>Counselling and Psychotherapy Research</i> . Vol. 5, No. 4, pp. 265-272.	Quality of life, levels of anxiety and depression	People aged 50 years or over	Well-supported practice	Systematic review of research relating to counselling of older people, particularly depression, anxiety, dementia and the psychological impact of physical conditions such as chronic obstructive pulmonary disease (COPD). The review found that counselling is efficacious with older people, particularly in the treatment of anxiety and depression, but evidence re the efficacy of counselling for treating dementia is weak.
Markle-Reid M, Browne G, et al. (2006) The effectiveness and efficiency of home-based nursing health promotion for older people: a review of the literature. <i>Medical Care Research and Review</i> . Vol. 63 No. 5, pp. 531-569	Health and functional status, mortality, hospital and nursing home admission and costs	65 years and older	Well-supported practice	Systematic review into the effectiveness of health promotion conducted by community nurses to older people at home. "The findings suggest that a diversity of home visiting interventions carried out by nurses can favourably affect health and functional status, mortality rates, use of hospitalization and nursing homes, and costs. Further research is needed that focuses on the outcomes of quality of life, mental health, social support, caregiver burden, the acceptability of intervention, and specific subgroups of clients who benefit most. Findings also indicate the need for a theoretical foundation, increased emphasis on health-promotion strategies, and more research using a more complete economic evaluation to establish efficiency." (Abstract)
Owens GP, Baker DG, Kasckow J, Ciesla JA, Mohamed S (2005) Review of assessment and treatment of PTSD among elderly American armed forces veterans. <i>International Journal of Geriatric Psychiatry</i> . Vol. 20, No. 12, pp. 1118-1130.	Quality of life and functional status	US armed forces veterans (WWII and Korea)	Supported practice	Literature review that summarizes available research re difficulties in assessment with the elderly American Armed Forces veteran population, and discusses psychotherapeutic and pharmacological treatment interventions for posttraumatic stress disorder (PTSD). Review found that elderly veterans generally present more somatic symptoms of PTSD, complicated by comorbidities such as depression, substance abuse, or cognitive deficits. Evidence suggests that some psychotherapeutic and pharmacological interventions already utilized with younger individuals may be useful with the elderly veteran population, if modified.

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Pynoos J, Rose D, Rubenstein L, Hee Choi I and Sabata D (2006) Evidence-based interventions in fall prevention. <i>Home Health Care Services Quarterly</i> . Vol. 25, No. 1/2, pp. 55-73.	Prevention of falls-related injuries	Frail aged	Well-supported practice	Systematic review of the evidence on falls prevention. Multifactorial intervention strategies can effectively prevent and/or reduce falls among older adults.
Steultjens EMJ, Dekker J, Bouter LM, et al. (2004) Occupational therapy for community dwelling elderly people: a systematic review. <i>Age & Ageing</i> . Vol. 33, No. 5, pp. 453-460.	Functional ability, social participation and quality of life, as well as independent living	Community dwelling elderly people (age > or = 60 years)	Well-supported practice	Systematic review of occupational therapy interventions describes assistive devices, training of skills, comprehensive OT, home hazards assessment and counselling of primary caregiver. Useful in promoting an independence model, rather than a dependence model, for home care services. Also includes information on falls prevention and social participation. “Strong evidence is present for the efficacy of advising on assistive devices as part of a home hazards assessment on functional ability. There is some evidence for the efficacy of training of skills combined with a home hazard assessment in decreasing the incidence of falls in elderly people at high risk of falling. Some evidence is available for the efficacy of comprehensive occupational therapy on functional ability, social participation and quality of life. Insufficient evidence is present for the efficacy of counselling the primary caregiver of dementia patients about maintaining the patient’s functional abilities.” Abstract

Care Packages

The search process found the following relevant papers for care packages (see table below). They highlight a number of key issues in respect to the effective application of care packages for older people living in the community. Each paper is briefly described below with a description of its care package.

Albert et al. (2005) in a naturalistic study into the New York City Medicaid Home Care Services Program found this intensive home care and case management service did significantly reduce mortality for disabled elders in the program 3-5 years later. The package of care included light housekeeping, provisioning and preparing of meals, and personal assistance – high intensity if required - and regular nursing assessments with case management, referral and evaluation.

Vass et al. (2005) provides further evidence of the benefits of preventative home visits upon functional status using a randomised controlled trial design based on local areas. (The package of care included: home visits, telephone calls, short standardised assessments, monitoring and GP training and referrals)

Nakatani and Shimanouchi (2004) found evidence for the benefits of home care with increased service use and monitoring to preventing functional decline in a group of Japanese older people. The package of care included care planning, monitoring and evaluation in terms of service delivery. However service delivery issues were not defined apart from their cost. Care items addressed included housekeeping, security, hygiene, eating, ADLs, and the preparing of wills.)

McCusker and Verdon (2006) in their systematic review of interventions to reduce emergency department (ED) visits found that 3 out of 4 home care studies they identified were successful in

reducing ED utilisation. The packages of care included comprehensive assessment, multidisciplinary teams and case management, one issue was that the types of services delivered were not defined.)

Landi et al. (2001) also outline a home care program in Italy based on comprehensive assessment and case management which has significantly reduced hospitalisations. However, they have used a pre-post analysis without a control group.

The important systematic review by Johri et al. (2003) into demonstration projects across the OECD is outlined in the practice review section on hospital avoidance (p.135).

Marek et al. (2005) compared a nurse coordinated home care service versus the standard home care service in Missouri, using standardised assessments. It found that clients with nurse coordination scored better on measures of pain, breathing and ADL functioning at 12 months. There was some evidence that the nurse coordinated service was better integrated as it used fewer providers. The package of care included basic and advanced personal care, homemaker care and respite - with or without nurse coordination.

Rassen (2003) documents a case management program for elders living in the community in San Francisco showing improvements in quality of life and reduced utilisation of medical resources. The package of care included GP and medical centre staff training, comprehensive assessment, case management, home visiting, therapy, telephone calls, monitoring, referral to local volunteer services [e.g. meals on wheels], bill paying, medical equipment, adult day care, transportation and respite services.

Bierlein et al. (2006) also provides important survey data for clients who were case coordinated in the community in Canada, showing that the majority improved in physical and mental health status at 6 months. They also found that nursing, occupational therapy and domestic assistance were the main services used.

While the important point is made by Frich (2003) that there is a lack of required detail when describing interventions with older people, key concepts or issues for effective care package delivery do emerge from this brief review of these identified papers.

These key concepts are: service intensity, training of other providers in the community, assessment and monitoring, care planning and management, multi-disciplinary teams, care coordination and evaluation, home visiting, telephone contact, equipment and transport, referral to other providers and volunteer agencies, as well as respite services.

Table 23 Description and evidence rating for the references relevant to care packages

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Albert SM, Simone B, Brassard A, et al. (2005) <i>Medicaid home care services and survival in New York City</i> . <i>Gerontologist</i> . Vol. 45, No.5, pp.609-616.	Reduced mortality	Frail aged - Medicaid clients (USA) 65 years and over	Promising practice	Naturalistic study - an example of a more intensive service type and its effects on survival Combines housekeeping, meals and personal assistance with nursing visiting / assessment and case management.
Bierlein C, Hadjistavropoulos H, Bourgault-Fagnou M, Sagan M (2006) <i>A six-month profile of community case coordinated older adults</i> . <i>Canadian Journal of Nursing Research</i> . Vol. 38, No. 3, pp. 32-50.	Improved quality of life; risk of institutionalisation	Older people aged 65 years and over	Promising practice	The study assessed the needs of older case coordinated clients receiving community health services, by examining changes in cognitive status, physical and mental health status, social support, risk for institutionalization, and service use over a 6-month period from initial intake into home care. Results reveal that physical and mental health improved,

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
				while cognitive status and subjective support remained stable. Risk of institutionalization decreased. Frequent review of needs may be warranted to maintain effective service plans.
Johri M, Beland F and Bergman H (2003) <i>International experiments in integrated care for the elderly: a synthesis of the evidence.</i> <u>International Journal of Geriatric Psychiatry</u> . Vol. 18, No.3, pp.222-235.	Reduced Mortality and reduced emergency admissions and delayed admission to residential care	Elderly - general and at risk	Well-supported practice	Systematic review / Literature review - Case management, geriatric assessment and multidisciplinary team; single entry point; financial levers
Landi F, Onder G, Russo A, Tabaccanti S, Rollo R, Federici S, Tua E, Cesari M and Bernabei R (2001) <i>A new model of integrated home care for the elderly: impact on hospital use.</i> <u>Journal of Clinical Epidemiology</u> . Vol. 54, No. 9, pp. 968-970.	Reduced hospital and emergency admissions	Frail older people	Promising practice	The study examined the effect of a home care program based on comprehensive geriatric assessment (Minimum Data Set for Home Care) and case management on hospital use/cost of frail elderly individuals. An integrated home care program based on the implementation of a comprehensive geriatric assessment instrument guided by a case manager has a significant impact on hospitalization and is cost-effective.
McCusker J and Verdon J (2006) <i>Do geriatric interventions reduce emergency department visits? A systematic review.</i> <u>Journals of Gerontology Series A-Biological Sciences & Medical Sciences</u> . Vol. 61, No. 1, pp. 53-62.	Reduced emergency admissions	Frail aged	Supported practice	RCTs - case management type interventions in home care; plus multi-disciplinary intervention (non random). Summary of evidence in relation to ED visits, some application to home care (p 59). Hospital-based interventions (mostly short-term assessment and/or liaison) had little overall effect on ED utilisation, whereas many interventions in outpatient and/or primary care or home care settings (including geriatric assessment and management and case management) reduced ED utilisation.
Marek KD, Popejoy L et al. (2005) <i>Clinical outcomes of aging in place.</i> <u>Nursing Research</u> . Vol. 54, No. 3, pp. 202-211.	Client ADLs, cognitive function, depression, incontinence, and pressure ulcers	Frail aged	Promising practice	Case-control evaluation study of an aged care package delivered in the community and coordinated by nurses. The purpose of this evaluation was to compare clinical outcomes between older adults who resided in residential aged care facilities (RACF) and a group of similar older adults who received services in the AIP (ageing in place) program. P205 "This study indicates that participants of the AIP program had favourable clinical outcomes when compared with similar individuals receiving long-term care in a [RACF]." P209
Nakatani H and Shimanouchi S (2004) <i>Factors in care management affecting client outcomes in home care.</i> <u>Nursing & Health Sciences</u> . Vol. 6, No.4, pp.239-246.	Care needs met, functioning and client satisfaction	Home care clients (60 years +) (Japan)	Promising practice	Path analysis into the care management processes (assessment, planning and monitoring etc) compared with client care plan items (eg. hygiene, fall prevention) and functional outcomes (FIM scores). "Improvement in care items was significantly related to the amount of services. Deterioration of the functional

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
				independence level was significantly related to the amount of service and lower implementation of monitoring." (Abstract)
Rassen AG (2003) <i>Seniors-at-home: a case management program for frail elders</i> . <u>Journal of Clinical Outcomes Management</u> . Vol. 10, No.11, pp.603-607.	Reduced health care costs	Community dwelling 65 year+ frail aged identified as 'at risk'	Promising practice	Case Management Program - People referred to the program receive a comprehensive assessment within 48 hours by a social work geriatric care manager. This includes identification of risk factors and assessment of mental status, health status, met and unmet ADLs and IADLs Care package may include domestic assistance
Vass M, Avlund K, Lauridsen J and Hendriksen C (2005) <i>Feasible model for prevention of functional decline in older people: Municipality – Randomized Controlled Trial</i> . <u>Journal of the American Geriatrics Society</u> . Vol. 53, No. 4, pp. 563-568.	Functional ability	Community dwelling older people, who were between 75 and 80 years of age	Supported practice	RCT into the effects of an educational program for health visitors and GPs into preventative healthcare (including a short geriatric assessment tool and referral to GP) for older people across 34 local areas in Denmark. For those in participating local areas, the education program improved functional ability in 80 years olds at 3 year follow-up. No differences were found in mortality or nursing home admissions. "Subjects aged 80 benefited from accepting and receiving in-home assessments with regular follow-ups" (Abstract)

Overall view of the literature on interventions related to home care

A large number of service utilisation studies (n=17) were found that included home care but these were regarded as beyond the scope of this review as they did not examine the efficacy or effectiveness of specific interventions. The utilisation studies examined the needs and personal characteristics (e.g. functional status, unmet needs, informal supports) of home care recipients. A paper by Kadushin (2004) is useful in this area as it reviews the literature on resource utilisation for home health care recipients.

The search process found the following relevant papers discussing several over-arching themes or trends observed in the literature (see table below). The first was the utilisation of technology in the delivery of home health care – e.g. the creation of smart homes e.g. use emergency alarms, monitors, sensors and special cameras (Demiris et al. 2006, Cheek et al. 2005) and Telehealth (see the VA Care Coordination Home Telehealth Program, Barnett et al. 2006); and telephone-based screening systems that include sophisticated algorithms that assist in selecting the right clients for the appropriate service response (Fries et al. 2002).

The second major trend was the rise of programs designed for restoring or improving functional abilities (or preventing functional decline) in the elderly receiving home care. These programs adopt a functional independence philosophy rather than a maintenance focus. Review papers and studies outline the beginning of this approach (Baker 2006, Giffords & Eggleton 2005, Tinetti et al. 2002). Though, as previously noted, the evidence base for these interventions is still being built (Mottram et al. 2002), and this is because of the difficulty of achieving well controlled studies in this area.

A good example of developing and well-supported practice is a brief report by Lewin et al. (2006) in a paper presented to the International Federation on Ageing and published in the Journal of the British Society of Gerontology, based on work with the Silver Chain organisation in Western Australia and called *Programs to Promote Independence at Home: How Effective Are They?* It reports on an evaluation of a Home Independence Program (HIP), and like other early-stage studies in the UK:

“... suggest(s) significant reductions in use of homecare services following ‘discharge’ from a reablement service, compared with assessed levels of need on ‘entry’ to the service. However, there is no evidence on the longer term duration of such reductions, or on the factors that might lead to subsequent (increases in) service use.” (Newbrunner et al. 2007, p.2)

The third major trend was the emergence of the importance of physical activity in the elderly and the rise of home exercise programs to prevent falls and disability in older adults, for an example see the paper by Robertson et al. (2001). A brief survey of systematic review papers found good evidence for falls prevention programs with some more population level work to be done (Gillespie et al. 2003, McClure et al. 2005). A review of the relationship between physical activity interventions and general health for older adults found a limited evidence base and the need for better designed trials (Conn et al. 2003, Cyarto et al. 2004).

As Depp and Jeste (2006) comment in their study describing successful ageing “the effectiveness of health-promotion programs has been limited” (page 17). For example, there is only limited published evidence that Tai Chi is effective in reducing falls and blood pressure in the elderly (see the reviews by Gillespie et al. 2003 and Verhagen et al. 2004). However, there is good evidence that physical activity interventions are related to a small but significant effect on well-being in older adults (see Netz et al. 2005).

A major issue for VHC is the absence of evidence in the academic literature to support claims for the cost-effectiveness of home care, and in particular ‘basic’ level home care offering a limited number of service types. While the limitations of the evidence for the impact of domestic assistance, personal care, respite and even physical activity programs in terms of ‘hard’ outcomes is an issue, these programs do seem to contribute to a sense of well-being for clients and carers.

The paper by Fries et. al. (2002) explains the dilemma for program managers in home and community based services (HBCS) very clearly. Given the expanding population and increased demand for long term care (LTC) and the reality of constrained budgets, governments:

“were primarily motivated to initiate these programs under the assumption that home care would provide LTC services in more cost-effective ways than would institutional care. However, over 2 decades of research and evaluation in the area has not supported this assumption...The inability to reach the appropriate population, namely those ‘who but for HCBS’ would actually move to a nursing home, has been cited as the reason that home care has not been the financially positive alternative originally posited ... (Large scale evaluations) have suggested that a screening process is critical to (the) successful use of home care to reduce nursing home admissions.” (p.463)

Table 24 Description and evidence rating for papers on overall trends in the literature

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Baker D (2006) <i>The science of improving function: implications for home healthcare</i> . <i>Journal for Healthcare Quality</i> . Vol. 28, No. 1, pp.20-28.	Functional outcomes	Home care clients	Supported practice	Describes a multifactorial geriatric model of care to improve functional outcomes. Presenting some evidence to support the model.
Barnett TE, Chumbler NR, Vogel WB, Beyth RJ, Qin H, and Kobb R (2003) <i>The effectiveness of the around-the-clock in-home care</i>	Healthcare utilisation	Older veterans with type 2 diabetes	Supported practice	Explores the use of Home telehealth technologies to allow the veteran and his or her care coordinator to maintain direct communication for veterans with diabetes

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
<p><i>system: did it prevent the institutionalization of frail elderly?</i> Public Health Nursing. Vol. 20, No. 1, pp. 13-24.</p>				mellitus (DM). The CCHT program reduced avoidable healthcare services for DM (such as hospitalizations) and reduced care coordinator-initiated primary care clinic visits.
<p>Cheek P, Nikpour L and Nowlin HD (2005) <i>Ageing well with smart technology</i>. Nursing Administration Quarterly. Vol. 29, No. 4, pp.329-338.</p>	Delayed admission to residential care	Frail aged	Descriptive study	Describes use of 'smart home' technology and its implications for nursing practice.
<p>Demiris G, Skubic M, Rantz MJ, Courtney KL, Aud MA, Tyrer HW, He Z and Lee J (2006) <i>Facilitating interdisciplinary design specification of "smart" homes for aging in place</i>. Studies in Health Technology & Informatics. Vol. 124, pp. 45-50.</p>	Delayed admission to residential care	Frail aged	Expert opinion	Focus group discussions involving clinicians and non-clinical experts around implementation of 'smart home' technology. An interdisciplinary approach to design is recommended.
<p>Fries BE, Shugarman LR, Morris JN, Simon SE and James M (2002) <i>A screening system for Michigan's home- and community-based long-term care programs</i>. Gerontologist. Vol. 42, No. 4, pp. 462-474.</p>	Eligibility criteria for services	Frail aged	Well supported practice	Describes development of a screening tool to identify eligibility and the right level of care for publicly funded home and community care services.
<p>Giffords ED and Eggleton E (2005) <i>Practical considerations for maintaining independence among individuals with functional impairment</i>. Journal of Gerontological Social Work. Vol. 46, No.1, pp.3-16.</p>	Delayed admission to residential care; improved function; improved quality of life	Aging, disabled and chronically ill older adults	Well supported practice	Systematic review / Literature review into maintaining independence in frail elders. A discussion of "prevention strategies to help facilitate functional consequences of aging, including chronic illness and disease and offer suggestions for assisting clients to cope and manage the consequences of illness in frail elder adults."
<p>Mottram P, Pitkala K and Lees C (2002) <i>Institutional versus at-home long term care for functionally dependent older people</i>. Cochrane Database of Systematic Reviews. (CD003542)</p>	Mortality, morbidity and functional status as well as satisfaction of clients and carers	Functionally dependent older people (65+)	NA	Systematic review into nursing home versus at home care. Only 1 RCT found. They found that "there is insufficient evidence to estimate the likely benefits, harms and cost of institutional or at-home care for functionally dependent older people" (Abstract)
<p>Robertson MC, Devlin N, Gardner MM and Campbell AJ (2001) <i>Effectiveness and economic evaluation of a nurse delivered home exercise programme to prevent falls. 1: Randomised controlled trial</i>. British Medical Journal. Vol. 322, pp. 1-6.</p>	Prevention of falls-related injuries	Community dwelling men and women aged 75 years and over	Well supported practice	RCT with one year's follow-up. Delivery of exercise program by district nurse (with no prior experience) in a GP clinic. Falls were reduced by 46%; cost effective for over 80year olds. "An exercise programme delivered by a physiotherapist or trained district nurse was successful in reducing falls and moderate injuries in elderly people" (page 5)
<p>Tinetti ME, Baker D, Gallo WT, Nanda A, Charpentier P and O'Leary J (2002) <i>Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care</i>. Journal of the American Medical Association. Vol. 287, No. 16, pp. 2098-2105.</p>	Functional status, residential status, ED admissions	People aged 65 years at risk of functional decline after acute illness or hospitalisation	Supported practice	Controlled clinical trial in Connecticut USA comparing a restorative model of home care (one office) with usual home care performed in five other agency offices. "Key characteristics of the restorative care included: 1) training of the home care nurses, therapists, and home health aides in issues relevant to rehabilitation,

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
				<p>geriatric medicine, and goal attainment; (2) reorganization of the home care staff from individual care providers into an integrated, coordinated, interdisciplinary team with shared goals; (3) reorientation of the focus of the home care team from primarily treating diseases and “taking care of” patients toward working together to maximize function and comfort; and (4) the establishment of goals based on input from the patient, family and home care staff, and agreement among this group on the process for reaching these goals” p.2100</p> <p>“Compared with usual care, the restorative care model was associated with a greater likelihood of remaining at home ... and a reduced likelihood of visiting an emergency department.” (Abstract) Home care episodes were also shorter and restorative clients had better scores on self-care, home management and mobility on discharge.</p>

Finally, in the absence of clear findings on the effectiveness of the specific VHC service types of domestic assistance, personal care, and home and garden maintenance, or on the effectiveness of ‘basic’ level services without being in combination with a range of other services, further analyses were undertaken of papers describing packages of care.

Conclusions on interventions found in the international/academic literature

If the Department were to design a home care program for veterans from the ground up today, it would design more active interventions that promote health and functional independence. It would also provide a more diverse suite of package care interventions to respond to a broad range of service needs, not just focus on ‘basic’ levels of care.

Best practice home care programs use a team based approach to service delivery that is both integrated and carefully targeted, not based on relatively rigid eligibility criteria. A best practice program would be capable of selecting the right clients for the program and directing those not eligible other levels of support through a local referral process. It would use empirically derived screening algorithms to allocate clients at the entry point to either a priority rating category or individually tailored service response that leads to:

- no services (for those not eligible or with insufficient levels of need)
- direct to service delivery based a straightforward decision about their care based on their level of need as determined at the screening level
- more detailed and usually home-based assessment before devising a care plan.

A best practice program would also be designed to be capable of rigorously collecting data on outcomes and effectiveness so that it can shape its own empirically-based service development strategy. This component is important in the absence of firm guidance from the scientific literature on what the most effective interventions are likely to be.

To get a more rounded picture of the community field, it is necessary to go beyond the findings in the academic literature, since a review process that is relying on a relatively narrowly defined

academic perspective will, of necessity, be biased towards the areas where the evidence is judged to be strongest. The best evidence will be found in the areas that are more professionalised and where the control of variables and interventions is easiest to achieve and the ability to collect reliable data is more possible. These are not the common characteristics of the community care sector.

To this end the search strategy was supplemented by an examination of the practice literature in order to achieve a balanced perspective on the strength of the evidence by combining academic knowledge with more practice based developments.

Interventions found in the practice literature

An examination of the internet was also undertaken to supplement this core search for effective interventions or treatments in home care. This search examined promising or emerging practices in home care from the academic literature as well as reports that have not been published in the academic literature. In this way, our search strategy “moves out into the web” to examine the practice literature.

This search follows the outline provided in Section 2 and is divided into two parts. The first search involved examining the veterans-specific departmental web-sites, and the second search, which expanded on the first search, examined other web-sites identified in the international literature.

Table 25 Specific departmental (veterans) web-sites examined

Australia	http://www.dva.gov.au/
Canada	http://www.vac-acc.gc.ca/general/
New Zealand	http://www.veteransaffairs.mil.nz/default.htm
United Kingdom	http://www.veterans-uk.info/
United States of America	http://www.va.gov/

An issue for consideration in this knowledge area is that there are no open and aggregated sites looking at innovative and evidence based practice in aged care in the community. This is a useful finding as there are no sites of similar quality to the US based Promising Practices Network in child and family health (<http://www.promisingpractices.net/> or the California Evidence-Based Clearinghouse for Child Welfare) (<http://www.cachildwelfareclearinghouse.org/>). This indicates an important ‘evidence gap’ in the Australian community care context, that should it be filled, would be a way to support the development of more effective practices.

Highlights of the relevant results from these two searches conducted on 5 October 2007 are outlined below.

Results from specific departmental web-sites

Examining specific veteran’s departmental web-sites, the best documented program on the internet is the Veterans Independence Program (VIP) from Canada (see <http://www.vac-acc.gc.ca/clients/sub.cfm?source=services/vip>). It includes the following services: grounds maintenance (grass cutting and snow removal), housekeeping, personal care services, access to nutrition services, and health and support services; as well as out-patient health care, transportation costs, home adaptations, nursing home care. As can be seen this program is closely related to VHC.

VIP has had a full scale performance evaluation conducted recently (see http://www.vac-acc.gc.ca/general/sub.cfm?source=department/reports/deptaudre/vip_baseline_dec_2006#02a) with cost data, target data and an attempt to quantify cost savings by comparing the target veteran population with statistics for nursing home bed utilisation. This shows some evidence for the VIP program in “eliminating or delaying the need for institutionalisation”.

This Canadian Veterans program provides a very useful model for DVA and a strategic direction for how VHC could evolve more in the direction of fostering greater independence and a restorative/rehabilitation focus, rather than its current maintenance focus.

Another relevant veterans' website was linked to the New Zealand government. Here there is emphasis on case management to assist veterans to access particular services and the model is outlined briefly below. They use a brokerage model based out of a single centre in Wellington. <http://www.veteransaffairs.mil.nz/case-management/index.html>

Key characteristics of the service model used by Veterans' Affairs in New Zealand were:

- The case management service runs on a brokerage model.
- Case managers connect veterans and their families to appropriate services within the community that best address their needs and assist with improving and maintaining their quality of life.
- The focus is the case manager facilitating access to existing publicly funded health and disability services and to the entitlements that are available through the social assistance and war pensions frameworks.
- Veterans' Affairs New Zealand provides funding in situations where the need, generated by service, is urgent and no other service is available.

In terms of additional Australian information, it is important to note the significance of the DVA material on related programs; in particular the Department of Veterans' Affairs' Clinical Pathways (originally developed in 2000) and their links with the Guidelines for the Provision of Community Nursing Care (updated in 2007), provide a highly developed information environment for the conduct of clinical interventions using a 'casemix' type classification system. (http://www.dva.gov.au/health/provider/community_nursing/pathways/pathindex.htm)

The information in the Guidelines (see version 1, May 2006) shows how the DVA community nursing classification system operates for DVA contracted providers:

- The first level is a split by client type - assessment only; bereavement follow up; acute/post acute; support and maintenance; personal care; medication administration; and palliative.
- The second level is duration (short and medium term for acute/post-acute) and palliative phases.
- The third level is dependency for the support and maintenance client type.
- The fourth level is for nursing interventions (generalist, technical and other).

The provider assesses the clinical and/or personal care needs using validated assessment tools to determine the goal of care, community nursing services required and the expected outcomes. For the need for personal care, the split between VHC and nursing is based on VHC taking up low level care (up to 1.5 hours per week) and the entitled person not having a clinical need for community nursing services.

The UK and US web-site search found little additional intervention-related information that influenced the overall findings. From the US Veterans' Administration (VA) site (<http://www1.va.gov/geriatricsshq/>) further two programs stand out:

- the Geriatric Evaluation and Management (GEM) Program with its focus on multi-disciplinary assessment, followed by a care plan, health treatment, rehabilitation or prevention with follow-up health and human services; and
- the Geriatric Research, Education and Clinical Centers (GRECCs) which place an emphasis on knowledge transfer, quality clinical care and R&D in the VA system

Published papers from these two innovative US programs have been noted in the academic literature search, (Cordato et al. 2002). Additional innovative activities by the VA in the area of tele-health have also been described in the academic literature (Barnett et al. 2003).

Additional web-based information not specific to veterans

Beyond the search of veterans-specific sites the coverage was expanded to include home care in general. The search for relevant documents examined the following web-sites identified from the literature search, as listed in the table below:

Table 26 Other web-sites examined

Site	Web address
Agency for Healthcare Research and Quality (AHRQ)	http://www.ahrq.gov/
Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services, National Guidelines Clearinghouse	http://www.guideline.gov/
Ageing Research Online	http://www.aro.gov.au/
Amazon.com	http://www.amazon.com/
American Association of Retired Persons (AARP)	http://www.aarp.org/research/
Campbell Collaboration	http://www.campbellcollaboration.org/
Care Services Efficiency Delivery Programme (CSED)	http://www.csed.csip.org.uk/
National Institute for Health Research, Health Technology Assessment Programme (HTA)	http://www.hta.nhsweb.nhs.uk/
National Institute for Health and Clinical Excellence (NICE)	http://www.nice.org.uk/
New Zealand Guidelines Group	http://www.nzgg.org.nz/
RAND Corporation (a non-profit research and analysis institution)	http://www.rand.org/
Scottish Intercollegiate Guidelines Network (SIGN)	http://www.sign.ac.uk/
US Department of Health and Human Services, Administration on Aging (AoA)	http://www.aoa.gov/

Expanding the internet search to home care in general, it was found that Canada had the most detailed and relevant information on community based care available on the internet. Canada has developed, after a considerable period of consultation and development, a Home Care Reporting System (HCERS) using indicators of program effectiveness and quality, in order to enable comparison between the various provinces and territories.

http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=services_hcrs_e

The system is designed to be capable of producing reports on the following issues (with the first official reports expected to be made in September 2008):

- access to home care services;
- health and functional status measures;
- clinical outcomes and waiting times; quality of care;
- informal support; and
- service utilisation by setting and provider type.

This reporting system is based on the well-recognised comprehensive geriatric assessment known as the *interRAI*. The Canadians have also undertaken detailed cost-effectiveness work (see

<http://www.homecarestudy.com/overview/index.html>). Another recent expenditure study in Canada (Canadian Institute for Health Information, 2007) found that between 1994/95 and 2003/04 home health services (nursing care and health services) are taking up an increasing proportion of total home care services (home care services in the Canadian context include home health plus home support).

In terms of other, more general areas relevant to this work, a range of additional documents (mainly from the USA) on service delivery and innovative practice were found through the internet search.

The Agency for Healthcare Research and Quality (AHRQ) database outlines a useful technological project to promote information sharing amongst providers covering the community care sector (see <http://www.ahrq.gov/qual/etransitions/etransitions2.htm#web>).

Latest developments in policy advocacy for consumers are outlined in the American Association of Retired Persons (AARP) Re-imagining America (2006) document. In the area of home care, these include: the greater support of family carers (including financial and respite services); greater use of home and community care services rather than institutional care; greater use of consumer directed approaches; greater use of adult day care centres with transportation services provided; and the expanded use of volunteers. Additional areas of policy development are paying for performance in home care (rather than paying for services) and the increased use of technology or tele-health interventions (http://www.aarp.org/research/international/perspectives/oct_06_handy_LTC.html).

The Campbell Collaboration is an independent, international, non-profit organization that aims to provide decision-makers with evidence-based information for well-informed decisions about the effects of interventions in the social, behavioural and educational arenas. A Campbell Collaboration review of preventive home visits and their effect on functioning and mortality is currently underway. (http://www.campbellcollaboration.org/doc-pdf/Protocol_Home_Visits_FINAL.pdf)

Ageing Research Online provides a gateway to a range of very useful developing practice by describing ongoing studies as well as links to published studies. This provided a description of the work published by Lewin et al. (2006) reporting early insights from a study currently being run by the Silver Chain agency in WA into a program of early intervention for HACC eligible clients to maintain their functioning and promote health called 'Home Independence - A New Paradigm for Home Care.' (<http://www.aro.gov.au/aro/researchEntryView.do;jsessionid=IANDHEMGAONO?id=2621&type=keyword>)

The Department of Veterans' Affairs has recently joined the collaborative efforts of Ageing Research Online, aiming to post links to research associated with the veteran community/DVA covering directly commissioned research or research conducted by organisations which receive some DVA funding such as the Australian Centre for Posttraumatic Mental Health (ACPMH), and the Centre for Military and Veterans' Health (CMVH). <http://www.aro.gov.au/veteransresearch.html>

The management of home care services is different in the UK to in Australia, as it is described as 'social care' and mostly achieved through local government. A recent overview of services (Commission for Social Care Inspection, 2006) highlighted the innovative practice of services that offer an active component of 're-ablement':

“an approach that aims to restore people's capacity to do things for themselves rather than doing things for them.” (page 8).

The Care Services Efficiency Delivery Programme (CSED) provides links to innovative social care programs in the UK. It works collaboratively with all councils throughout England, supporting them to achieve 'sustainable efficiency' and improvements in adult social care. <http://www.csed.csip.org.uk/> One of the CSED work streams is on 'Homecare Re-ablement' work that seeks to improve choice and quality of life for adults who need care, maximise long-term independence by appropriately

minimising ongoing support required thereby minimising the whole life cost of care. There is useful link to a Retrospective Longitudinal Study (Version HRA 006: November 2007) described in the paper by Newbronner et al. (2007). <http://www.csed.csip.org.uk/silo/files/longit-study-bc.pdf>

A paper by Folkemer & Coleman (2006) for the American Association of Retired Persons (AARP) identified three quality projects involving person centred home care in the states of Wisconsin, Washington and South Carolina. These included developing an interview tool to investigate consumer outcomes (e.g. self-determination, privacy, satisfaction, safety); use of case management and comprehensive assessment; and the effective use of information technology.

Another policy development in the US is the need for the development of back-up services and systems when personal care services can not be provided on a particular day (e.g. personal hygiene, transfers from bed to a wheelchair, medications) (see the AARP brief http://assets.aarp.org/rgcenter/il/inb130_pcs.pdf)

Two recent reports from the US General Accounting Office (see <http://www.gao.gov/new.items/d04913.pdf> and <http://www.gao.gov/new.items/d02652t.pdf>) highlight poor measurement of the home care workload and the unevenness in the availability of home care services in the VA system. This is in the context of a nation-wide reorientation of long term care services away from institutional care with home care moving from 15% of the US Medicaid spending in 1992 to 37% in 2005 (see http://assets.aarp.org/rgcenter/il/fs132_hcbs.pdf) and a great deal of variability across states in home care service delivery on the ground (see <http://www.gao.gov/new.items/d021121.pdf>).

Lynn and Adamson (2003) for the RAND Corporation identified a series of trajectories of different illness types that imply different models of care. The key clinical issues for the geriatric population at risk for hospitalisation include: early detection, care coordination, and the integration of information; as well as the need for better targeting of health interventions for older people.

Finally, in Sweden, with its high expenditure on home care (0.82% of GDP) (OECD Health Project, 2005), there is still a need for better integration of services with health promotion and prevention; as well as a greater emphasis on maintaining functional abilities (see the comments on the Swedish experience by Dr. Britt Mari Hellner http://www.aarp.org/research/international/gra/gra_special_05/care_at_home.html).

These documents found on the internet support the general themes or trends identified by the investigation of the academic literature. These are the importance of assessment, of case management and coordination, of the integration of services and information systems, the need for rehabilitation and prevention programs to maintain functioning, the use of technology, the need for carer support services, on self-determination and the consumer direction of services, as well as the development of adult day care centres. Plus the new theme in home care service delivery of having adequate back-up systems in place.

The New Zealand Ministry of Health (2002) completed an international review of coordination and integration of services. This work provides a useful historical perspective of policy and practice developments in the aged carer sector – including the issues of integration, assessment and respite care.

Wainwright (2003), in a review of home care service development in the UK, Australia, Canada and the USA, came up with similar recommendations for New Zealand services. They include: better coordination and integration of services (including case management for complex cases); use of a minimum data set with expenditure information; use of a standard assessment tool; development of rehabilitation and carer support services; examination of the relationship between home care utilisation and hospital admission data; examination of health utilisation and cost effectiveness data – across the whole aged care sector; organisational integration; good information systems; incentives for GPs; development of disease management and prevention programs; and consideration of supportive housing options.

Wiener et al. (2004) in the US conducted a detailed literature review into home care services using it to develop a research agenda. In terms of the issues relevant to an Australian context, they found that there needs to be further empirical investigation into the role of home care services in reducing the total costs of long term care; and that new service approaches using technology, carer support and respite, and consumer self-direction need to be investigated.

Examination of these reviews shows that they support a number of themes identified earlier in the review. The paper by Wiener et al. (2004), in particular, brings out a further theme on the need for high quality studies into home care cost effectiveness.

In summary by examining the practice literature on the internet we found:

- Examining specific departmental web-sites, evidence was found on the effectiveness of a brokerage model in New Zealand and how the Veterans Independence Program (VIP) in Canada is evaluating itself by examining 'hard' performance data as outcome measures, like nursing home admissions.
- An examination of the wider practice literature found support for many of the themes identified in the academic literature, as well as a new theme (or policy driver) on the need for high quality studies into home care cost effectiveness (Wiener et al. 2004).

Review of the practice literature on service models and policy

This search was then extended to examine the practice literature on service models and policies in home care. Additional websites searched included:

Australia <http://www.health.gov.au/>
United Kingdom http://www.cpa.org.uk/sap/caf_more_about.html
<http://www.csed.csip.org.uk/>

These sites provide well-documented information on systems of home care including *The Way Forward* agenda and the *Review of Subsidies and Services* in the Australian context and the standardisation of common assessment processes and an interesting home care 're-ablement' approach in the UK.

Australian health and community care

The full literature on assessment methods will not be separately reviewed here, as useful summaries have been prepared under the work commissioned for *The Way Forward* focussed on targeting of services (Howe et. al. 2006) and screening and assessment tools (Samsa et. al. 2007). The key findings from the Australian assessment related work are that a common approach across programs is a complex but achievable task, and an important corollary to that finding is that the VHC program can share the benefits of adopting the common approach.

This conclusion is based on the assumptions that agreement has been reached on a typology of assessment, the usefulness of tiered and modular approach is also accepted, and the content of a data item pool to capture client characteristics is generally agreed upon. The remaining steps towards a common system that would allow client assessment data to be shared should be able to take place within a framework agreed by the various programs and jurisdictions, as the differences between the various related programs are minimal (Samsa et. al. 2007).

The paper by Howe et al. (2006) includes a literature review and makes useful distinctions based on "the various definitions of what 'provision of low to medium levels' of services could mean in practice. Low to medium levels of service could refer to one or a combination of:

- the number of services received;
- a distinction between clients receiving one service or more services;

- the frequency and/or duration of receipt of services;
- the complexity of the service, either a single service such as complex nursing care or a mix of services...

It is important to note that clients who received low levels of community care services were not necessarily low dependency clients. The literature showed that very few clients using community care had 'low dependency'; most were in the middle range of dependency and many were highly dependent." (p. 29)

Howe et al. (2006) in a report for the Australian community care review process concluded that the academic literature provided evidence of the effectiveness of specific, low to moderate intensity and short-term interventions in restoring client functioning and thereby assisting them to remain in the community. However these are not services provided by VHC. "Specific allied health interventions were among those for which there was strong evidence of positive outcomes. The implications arising concern the place of allied health and related therapy services in HACC and support the development of more active interventions to support client independence. An associated implication of the findings of use of aids and equipment, without or with personal care, is that greater recognition needs to be given to the benefits of these supports." (p. 6)

Submissions to the Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs

In September 2006, the Minister for Ageing announced the Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs to complement The Way Forward and specifically examine the structure and funding arrangements for Australian Government funded community aged care programs.

Fifty-two organisations in total provided submissions. These were reviewed and comments and recommendations relevant to the Veterans' Home Care program were extracted from the Department's website (http://www.health.gov.au/internet/wcms/publishing.nsf/content/ageing-reviews-submissions_received.htm Accessed 17/07/2007). The key relevant recommendations are summarised at Table 30.

Although the questions that were posed related to DOHA funded programs such as HACC and packaged care, the recommendations have relevance for VHC. The submissions to the *Review* in the main pointed to the tendency of new programs to create service gaps and overlaps and excessive administrative complexity particularly around the HACC, CACP, EACH and Veterans' Health Care programs. VHC respite, NRCP and residential respite were mentioned as programs where in theory, each program has its own discrete role and the aim is to provide separate but complementary respite services, yet the resulting complexity of guidelines and eligibility criteria pose problems for clients and their carers.

The submissions indicate that the integration of programs and local services remains a paramount concern to the community care sector including VHC providers. The variation in access to services provided under the various program types is significant and clients and their carers may receive an amount of care that is not commensurate with their levels of need. The submissions did not identify any efficient or effective way to reform the community care system to ensure that the clients of all types of programs will benefit in a consistent and equitable way.

Any reform will make different impacts across the programs, and for those veterans who generally perceive they have an entitlement to a high level of service provision, a move towards greater uniformity and equity across the whole system may involve a change in expectations.

The submissions to the Review of Subsidies and Services consistently noted that the provision of 'basic' services is not the same as a client having basic needs, as basic services are commonly

needed and used by those clients of greater complexity and have to be part of a more complex service response.

The UK approach to common assessment in health and social care

The UK White Paper, 'Our Health, Our Care, Our Say' (January 2006) proposed an essentially similar development pathway with its Common Assessment Framework for Adults to be developed primarily from the experience to date from implementing a range of programs for the frail aged, and people with disabilities, including mental health. The aim of adopting a common framework was "to remove the artificial boundary of 'older age', and provide continuity of a person centred approach throughout adult life, geared towards self-determination and planning for independence." (http://www.cpa.org.uk/sap/caf_more_about.html)

In the UK, the Framework and the Single Assessment Process is increasingly being used for other adult groups as well as older people, and many regions now apply the principles when delivering care to everyone over 18 years of age. National policy documents are promoting the process as a model for a Comprehensive Assessment Framework to deliver person centred care.

The step beyond assessment to organise an effective service response is where in practice there is a lesser level of agreement. In a rational approach to health and social care, it is important to know what are the effective 'treatments' or interventions in an area, but the literature synthesis reveals that there is very little available to guide practice in community care.

A relevant example of a strongly empirical approach in the UK is the Care Services Efficiency Delivery (CSED) program. In January 2007, CSED published a discussion document that brought together a body of evidence about the benefits of homecare 're-ablement schemes'. <http://www.csed.csip.org.uk/silo/files/longit-study-bc.pdf> Through a range of case studies and further information from schemes in operation, it became clear that significant benefits could be derived for users, in terms of improving their level of independence. There were also benefits for councils with social service responsibilities through an appropriate reduction in the number of commissioned care hours required. An evaluation study showed that, on average, a 28% reduction in commissioned hours had been achieved by those undergoing a phase of re-ablement when compared to a control group that had not.¹²

This gap in the evidence is attributable to the nature of the community care sector in Australia, including its focus on data collection which is mainly descriptive without sufficient analysis of what those data can reveal. The recent history reveals the lack of agreed outcome measurement tools and (with a few notable exceptions), a reliance on many one-off 'consultancy' type studies, and an under-emphasis on building an empirical research 'culture' (Stevermuer 2007 p.592). This is consistent with the international literature findings which emphasise how difficult it has been (again with a few notable exceptions e.g. Fries et al 2002, Weissert et al 2003, Leutz 2005) to attain sufficient control of variation and sufficiently large data bases in community care settings in order to carry out the more rigorous studies that are needed to build up a reliable basis in evidence.

Practice and academic literature on service models for the prevention and avoidance of hospitalisation

"The concepts "avoidable hospitalisations" and "avoidable mortality" have been proposed as a way of identifying hospital admissions and premature mortality that could potentially be prevented by timely and effective health interventions." (Sheerin et al 2006). This quote comes from a study of avoidable admissions reported from Christchurch New Zealand where a retrospective look at hospital admissions for older people concluded that:

"potentially "avoidable hospitalisations" to Christchurch Hospital comprised 31% of all hospital admissions."

¹² Homecare Re-ablement: Retrospective Longitudinal Study Version HRA 006: November 2007

The New Zealand authors described their target group in diagnostic terms:

“The majority of potentially “avoidable hospitalisations” involve conditions that could have been identified and treated earlier by either public health or primary healthcare interventions, thereby preventing deterioration that may involve a hospital admission or even death. Examples include lung disease; cervical and breast cancer; traffic accidents; infectious, cardiovascular, and vaccine preventable diseases; early detection and excision of melanoma; and effective glycaemic control in people with diabetes.” (Sheerin et al 2006).

The assumptions behind the conclusions were that the conditions could have been identified in real time and that these conditions could have been treated earlier by either public health or primary healthcare interventions. Early detection is the key concept, and after early detection, timely and relevant interventions of a medical/clinical or community/social type (or a combination of both) were assumed to be available and capable of being organised in support of the prevention effort.

The biggest challenge in any study of preventing “avoidable hospitalisations” (and VHC is a prime example of program with this aim) is in integrating the information on the effectiveness of community care service interventions and client outcomes sufficiently well so to make attribution possible in a highly complex environment with clients with complex, chronic and co-morbid conditions (this issue is discussed further below).

The international literature on hospital-based geriatric assessment was described in the work done by Cordato et al (2005) to support the Working Group on Care of Older People in NSW Health Care System and build the Framework for integrated support and management of older people in the NSW health care system 2004-2006. It provides important background lessons and useful information from the hospital viewpoint, but covers few of the research areas relevant to the community perspective required to understand the impact of the VHC program.

The areas that are emphasised in the present Review include the common mechanisms to promote integrated care, the existing evidence on the effectiveness of community care interventions, with a focus on interpreting the results in the context the overall VHC Review.

Johri et al. (2003) conducted a systematic review of recent demonstration projects testing innovative models of care for the elderly in OECD countries. They noted that:

“To date, the only reform initiatives that have been successfully implemented on a large scale are single-entry point systems with geriatric assessment and case-management, in publicly funded systems of care.” (p. 234),

McCusker and Verdon (2006) looked at the question of preventing emergency department (ED) admissions by geriatric interventions. It is a recent summary paper of relevance for VHC as it looked at emergency department impacts of geriatric interventions and concluded the locus of care was important but the level of evidence was still an issue. They found

“Hospital-based interventions (mostly short-term assessment and / or liaison) had little overall effect on ED utilisation, whereas many interventions in outpatient and / or primary care or home care settings (including geriatric assessment and management and case management) reduce ED utilisation. Heterogeneity in study methods, measures of comorbidity, functional status and ED utilization precluded meta-analysis of the results.” (Abstract)

Kumar and Grimmer-Somers (2007) conducted a re-examination of general hospital avoidance and discharge planning strategies and also emphasise the issue of the level of evidence in community care settings when saying:

“There is only limited evidence on interventions such as GP collocations, specialist outreach clinics and provision of primary care in the community as an alternative to hospital care. This evidence is derived from methodologically poor publications and hence results of these publications should be considered with caution.” (p. 46)

When the focus of investigation in community care settings is not directly on outcomes such as hospital admissions, the evidence on the effectiveness of different interventions is stronger. The factors affecting the outcome of community care service interventions were investigated over a decade ago in a relevant literature review by Fine and Thomson in 1995 for the (then) Commonwealth Department of Human Services and Health (Fine and Thomson, 1995). Their focus (like Johri et al. 2003) was on the large scale trials of the effectiveness of community care, especially case management, in the US, the UK and Europe.

“One of the few consistent findings is that low levels of standardised services for people with complex or high levels of need are relatively ineffective. Case management was a favoured approach to service provision, but a number of studies indicated concern at the high costs associated with it and questioned whether it was a necessary element in the organisation of services for most recipients.” (Fine and Thomson, 1995, p.34)

Specific evaluation studies of more medically focussed programs have reached similar conclusions to the more broad ranging reviews of community care. The ‘Keep Well at Home Project’ as described by Walker and Jamrozik, (2005) was a general practice based two-phase screening and intervention program aimed at persons aged 75 years or older who were ‘at risk’ of medical emergencies. The authors concluded it

“has failed to achieve one of its key aims: a reduction in emergency admissions to hospital among patients aged 75 years or more ... This study showed that, despite being mandated by official policy, systematic screening of community-dwelling, elderly people for disability, coupled with provision of additional health and social care services did not reduce emergency attendances at, or admission to, hospital in one London PCT (Primary Care Trust). A randomised controlled trial in Australia recently reported a similar result in relation specifically to admissions to hospital”.

In describing their findings of the UK study, the authors made reference to work on the impact of health assessments on veterans and war widows by Byles et al, (2004). The dependent variable in that study was admission to institutions and the analysis did not include information on the outcomes of subsequent interventions. The study used 3-year follow-up interviews for 1031 participants and found:

“no significant difference in the probability of hospital admission or death between intervention and control groups over the study period. Significantly more participants in the intervention group were admitted to nursing homes compared with the control group.” (p. 186, Abstract)

It is clear that assessment per se is insufficient to achieve outcomes for clients. Work by the New Zealand Guidelines Group (2003) looked beyond health assessment towards the system changes that can make an impact on the depth of assessment. That body of work provided more detailed evidence based recommendations for assessment processes for elderly people, including chapters on the location of assessment, assessor skills and support, and working together.

Even where the study methods included more depth of investigation on the consequences of the assessment, there is still no clear evidence of differential benefits for those receiving follow-up interventions or fewer admissions. Fletcher et al. (2004) in their large, multi-centre, general practice trial in the United Kingdom found:

“no benefit of an intensive in-depth assessment on mortality or admissions compared with a targeted approach, irrespective of whether the in-depth assessment was followed by clinical examination by a hospital-based geriatric team or usual primary care.” (p. 1675)

These papers and the study by Wenger et al (2003) highlight the caution involved with any expectation that any one component, or even the combinations of the elements of the VHC Program, can bring about the changes required to make an effective and cost-effective impact at the level of the hospital system.

Changes in community care assessment and support services outside the hospital are where the most gains can be expected to be made, but due to the complexity of these systems, these gains

cannot be easily measured or shown to be achieved in the amount of time and with the span of control within which VHC has been operating.

These summary papers highlight the research / evidence gaps in the community care literature and suggest that “proving” the effectiveness of the VHC program requires quite sophisticated systems for detecting, assessing, and monitoring the functional status and outcomes for the clients in community settings. While VHC is not aiming to be an integrated community care program for the elderly, and does not seek to be explicitly aimed at avoiding hospital admissions, these aims are broadly conceived to be part of its ‘preventive’ function. The current evidence base suggests that any longer term aim of bringing potentially effective elements together into a coherent program, with a focus on avoiding institutional forms of care, and doing that from a community care perspective, is a goal that is yet to be achieved elsewhere.

The complexity of the issues around integration with community care, merging health and social care, and the related information technology questions that remain open to further work, all are well understood in the literature and suggest the initial business case arguments were sound.

However the organisational and policy issues for integrating health and social/community care are the main barriers to implementation and these are outside the span of control of any one program. In this context the best that can be expected of the VHC Program is that it can highlight where these barriers still exist, make some measurable marginal gains and establish some useful pre-conditions for a more systematic approach to be used at its next stage of development.

Academic and practice literature on finding the right clients for home care interventions

The academic and practice literature on finding the right clients for the program, prioritising their level of need and matching service responses to meet their needs is covered next. This literature addresses one of the key questions for community care programs like VHC; how best to ‘target’ the clients who will benefit most, depending on the goal of the program.

The search found there is relatively little empirical evidence or at least limited evidence regarding the best means of targeting, early detection and formulating interventions to achieve the optimal outcomes of programs like VHC which are targeted at ‘basic’ care needs.

These issues are addressed by a major paper in the literature by Stuck et al. (2002). The two questions are: do you target interventions to the “old-old” or “young-old”; and given the age cohort selected, what is the target for the interventions - functional decline or mortality?

The literature / evidence base for preventive, multi-disciplinary assessment and home visitation programs suggest you need to “target those persons at a low risk for death and those who are relatively young” (Stuck et al. 2002, p.1027). This meta-analysis also supports the idea that the clients’ needs have to be matched by the goal of care, expressed as:

“the notion that different processes of care are important in mortality and functional status outcomes.” (p.1027).

The ability to assess people in the context of their home environment to appraise their needs and risks and potential for improvement is a key to formulating a service response to meet their needs. Some very useful work by Weissert et al. (2003) was based a series of studies of home care clients in Michigan in the US. This approach is described below as an example of an approach that goes beyond the methods commonly used in community care in Australia, which are based mainly on targeting via broad eligibility criteria (Howe et al 2006).

A more rigorous approach to understanding the variability in the client population is generally recommended by the international literature. Fries et al. (2002) point out that home and community based services “do not identify accurately the appropriate population to be served”, and that screening systems “all were developed in-house through non-empirical means and adjusted over time to reflect changing policy goals.” (p.463)

Screening should be designed in terms of the goal of care, level of dependency and the presence or absence of key risks such as carer status, psychosocial problems, presence or absence of wounds, and environmental factors. More of the variation in care should be explained by client characteristics rather than by the characteristics of the program from which the person happens to be receiving their care. (Weissert et al. 2003, p.121)

The lesson from this literature is that targeting the VHC Program to the right people is extremely important, but doing so means looking to the longer term redesign of systems, rather than expecting that this is easy to achieve within one program. These “targeting” issues are expressed in the discussions around eligibility in the policy context of the Australian Government’s agenda in *The Way Forward* (Australian Government 2004). It means selecting people who are not too sick such as they do in fact already need hospitalisation, and not too well in that they have relatively low levels of need and risks that may not warrant a service response.

There are indications from recent work under the Council of Australian Governments (COAG) agenda and *The Way Forward*, on standardising assessment in the community care sector that suggests that the means of building a classification approach are at hand. Those who can benefit from prevention activities can be reliably detected, and assessed in a way that generates a goal of care and the start of a care plan. The main limitation is that the Australian Community Care Needs Assessment (ACCNA) (Samsa et al. 2007) is necessarily for those accessing community care or already in the community care system, so does not reach those who are socially isolated and not in touch with services. However it does provide a way of assigning a priority to those who enter the community care system.

Many standardised community care assessment tools do not go beyond measuring disability to give a basis for care planning and referral to a range of services that may prevent subsequent hospitalisations, including more in-depth assessment. That level of functionality requires a level of ‘interoperability’ of information (Walker et al. 2005) that is yet to be achieved in routine practice in community care in Australia, where information systems are still mainly paper-based.

This work by Samsa et al. (2007) and related work on *A National Approach to Assessing the Needs of Carers* by Ramsay et al. (2007), both on a common pool of data elements and electronic information transfer is not yet published but is being used as the basis for further development work under *The Way Forward*. It is based on a requirement of COAG to achieve a national version of the type of tool represented by the Queensland ONI, i.e. a broad but shallow assessment of need that can be shared across programs in an electronic format and help assign a priority for interventions (Owen et al. 2004). This national work is still some distance from achieving the levels of interoperability assumed to be most useful to the VHC Program in its future development.

The ACCNA and carers field testing showed it was possible to detect new and existing community care clients who were identified by the assessor as likely to benefit from rehabilitation. Just over four out of ten (42.5%) clients assessed were triggered for a rehabilitation assessment on the tool. The assessment trigger corresponded well with those considered by the assessor likely to benefit from rehabilitation (99.4% v 0.4%) (Samsa et al. 2007).

Given that over 40% of those assessed were identified as having the potential to become more independent, these results suggest that there is considerable scope to review current community care policies to give increasing attention to early intervention services for people to prevent ‘avoidable hospitalisations’ and to select those meeting the current (and future) criteria for VHC service responses. As experience from related programs indicates, investment in training to support the use of reliable tools in community care assessment systems would be a pre-requisite for the effectiveness of such an approach.

Table 27 Description and evidence rating for practice literature on prevention and hospital avoidance

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Aminzadeh F and Dalziel WB (2002) <i>Older adults in the Emergency Department: A systematic review of patterns of use, adverse outcomes, and effectiveness of interventions.</i> <u>Annals of Emergency Medicine</u> . Vol. 39, pp.238 - 247.	Emergency Department attendances	65 years plus	Well-supported practice	Reduce emergency admissions through screening / assessment + discharge planning. Not targeted to those at risk of hospitalisation
Australian Government (2004) <i>A New Strategy for Community Care The Way Forward.</i> Department of Health and Ageing.	Models are described	Frail older people and people with disabilities	Promising practice	Home Visiting + Screening / Assessment. Not targeted to those at risk of hospitalisation
Bergman H, Beland F, Lebel P, et al. 1997. <i>Care for Canada's frail elderly population: fragmentation or integration?</i> <u>Canadian Medical Association Journal</u> 157: 1116-1121. (Quoted in Johri et al, 2003)	Models are described	Frail older people	Promising practice	Commentary on the difficulties of achieving integration. Not targeted to those at risk of hospitalisation
Byles, J. E. (2000). <i>A thorough going over: Evidence for health assessment for older persons.</i> <u>Australian and New Zealand Journal of Public Health</u> , 24(2), 117-123.	Models are described	65 years plus	Promising practice	Literature review of health assessments for older people living in the community Not targeted to those at risk of hospitalisation
Byles JE, Tavener M, O'Connell RL, et al (2004) <i>Randomised controlled trial of health assessment for older Australian veterans and war widows.</i> <u>Medical Journal of Australia</u> . Vol. 181, No.4, pp.186 - 190.	Models of screening and assessment are described	70 years plus	Well-supported practice	Controlled study into Screening / Assessment of veterans and war widows Not targeted to those at risk of hospitalisation. No significant difference in the probability of hospital admission or death between intervention and control groups
Capewell, S., 1996. 'The continuing rise in emergency admissions', <u>British Medical Journal</u> , 312: 991-2.	Models are described	People at risk of hospitalisation	Promising practice	Editorial on increasing emergency admissions in UK
Centre for Health Service Development (2000) <i>The Illawarra Coordinated Care Trial Model of Care: defining consumer needs, community care interventions and care packages.</i> University of Wollongong	Models are described	Older people	Promising practice	Describes a methodology for classification and costing of packages of care for frail older people, using routinely collected data items.
Cordato, N, Saha, S and Price, M. (2005) <i>Geriatric interventions: the evidence base for comprehensive health care services for older people.</i> <u>Australian Health Review</u> May 2005 Vol 29, No 2 151-155.	Models are described	Older people	Well-supported practice	Based on a literature review for the Working Group on Care of Older People in NSW Health Care System in September 2002.
Dickinson A (2006) <i>Implementing the Single Assessment Process: Opportunities and challenges.</i> <u>Journal of Interprofessional Care</u> . Vol. 20, No.4, pp.365 - 379.	Models are described	65 years plus	Promising practice	Qualitative study into introduction of single assessment process in UK Discusses implementation issues
Dudgeon, D., Knott, C., Viola, R., Van Dijk, J. P., Preston, S., Eichholtz, M., Batchelor, D., Chapman, C. and Bartfay, E., 2004. <i>Managing continuity through collaborative care plans: a study of palliative care</i>	Models are described	Palliative care clients at risk of hospitalisation	Supported practice	Integration project for people with palliative care, focus on case management Not specifically targeting people 65 and over

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
<i>patients</i> , Canadian Health Services Research Foundation				
Eagar K, Owen A, Marosszky N and Poulos R (2006) <i>Towards a measure of function for Home and Community Care Services in Australia: Part 1 – Development of a standard national approach</i> . <u>Australian Journal of Primary Health</u> . Vol.12, No.1, pp.73-81.	Development of standardised tools	Frail older people and people with disabilities	Promising practice	Outline of functional screening / assessment and its use in early detection.
Fatovich, D. M., Nagree, Y., and Sprivilis, P., 2005. 'Access block causes emergency department overcrowding and ambulance diversion in Perth, Western Australia', <u>Emergency Medicine Journal</u> , 22: 352- 354.	ED presentations	People at risk of hospitalisation	Promising practice	Retrospective analysis of ED admissions
Fatovich, D. M. and Hirsch R. L., 2003. 'Entry overload, emergency department overcrowding and ambulance bypass', <u>Emergency Medicine Journal</u> , 20:406-409.	ED presentations	People at risk of hospitalisation	Promising practice	Study into ED admissions and ambulance bypass (prospective and observational)
Fine, M and Thomson C (1995) <i>Factors affecting the outcome of community care service intervention: a literature review</i> . <u>Aged and Community Care Service Development and Evaluation Reports No. 20</u> . Department of Human Services and Health, Aged and Community Care Division. AGPS, Canberra, October 1995.	Models are described	Frail older people and people with disabilities	Well-supported practice	Historical review of case management trials in international literature
Fletcher AE, Price GM, Ng ESW, et al (2004) <i>Population-based multidimensional assessment of older people in UK general practice: A cluster-randomised factorial trial</i> . <u>The Lancet</u> . Vol. 364, pp.1667 - 1677.	Hospital and nursing home admissions.	75 years plus	Well-supported practice	Cluster randomised trial comparing universal and targeted assessment procedures (with management). Groups did not differ in mortality or hospital/nursing home admissions.
Florio ER, Rockwood TH, Hendryx MS, et al (1996) <i>A model gatekeeper program to find the at-risk elderly</i> . <u>Journal of Case Management</u> . Vol. 5, pp.106 - 114.	Models are described	65 years plus	Well-supported practice	Study describes an innovative approach to tackle social isolation using community workers eg, bank clerks and postal workers.
Godfrey, M., Townsend, J. and Denby, T. (2004). <i>Building a good life for older people in local communities: the experience of ageing in time and place</i> , The Joseph Rowntree Foundation.	Models are described	65 years plus	Promising practice	Descriptive study of older people living in the community and their quality of life
Green J, Eagar K, Owen A, Gordon R and Quinsey K (2006) <i>Towards a measure of function for Home and Community Care Services in Australia: Part 2 – Evaluation of the screening tool and assessment instruments</i> . <u>Australian Journal of Primary Health</u> . Vol.12, No.1, pp.82-88.	Development of standardised tools	Frail older people and people with disabilities	Promising practice	Outline of functional screening / assessment and its use in early detection, with data on how the items performed in field testing.
Gruen RL, Weeramanthri TS, Knight SE, et al (2003) <i>Specialist outreach</i>	Models are described	All ages	Well-supported	Cochrane review into specialist outreach clinics / primary care in community. Little

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
<i>clinics in primary care and rural hospital settings. Cochrane Database of Systematic Reviews. CD003798.</i>			practice	benefit found for urban non-disadvantaged communities.
Johri M, Beland F and Bergman H (2003) <i>International experiments in integrated care for the elderly: A synthesis of the evidence. International Journal of Geriatric Psychiatry. Vol. 18, pp.222-235.</i>	Models are described	65 years plus	Well-supported practice	Review of demonstration projects into integrated care. Evidence base for screening / assessment and case management
Kumar S and Grimmer-Somers K (2007) <i>A synthesis of the secondary literature on effectiveness of hospital avoidance and discharge programs. Australian Health Review. Vol. 31, No.1, pp.34 - 49.</i>	ED presentations	All ages	Well-supported practice	Review of hospital avoidance and discharge planning, with some comments on specialist outreach clinics / primary care in community. Methodological problems with most hospital avoidance studies found. Not specifically targeting older people.
Leutz W. (1999) <i>Five laws for integrating medical and social services: lessons from the United States and the United Kingdom. Milbank Quarterly: 77; 77-110.</i>	Models are described	NA	Promising practice	Review of lessons from trials to improve integration.
Lynn J and Adamson DM (2003) <i>Living Well at the End of Life: Adapting Health Care to Serious Chronic Illness in Old Age. Rand Health, Rand Corporation, Santa Monica</i>	Models are described	People with chronic disease	Well-supported practice	Rand Review of evidence on management of serious chronic illness at end of life stage. Advocates targeting of services to match severity and need.
Lowenstein S. R., Crencenzi, C. A., Kern, D. C. and Steel, K., 1986. 'Care of the elderly in the emergency department', <i>Annals of Emergency Medicine</i> , 15 (5): 528-535.	ED presentations	65 years plus	Supported practice	Study examining emergency admissions for older people (prospective).
McCusker J and Verdon J (2006) <i>Do geriatric interventions reduce Emergency Department visits? A systematic review. Journals of Gerontology. Vol. 61A, Issue 1, pp.53-62.</i>	ED presentations	65 years plus	Well-supported practice	Systematic review of screening / assessment and case Management. Reviews effects of innovative geriatric interventions on ED visits. However, when further examined, the evidence is weak for people at risk of ED presentations.
National Health Strategy (1991) <i>The Australian Health Jigsaw. Integration of Health Care Delivery. National Health Strategy Issues Paper No. 1, July 1991</i>	Models are described	All ages	Promising practice	Issues paper demonstrating long history of national moves to improve integration issues in community care
New Zealand Guidelines Group (2003) <i>Best Practice Evidence-Based Guideline - Assessment processes for older people. New Zealand Guidelines Group.</i>	Models are described	65 years plus	Well-supported practice	Evidence based report into screening / assessment framework including care planning and process guidelines
NHS Institute for Innovation and Improvement (2006) <i>Delivering Quality and Value. Focus on: Frail Older People</i>	Models are described	Frail Older people	Promising practice	UK Policy Framework includes discussion of 'intermediate care' – such as rapid response, single entry point, multi-disciplinary, case management etc. Focus on one condition (UTI) as an example.
NSW Health (2002) <i>Framework for integrated support and management of older people in the NSW health care system 2004-2006.</i>	Models are described	65 years plus	Promising practice	Contains a set of standards and a literature review for the Working Group on Care of Older People in NSW Health Care System in September 2002.

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
NSW Health (2006) <i>Clinical Services Redesign Program: Model of Care for ComPacks</i> . NSW Health.	Models are described	Frail older people and people with disabilities	Promising practice	Outlines model of care including Discharge Planning and care coordination model
Owen, A, Ramsay, L., Holt, N, Eagar, K (2004) <i>Ongoing Needs Assessment in Queensland Community Care: Why Use the Tier 1 Screening and Referral Tools -Evidence and Explanations</i> . Centre for Health Service Development, University of Wollongong	Development of standardised tools	Frail older people and people with disabilities	Promising practice	Report on screening / assessment tools for use in referral systems with implementation in Qld. Includes literature review
Perkins D, Owen A, Cromwell D, Adamson L, Eagar K, Quinsey K and Green J (2001). <i>The Illawarra Coordinated Care Trial: better outcomes with existing resources?</i> <u>Australian Health Review</u> , Vol 24, No 2, 163-173, 2001.	Mix of standardised tools	Frail older people	Well-supported practice	Assessment, case management and integrated community care. Not targeting people at risk of ED presentation Intervention group cost more than control group and went to residential care at a higher rate
Ramsay L et al (2007) <i>A National Approach to Assessing the Needs of Carers</i> . Centre for Health Service Development, University of Wollongong.	Development of standardised tools	Frail older people and people with disabilities	Promising practice	Report on screening / assessment, care planning, early detection and referral systems to meet the needs of carers Not targeting people at risk of ED presentation
Rockwood, K., 2002. 'Future of health care for frail older adults', <u>Geriatrics Today</u> , 5(56): 5-6.	Models are described	Frail older people	Promising practice	Editorial into impact of frailty on emergency admissions Not targeting people at risk of ED presentation
Rosenfeld, T., Thomas, M., Robertson, H., Basser, M., Abraham, K., Broe, T., Collings, A. and Singer, A., 2003. <i>Survey of Pre-Acute Care of Older People – Final Report</i> . Department of Geriatric Medicine, Community Health and Aged Care, Prince of Wales Hospital, South East Sydney Area Health Service.	ED presentations	75 years plus	Promising practice	Retrospective study of emergency admissions to identify potential service options to reduce unnecessary ED presentations.
Samsa P et al (2007) <i>The Australian Community Care Needs Assessment (ACCNA): towards a national standard</i> . Centre for Health Service Development, University of Wollongong.	Development of standardised tools	Frail older people and people with disabilities	Promising practice	Report on screening / assessment, care planning, early detection and referral systems to meet the needs of carer recipients Not targeting people at risk of ED presentation
Sanders MR and Morawska A (2006) <i>Towards a public health approach to parenting</i> . <u>The Psychologist</u> . Vol. 19, No. 8, pp. 476-479.	Methods paper	NA	Promising practice	Commentary on evidence categorisation method
Sheerin I, Allen G, Henare M, and Craig K, (2006) <i>Avoidable hospitalisations: potential for primary and public health initiatives in Canterbury, New Zealand</i> . <u>The New Zealand Medical Journal</u> Vol.119, No.1236/2029.	ED presentations	All ages	Promising practice	Retrospective case review of avoidable hospitalisations using DRGs. Focus on disease-base, rather than age-specific.
Stathers, G. M., Delpech, V. and Raftos, J. R., 1992. 'Factors	ED presentation	65 years plus	Promising	Reviews of emergency admissions in Sutherland area. Retrospective and

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
<i>influencing the presentation and care of the elderly people in the Emergency Department</i> , <u>Medical Journal of Australia</u> , 156: 197-200, 1992.	s		practice	prospective.
Stuck AE, Egger M, Hammer A, et al (2002) <i>Home visits to prevent Nursing Home admission and functional decline in elderly people</i> . <u>JAMA</u> . Vol. 287, pp.1022 - 1028.	Resi care admissions	65 years plus	Well-supported practice	Meta-analysis of home visiting and screening / assessment for older people. Examining functional decline and nursing home admission reduction.
Temlett, J. and Thompson, P., 2006. <i>'Reasons for admission to hospital for Parkinson's Disease'</i> , <u>Internal Medicine Journal</u> , 36(2006): 524-526.	ED admissions	People with Parkinson's disease	Supported practice	Review of hospital admissions of people with Parkinson's Disease. Retrospectively suggests presentations are potentially avoidable with better planning of management in the outpatient and community setting.
Thomas, F., 1999. <i>'Ambulatory and Community-Based Services'</i> , <u>Health Care Financing Review</u> , 20(4): 1-6.	Models are described	65 years plus	Promising practice	Editorial on case management and discharge planning projects in US.
Tulloch A. J., 2005. <i>'Effectiveness of preventive care programmes in the elderly'</i> , <u>Age and Ageing</u> , 34: 203-204.	Models are described	75 years plus	Promising practice	Editorial with useful advice re implementation of preventive programs for older people. Not targeting people at risk of ED presentation
Ustun TB (2000) <i>Unmet need for management of mental disorders in primary care</i> . In Andrews G, Henderson S (Eds) <u>Unmet need in psychiatry: Problems, resources, responses</u> . Cambridge: Cambridge University Press.	Models are described	NA	Promising practice	Useful opinion piece on the measurement of unmet needs (theoretical basis).
Walker J et al (2005) <i>The Value of Health Care Information Exchange and Interoperability</i> <u>Health Affairs</u> 19 January, 2005.	Models are described	NA	Promising practice	Expert opinion on possible savings due to improved interoperability.
Walker L and Jamrozik K (2005) <i>Effectiveness of screening for risk of medical emergencies in the elderly</i> . <u>Age and Ageing</u> . Vol. 34, pp.238 - 242.	ED admissions	75 years plus at risk of ED presentation	Well-supported practice	Study into screening / assessment and home visiting which found no impact on emergency department admissions.
Walters K, Iliffe S and Orrell M (2001) <i>An exploration of help-seeking behaviour in older people with unmet needs</i> . <u>Family Practice</u> . Vol. 18, pp.277 - 282.	Models are described	65 years plus	Views of clients and carers	Qualitative study exploring the theme of help-seeking behaviour and impact of social isolation. Not targeting people at risk of ED presentation
Walters K, Iliffe S, Orrell M, et al (2004) <i>The CANE in primary care settings: Its feasibility and utility as a research and clinical tool</i> . In Orrell M, Hancock G (Eds) <u>CANE: Camberwell assessment of need for the elderly</u> . London: Royal College of Psychiatry	Models are described	65 years plus	Views of clients and carers	Comment on qualitative study exploring the theme of help-seeking behaviour and impact of social isolation. Not targeting people at risk of ED presentation
Weissert W, Chernew M and Hirth R (2003) <i>Titrating versus targeting home care services to frail elderly clients</i> . <u>Journal of Aging and Health</u> . Vol. 15, No.1, pp.99-123.	Models are described	Frail older people	Well-supported practice	Policy article advocating the need for better targeting of home care services Not targeting people at risk of ED presentation

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Wenger, N. S., Solomon, D. H., Roth, C. P., et al (2003). 'The quality of care provided to vulnerable community-dwelling older patients', <i>Annals of Internal Medicine</i> , 139: 740-747.	Models are described	65 years plus	Views of clients and carers	Rand study designed to develop quality benchmarks for the care of vulnerable community dwelling older patients. Not targeting people at risk of ED presentation.
Yarmo-Roberts D and Stoelwinder J (2006) <i>Untangling the web: The need to clarify care co-ordinating models for people with chronic and complex conditions</i> . <i>Aust N Z J Public Health</i> . Vol. 30, pp.413 - 415.	Models are described	NA	Views of clients and carers	Useful typology for case management approaches.

Conclusions on strategies for the prevention and avoidance of hospitalisation

The findings on the value of comprehensive assessment and care plans coordinated on the basis of that broad assessment are reinforced by examination of the literature on programs for frail elderly people living in the community and at risk of hospitalisation.

This section of the literature review is best summarised by the key work by Johri et al. (2003) who conducted a systematic review into recent demonstration projects testing innovative models of care for the elderly in OECD countries. One of their main findings was that. "To date, the only reform initiatives that have been successfully implemented on a large scale are single-entry point systems with geriatric assessment and case-management, in publicly funded systems of care." (p. 234). The review went on to outline a number of common mechanisms to promote integrated care for the elderly:

- Single point of entry
- Breadth of service provision
- Degree of responsibility for patient
- Case management
- Geriatric services
- Multidisciplinary team
- Financing mechanisms
- Physician integration and patient choice

Additional issues that were examined in this part of the literature review included: hospital avoidance and discharge planning strategies; assessment guidelines; and coordinated care models.

This part of the literature review emphasised major barriers in terms of organisational and policy issues, and the complexity of the out of hospital care environment. The operational aspects of successful services that bring health and community care together and prevent further deterioration that may warrant hospitalisations are:

- Be client focussed rather than focussed on a narrow range of service types
- Go beyond a maintenance function to enable the client to be at home and independent
- Develop service support systems that are easy to access and provide timely and responsive care
- Be flexible in providing care as it is essential the care fits the client's needs and these change over time

- Be visible in local settings to raise awareness and educate the local community about the services available
- Provide seamless transition mechanisms into the range of community and extended support services.

In summary, the search strategies found the following conclusions on effective interventions in home care to be applicable to Australian veterans:

- The scientific evidence base on respite care needs to be improved in order to derive reliable guidelines with regard to care practices (Mason et al. 2007, Ingleton et al. 2003).
- There is a lack of specific service information on domestic assistance services, personal care services, and home and garden maintenance services available in the literature. This information is commonly subsumed into health or other social support interventions and care packages.
- Evidence was found which supported the targeted use of preventative health visits for the elderly.
- A brief review of identified high quality papers on care packages found the following key concepts described:
 - effectiveness is usually associated with service intensity, and the training of other providers in the community, assessment and monitoring, care planning and management;
 - effectiveness is usually associated with the use of multi-disciplinary teams (that include nursing and allied health components), care coordination and ongoing client evaluation;
 - effectiveness is usually associated with regular home visiting, telephone contact, supply of equipment and transport, and facilitated referral to other providers and volunteer agencies, as well as respite services.

Additional review papers on other DVA services available to Veterans' Home Care clients were found. Three major trends were noted from the literature into home care services:

- the use of technology to improve health care delivery;
- the rise of programs that address functional independence or restoration, rather than maintenance; and
- the importance of physical activity or exercise for the elderly.

Key clinical issues for the geriatric population at risk for hospitalisation include: early detection, care coordination, and the integration of information; as well as the need for better targeting of health interventions for older people (Stuck et al. 2002, Lynn and Adamson 2003)

In terms of health care integration for the elderly (according to a large study within the OECD), only single-entry point systems with geriatric assessment and case-management / case coordination have been successfully implemented in public health systems (Johri et al. 2003).

This synthesis of the findings, based on treatment effectiveness research and rational approaches to consumer need and service delivery is now added to by examining more directly the literature on service models and organisation around models of care. It is followed by a sub-section examining the views of major stakeholders on best practice models of care and including recommendations for policy developments in the field of home care that may be applicable to veterans in Australia.

Best practice service models in community care

As well as the evidence on interventions and models, practice literature and policy documents were an important additional component of the literature review. In addition to the Department of Veterans' Affairs publications and the VHC program documents, reviews and past evaluations, there is a large amount of related program material.

The Commonwealth Department of Health and Ageing, as well as State and Territory-based health and community care departmental public web sites were searched for relevant materials. Policy or practice documents and guidelines in relation to the Home and Community Care Program (Commonwealth of Australia 2007) and references to relevant service types as well as comprehensive assessment and screening in the national reform agenda under *The Way Forward* were also reviewed. The Department of Health and Ageing web site¹³ included (in July 2007) the submissions to the Review of Subsidies and Services, which were reviewed for observations and recommendations relevant to the VHC Review and to look for lessons from the experience of agencies and organisations managing other programs as well as VHC.

This broader policy material filled out the evidence base for the Review by moving into the web from the starting point of systematic reviews and meta-analyses, and other important papers and reports identified by the Review team, and advice from people in the field. The aim was not to provide an exhaustive review of all the issues in and around Australian community care. The aim was more modest - to provide some guidance to the Review of the VHC Program and to help clarify the conceptual frameworks of relevance to the Review questions.

The last two decades have seen a number of developments in models of care for older people living in the community. A number of these are outlined in the academic and practice literature, and represent a shift from the previous service-provider or service-specific orientations to a more consumer-centric perspective. Developments include the introduction of comprehensive (as opposed to service-specific) assessments, multidisciplinary geriatric care teams, case management / care coordination, individualised care packages, functional gain and health maintenance programs, and the recognition of informal carers as important partners in the provision of care and clients in their own right.

At the same time, a number of initiatives have been produced which aim to provide consumers/clients with greater control over their care needs and circumstances, such as advanced care directives and plans and self-directed care models of care including the introduction of vouchers.

The impetus for these shifts in models of care for older people have been, variously, the independent living movement among people with disabilities, which emerged during the 1980s and had a focus on consumer empowerment; the recognition that many older people have multiple and complex care needs, including interacting medical, functional and psychosocial needs; and, the impact of an ageing population on the costs and resources of the acute and long-term residential care sectors.

The common theme to emerge has been the need to have a comprehensive approach to care, tailored to the needs of the individual and their circumstances. In Australia, the dominant approach of the multidisciplinary Geriatric Domiciliary Care/Aged Care Assessment Teams is based on the principles of Comprehensive Geriatric Assessment (CGA) and Geriatric Evaluation and Management (GEM). These aim to "uncover the multidimensional problems of at risk frail elderly, with the purpose of planning and/or implementing coordinated medical, psychosocial and rehabilitative care tailored to the patient's specific needs' and also to provide therapy (GEM)." (Cordato 2002, p.43)

In his literature review of GEM programs, Cordato (2002) concludes that:

¹³ http://www.health.gov.au/internet/wcms/publishing.nsf/content/ageing-reviews-submissions_received.htm

“a fairly unifying picture emerges of improvements to patient functional status as well as reductions in rates of hospitalisation and long-term institutionalisation related to these interventions. These programs are cost-effective and have their greatest impact when they appropriately target elderly patients with multi-dimensional problems.” (p.46)

The model home care team approach of the Johns Hopkins Bayview Medical Centre General Clinical Research Centre, outlined by Frock and Barnes (2003), is an extension on this model, providing a physician-led interdisciplinary home care, which includes case managers who initiate, coordinate and even partially provide the services required. After 6 months pilot test of the model, its older clients:

“demonstrated significantly greater use of in-home services and greater satisfaction with care by the family caregivers as well as consistent trends toward the lower use of clinics, institutional services, and total resources.” (Edelson 1999, p.301 cited in Frock and Barnes, 2003)

The US Veterans' Health Administration has also adopted a model of health care coordination, coupled with Advanced Clinic Access (ACA) and patient self-management. Care coordination focuses on the right care at the right time in the right place, having the care coordinator manage care for a select patient population across the continuum of care. This is underpinned by the principles of self-management, which are the actions lay people take to recognise, treat, and manage their own chronic disease(s) on an ongoing, often daily basis. Wertenberger et al. (2006) conclude that the measurable outcomes of this combined approach include:

“improved clinical outcomes as they relate to the management of chronic diseases, decreased waiting times and delays for clinical care, increased patient satisfaction, improved staff satisfaction and improved clinical performance measures for preventative healthcare.” (p.145)

There are a number of elements to facilitating self-management or self-directed care, ranging from advanced care planning and directives to providing clients with the funding and means to purchase and arrange their own care requirements. From a consumer's perspective, it is expected that greater control over one's services will result in improved quality of life.

One approach undertaken by US authorities has been the provision of vouchers, together with a co-payment, such as the Medicare Primary and Consumer-Directed Care (PCDC) Demonstration project in the US described by Meng et al. (2006). In that program, participants received a monthly personal assistance voucher benefit of up to \$250 (with a 20% co-payment) in addition to their Medicare benefits, compared to the control group which received only their regular Medicare benefits. The study found that the “voucher benefit increases the likelihood of any personal assistance use by 12%” (p.190), which overall, translates into “only 2.4% of total Medicare spending” (p.191). It noted that the people were more likely to access personal assistance goods than services, concluding that:

“these findings suggest that personal assistance goods and services may serve as substitutes for some individuals but as supplements for others”...and that this may be explained by the “accessibility and less intrusive nature of personal assistance goods.” (p.191)

The Cash and Counselling Demonstration and Evaluation (CCDE) model in the US provided “a cash allowance and information services to clients so they can purchase personal care services, assistive devices, or home modifications that best meet their individual needs. Information services included assistance with cash management tasks such as hiring, training, and managing workers as well as payment responsibilities.” (Mahoney et al. 2004, p.646) The research found that:

“respondents who had an informal caregiver, and particularly an informal caregiver who lived in, were more interested in the cash option than were those who did not.” In particular, some ethnic groups were more interested in the option, e.g., African Americans and Hispanics, compared to Caucasians. It was possible that this was because the “strong family networks that emphasize caring for one another.” (p.659)

There has been much debate in the literature and amongst advocates of the benefits of consumer-directed care; however the literature does not support the assumption that it has universal appeal

and/or benefits for all recipients of home care services. In conclusion to their study of the CCDE, Mahoney et al. (2004) noted that:

“a sizeable percentage of the eligible population would not be interested in a consumer-directed option.” (p.660).

There have also been some suggestions that age may impact on the level of interest in and ability to manage a self-directed care model. This theory was tested by Benjamin and Matthias (2001), who randomly sampled recipients of in-home support services in California. That study concluded that “old age is far from an inevitable barrier to self-direction of supportive services in the home”, however, it does finish with the comment that it will be:

“important to continue collecting and examining evidence about the experience and outcomes of self-directed services across the life span.” (p.641)

Table 28 Best practice service models found in the literature review

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Benjamin AE and Matthias RE (2001) <i>Age, consumer direction, and outcomes of supportive services at home</i> . <i>Gerontologist</i> . Vol. 41, No.5, pp.632-642.	Empowerment, unmet Needs and satisfaction with services	Home care clients – frail aged and younger disabled	Promising practice	Description of a model of self-directed services in home care "Typically, this model permits or requires the recipient to recruit, select, hire, train, and supervise a home care provider(s) without the participation of a home care agency. Recipients in effect are small employers. . . ." (page 632)
Cordato, N (2002) <i>Geriatric interventions – The evidence base for comprehensive aged care services</i> pp43-48, in <i>Framework for integrated support and management of older people in the NSW health care system 2004 – 2006</i> , NSW Health Department 2004	Effectiveness of GEM model, in terms of impact on rates of institutionalisation, hospitalisation, functional gain and cost.	Frail older people requiring health care services		Literature review undertaken for Working Group on Care of Older People in NSW Health Care System. Considers evidence for Geriatric Evaluation and Management (GEM) approaches in inpatient, geriatric inpatient consultation, and outpatient services.
Frock AH and Barnes PA (2003) <i>The model home care team</i> . <i>Home Health Care Management & Practice</i> . Vol. 15, No.4, pp.300-304.	Descriptive Model	Home care clients – frail aged, younger disabled	Promising practice	Description of focusing on the clinical team (Johns Hopkins Home Care Group Geriatric Team)
Mahoney KJ, Simon-Rusinowitz L, Loughlin DM, et al (2004) <i>Determining personal care consumers' preferences for a consumer-directed cash and counseling option: survey results from Arkansas, Florida, New Jersey, and New York elders and adults with physical disabilities</i> . <i>Health Services Research</i> . Vol. 39, No.3, pp.643-663.	Consumer preferences for model of service delivery	Medicaid clients (USA), all ages	Views of clients and carers	Survey into preferences for vouchers / cash option. In the United States, most existing public programs that finance personal care services follow the vendor payment model where the program purchases services for consumers from authorized vendors (i.e., service providers or equipment suppliers). The cash and counselling model offers a cash allowance and information services to clients so they can purchase personal care services, assistive devices, or home modifications that best meet their individual needs... In theory, consumers who shop for the most cost-effective providers may then (through such savings) have funds to purchase additional services (Kapp 1996)' p 646

Paper	Outcome	Target Group	Evidence Rating	Description of document / intervention / comments
Meng H, Friedman B, Dick AW, et al (2006) <i>Effect of a voucher benefit on the demand for paid personal assistance</i> . <u>Gerontologist</u> . Vol. 46, No.2, pp.183-92.	Service use under different models of service delivery	Medicare clients (USA) 65 years and over	Promising practice	Voucher system - 'Participants were randomly assigned to either a voucher group, in which individuals received a monthly personal assistance voucher benefit of up to \$250 (with 20% copay) in addition to their Medicare benefits, or a control group, in which individuals received only their regular Medicare benefits' p 185
Wertenberger S, Yerardi R, Drake AC and Parlier R (2006) <i>Veterans' Health Administration Office of Nursing Services exploration of positive patient care synergies fueled by consumer demand: care coordination, advanced clinic access, and patient self-management</i> . <u>Nursing Administration Quarterly</u> . Vol. 30, No. 2, pp.137-146.	Improved access to care, improved independence, reduced complication rates for multiple chronic conditions, and reduced hospital admissions for veterans within specific patient populations, staff satisfaction.	Consumers using the Veterans' Health Administration healthcare system in the States.	Promising practice	Discussion of two interdisciplinary synergistic processes/models of healthcare being implemented nationally - advanced clinic access and care coordination. These initiatives meet the needs of the Veteran (patient self-management initiatives were integrated with the models) and the staff managing their care. Processes/programs to ensure nurses have the knowledge, information, and skills to meet patient care demands at all levels were being defined.

Review of issues in current practice and policy development in home care

The Veterans' Home Care Program information page¹⁴ describes the aim of VHC in terms of maintaining the independence of veterans, and doing so within a context of a wider range of service types:

"The Veterans' Home Care (VHC) program provides a wide range of low level home care services designed to enable veterans and war widows/widowers to maintain their health and well being and remain living independently in their own homes.

VHC is part of a range of DVA services provided to eligible members of the veteran community. These include community nursing, allied health services, for example physiotherapy and podiatry, counselling services, transport for health care, home modifications and appliances through the Rehabilitation Appliances Program (RAP) and the HomeFront falls and accident prevention program.

VHC services include domestic assistance, personal care, safety-related home and garden maintenance and respite care."

The case for developing programs of 'low-level' support such as the VHC and HACC programs is essentially one of increasing client choice by enabling the substitution of community care interventions for institutional placement, and in particular it is based on the assumption that low levels of care are a preventive intervention to reduce the risks of admission to residential care institutions. The evidence on this assumption is by no means clear cut when carefully evaluated.

The integration issue

¹⁴ <http://www.dva.gov.au/health/homecare/mainvhc.htm>

At the policy level, there is a recognised 'down-side' to introducing new and essentially separate programs in that it increases the potential for fragmentation into the service system with the resulting problems for consumers in navigating what is perceived to be a maze, being assessed multiple times and if their needs are complex, dealing with a plethora of programs and service providers coming to their homes. This set of problems for consumers is now universally acknowledged and is the basis for the national community care reform agenda under the banner of *The Way Forward*, where the aim is develop "ways to improve the system to reduce complexity and achieve greater consistency, as well as simplifying and creating a fairer system for people requiring care to stay at home."¹⁵

So, while the advantages of having a range of separate programs and service types are seen in terms of improving consumer choice and increasing the range and reach of services, these advantages are balanced by the fragmentation and subsequent 'integration' problems that are created in the service system as a direct result. These boundary issues are well described by many reviewers, articulated in terms such as this quote from the important summary paper in the international literature:

"Care of the elderly, and in particular the frail elderly, poses a central challenge to current health care systems. Their medical needs are often complex: the frail elderly suffer from a mix of acute and chronic medical problems, and functional disabilities. Their social support networks are frequently overextended, or at risk of breaking down. These factors commonly lead to increased - and sometimes inappropriate - use of medical and social services

These individuals, therefore, need an elaborate and flexible combination of interventions. Internationally, many jurisdictions have attempted to facilitate this by establishing a single entry point system, with case management provided for continuing care in the community and for admissions to long-term care institutions. Although this coordination represents an important step towards reduced fragmentation and improved use of resources, significant limitations may remain, including the cleavage between medical and social care, acute and continuing care, and community and institutional care. Each agency continues to function autonomously in its own jurisdiction with its own budget (Bergman et al. 1997)." (cited in Johri et al. 2003, p.223)

The impact of basic services

The VHC program, being focussed on the provision of 'basic' care services, has essentially the same aims to the national Home and Community Care (HACC) Program as it was conceived in 1985, with the main difference being the smaller number of service types available to the veteran community. The rationale for the VHC program can be assumed to be similar to HACC in that it is based on a philosophy of "basic maintenance and support services to people ... who would otherwise be at risk of premature or inappropriate long term residential care. Its basic philosophy and underlying objectives receive widespread support in the community." (Home and Community Care Review Working Group 1988, p.v)

While evidence to support the effectiveness of the four service types provided by VHC, or the particular mix of those services used in combination, has not been found in the review of the literature the statement by the HACC Review in 1988 remains pertinent; the program has widespread support in spite of the lack of evidence for its effectiveness. This is because the VHC program, like the HACC program, provides a very useful role in achieving a balance of available care options (in the space between independent community living and residential aged care) by complementing the range other health and social support interventions that are available in the community.

The evidence from the literature that has been reviewed here indicates a program like VHC can have little impact in and of itself in preventing entry to residential care, or in avoiding hospital

¹⁵ <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/A+New+Strategy+for+Community+Care+-+The+Way+Forward-1>

admissions. Where VHC can have an impact is in being a well integrated part of a wider set of primary care and community aged care services. That in turn poses the major questions that have turned up consistently and repeatedly in the policy literature; how best to achieve a balance between formal and informal care (Fine 2007) and how to improve the integration of community care service interventions (National Hospitals and Health Services Commission 1973, National Health Strategy 1991, Leutz 1999, Leutz 2005, Tieman et al. 2006)

The indicators of best practice that are shown in the community care policy literature are the logical extension of what is known to work most effectively from the literature on home care models and community care interventions. Good quality and broadly-based assessment methods have to be coupled with an ability to flexibly organise a service response that is commensurate with the level and range of a client's needs and their formal and informal supports. The ability to assess people who are in their home environment and appraise their needs and risks as well as their potential for improvement is recognised as a key factor in choosing the best model of care (Fine and Thomson 1995).

A paper by Muramatsu et al. (2007) on the risk of nursing home admission among older Americans examined spending on home and community-based services and how family availability moderates the effects of the services. They used data showing how states vary greatly in their support for home and community-based services (HCBS) that are intended to help disabled seniors live in the community and examined how those differences affect the risk of nursing home admission among older Americans.

The study conducted a discrete time survival analysis of first long-term (90 or more days) nursing home admissions that occurred between 1995 and 2002, using data from respondents born in 1923 or earlier. The effects were conditional on child availability among older Americans, and living in a state with higher HCBS expenditures was associated with lower risk of nursing home admission among childless seniors. However, the association was not statistically significant among seniors with living children. The authors concluded that doubling state HCBS expenditures per person aged 65 or older would reduce the risk of nursing home admission among childless seniors by 35%.

The strength of the evidence from the results of the study by Muramatsu et al. (2007) can offset the lack of specific evidence for the effects of the limited range of service types offered by VHC. By covering a large number of states and using large data sets, the study incorporated a wide range of interventions of differing intensity across a seven year period. It provided modest but important evidence supportive of the effectiveness of increasing state investment in home and community-based services and underscored the importance of the availability of potential carers.

A paper by Lagergren et al. (2004) described a longitudinal study integrating population, care and social services data as part of the Swedish National Study on Aging and Care (SNAC). It indicates the value that can be gained from a well-designed longitudinal study inside a larger research and development program. A large national, and long-term, longitudinal and multi-purpose study was launched that involved four research centres collecting data in four different areas of Sweden. The study consists of two parts: a population part and a care and services part. In the population part, a large representative panel of older people in different age cohorts is followed over time to record and describe the aging process from different aspects. In the care and services part, a systematic, longitudinal, individually-based collection of data is performed concerning provision of care and services together with functional ability, specific health care problems, and living conditions of the recipients living in the area.

In Australia the Department of Veterans' Affairs already has experience in commissioning surveys (such as the DVA 1997 *Survey of Entitled Veterans, War Widows and Carers*) and longitudinal studies that describe issues such as social isolation, as reported in Gardner et al. (1999). As a result, DVA would be in a good position to commission a study with a degree of methodological sophistication and policy relevance such as that carried out in Sweden. It would enable comparisons between the participating areas with respect to the prevalence of disability among

those receiving different levels of care and social services in their homes and comparisons with those receiving care in different levels of accommodation. Comparisons would also be possible to examine the impacts of basic services and in particular the impact of different amounts of home help provided to subjects with a given disability.

Lagergren et al. (2004) point out that a project such as this has several advantages. It can be expected to generate a rich data base relevant for future research on ageing and care and to have a direct impact on the future of systems of care and services for older people.

In the Australian context, other longitudinal studies have been used for examining the characteristics of informal caregivers with relevance for the provision of respite care and other support services. They have the potential for examining the impact of basic services being provided on the people (carers and care recipients) who are surveyed. Michael Bittman and his colleagues have examined the effect of caring on employment, hours worked and earnings, and general outcome measures (self-rated health and life satisfaction) of carers as part of a broader project that aims to map the longer term effects on carers' life circumstances. The broader research project is supported by an ARC linkage grant in partnership with a consortium of relevant NSW government departments and Carers NSW. (Bittman et al. 2007, p.258, and 270)

The project coordinated by Bittman uses data from the longitudinal Household, Income and Labour Dynamics in Australia (HILDA) survey. The survey was initiated and funded by the Australian Government Department of Families, Community Services and Indigenous Affairs (FaCSIA) and managed by the Melbourne Institute of Applied Economic and Social Research. The HILDA survey began in 2001 and is following a multi-stage random national sample of 7,682 households (13,969 people).

Another relevant example where the impact of programs can be rigorously assessed is the Australian Longitudinal Study of Women's Health (ALSWH) which follows 40,000 women over 20 years in three cohorts (young, middle aged and old), surveyed every three years about their health and well being and social circumstances (Lee 2001). The National Respite for Carers Program has commissioned research based on the data from the fourth survey on the mid-age cohort where the focus is on the caring responsibilities of women in mid life from in order to support policy development for the Employed Carers Innovative Project (ECIP), a project implemented nationally within a range of sites with agencies funded through the NRCP. The rationale that shaped the questions being asked of the ALSWH data came from analyses on the impact of social trends on the need for and availability of primary carers.

The ALSWH findings have been reported in the international literature, highlighting findings from the surveys on older women (Lee 2001) and the mid-life cohort (Lee and Gramotnev 2007). Policy-relevant results have included observations of how services for the mid-age group break down after the acute phase of illness has passed, and descriptions of the most common form of assistance required of the older age group, all of which help to shape policy responses and the future development of services. Other policy-relevant results that linked the survey data with Medicare claims were able to report on the uptake of annual health assessments by women aged 75 to 78 years when Medicare EPC items were introduced. The study found that most women are not having annual assessments and there is some geographic inequity. (Byles et al. 2007)

Local coordination of service responses

One key point that was made by Walter Leutz, (who had integrated the findings from a number of internationally recognised demonstration projects) when reviewing the impact of his "Five Laws of Integration" (Leutz 2005) was that all integration is fundamentally a local process. This has been recognised in the various national initiatives in coordinated care trials with the frail elderly (Eagar et al. 2002), in mental health integration (Eagar et al. 2005) and in palliative care services. (Eagar et al. 2006)

An innovative method of cooperatively achieving improvements in coordination and streamlining of the processes of home care delivery is the UK-based Care Services Efficiency Delivery Programme (CSED)¹⁶. It would be relevant to DVA in building on its e-commerce strengths and would add value to local quality assurance, demand management and monitoring systems. The program has the aim to work collaboratively with all councils throughout England supporting them to achieve sustainable efficiency improvements in adult social care.

DVA has already invested in the development of coordination strategies. It already provides a degree of care coordination through various programs. For example, Local Medical Officers (LMOs) provide care coordination in respect of health and community care services and Veterans' Home Care (VHC) assessment agencies provide coordination of VHC services and referrals to other programs and health providers.

The Department has expressed an interest in exploring the possibility of introducing a more structured approach to care coordination. In 2005 the Repatriation Commission approved two different types of care coordination models be piloted (in NSW and Queensland). These pilots will examine and evaluate the benefits of different modes of delivery of care coordination, the ability for veterans to improve access to services and to generate the best possible health outcomes for the veteran. During this period the models will be reviewed and evaluated and the outcomes used to inform a final approach.

In NSW the Pilot is being conducted by McKesson Asia-Pacific who provide support and advice to selected veterans and war widows residing in NSW who have a diagnosis of Congestive Cardiac Failure (CCF). The pilot will investigate whether this approach will improve the health care of veterans with chronic health disease. Initially the Pilot was for a 12 month period (to finish in March 2007), but this has recently been extended for a further 12 months, and will now finish in March 2008. The pilot involves:

- Seeking veterans who have a provisional diagnosis of CCF to participate in the pilot (completed);
- Participating veterans were then randomly divided into a treatment group (currently, this group numbers 114) and a control group (completed);
- Providing a pro-active program of disease management for participants for a period of 24 months (in progress);
- Providing the LMO with regular updates regarding the veteran's progress. This will be achieved through written communication where the veteran's needs and recommended action will be addressed, and by encouraging the veteran to discuss their action plan with them (in progress);
- Providing immediate access for participants to a 24 hour clinical support and telephone triage service to complement the disease management intervention (in progress); and
- Collecting data (in progress).

Preliminary indications suggest that some behaviours and activities of participating veterans have changed over the first 12 month period, with positive outcomes on their knowledge of their disease, and their health in general. Most participants have agreed to continue to be enrolled in the Pilot, which reflects well on the Pilot and its processes and proposed outcomes.

The service that a veteran receives includes:

- An individualised assessment of the caller's condition and needs;
- Education and promotion of lifestyle issues;

¹⁶ <http://www.csed.csip.org.uk/>

- Education regarding medication taken by the caller;
- Assistance with motivational problems associated with medication compliance; and
- Access to a wide range of resources such as telephone counselling and written materials/facts sheets.

The Queensland trial provides a coordinated care program for veterans with moderate to high care needs who reside within the GP Partners Ltd's catchment area. The care coordination is undertaken by Service Coordinators who liaise with a veteran participant's Local Medical Officer, nurse and other health care providers who work with each other and the veteran to optimise health care outcomes.

The care coordination is supported by an Electronic Health Record which the veteran's nominated health care providers can access. The model is designed to assist veterans to remain healthy and active in the community. The health outcomes for veterans who participate in the trial will be compared with others outside the program. Evaluation of the outcomes will inform DVA of the benefits and cost effectiveness of care coordination.

Although the pilot was originally scheduled to end on 30 November 2007, early indicators are that the program is producing significant positive benefits and, with the final evaluation report due in December 2007, an extension until March 2008 was recently sought from the Repatriation Commission in order to continue the trial in maintenance phase until the evaluation report and recommendations have been fully considered. This extension was granted, meaning the alignment of the completion dates for both the Queensland and NSW trials.

It is envisaged that after 24 months the evaluation team will be able to evaluate the pilot and the treatment group's outcome on the basis of:

- The cost to the provider;
- The level of satisfaction for the veteran and their LMO; and
- Quality of life measures.

The team will compare the outcomes of the evaluation of the treatment group with the control group by comparing the service utilisation of the two groups over the 24 month period. (This summary is based on information provided to the Review by John Hall Assistant Director, Provider Partnering, 2 August 2007.)

Another relevant initiative to improve local coordination is the Department of Veterans' Affairs (DVA) Community Options Services (COPS) Brokerage project which is a fixed term project of targeted brokerage of HACC services, which are not available under the DVA Veterans' Home Care Program (VHC) for VHC eligible DVA Gold and White Cardholders through Community Options Services (COPS). This project is a partnership between DADHC, DVA, VHC Agencies and COPS with the aim: (1) to assist VHC eligible veterans to access HACC service types, which are not available through VHC. These services include; social-support services, centre-based day care, case management, non-medical transport and home maintenance services through the Home and Community Care (HACC) program; (2) improve the interface between VHC and HACC Programs and build service capacity.

Eligible clients are identified and referred by VHC Agencies as part of the VHC assessment and coordination process and may be clients with non-complex or complex needs. Clients may be referred to COPS for brokerage for single or multiple specified HACC service types. This project has also been extended in its timeline to allow more referrals to be made and more data to be collected. Early indications of the impact of the project that were picked up from the consultation component of the Review are that aims are being achieved, but that the numbers of referrals are

fewer than expected because of the deliberately limited promotion of the initiative in the community care sector.

Client classification for care coordination purposes

The body of work associated with the many reviews and reform initiatives in the HACC program will not be reviewed here, however the work on targeting community care that has been recently updated for *The Way Forward* agenda is directly relevant to the issue of classifying clients, prioritising access, and for the purpose of coordinating a service response commensurate with their level of need (Howe et al. 2006).

The HACC program (and to some extent VHC) has *not* been characterised by methodologically rigorous studies, and most work has been descriptive and focussed on process issues rather than outcomes, and results have been qualitative rather than data-based. The development of the HACC Program, while being less empirical, has been supported by the introduction of innovations that have been based on empirical work carried out elsewhere. For example, the Community Options Program of Wisconsin was 'exported' to Australia's HACC program in the nineteen eighties, and it has remained a robust model for home and community care in the U.S. for over a decade as well as being well accepted in the Australian context.

The US state of Wisconsin has continuously pursued new funding and policy strategies to further reduce the use of nursing homes and other institutions and to expand home and community care on the basis of rigorous research and development work. One such strategy has been the development of locally managed Aging and Disability Resource Centers (ARDC), designed to serve the general public as a 'one-stop shop' providing independent information on a wide range of issues affecting people who are ageing or living with disability, and to offer information and access to a range of service provider organisations and programs.

The Wisconsin ADRCs provide a web-based "functional screen" that determines the level of care for government-funded long-term care programs, and is the single entry point into Family Care. Wisconsin is expanding this constellation of managed care programs to deliver care management and direct services, including residential care, to persons that are elderly or disabled. Family Care combines all public funding - including Community Options dollars - into one funding stream. Based on a comprehensive assessment and care planning by an interdisciplinary Family Care team, individuals can choose the services and providers that will enable them to live in the community, or the residential care options they prefer. A recent report on the program suggested that Family Care is saving the state Medicaid program an average of over \$400 per month per person, and has dramatically reduced the use of nursing homes¹⁷.

Given the Departmental resources and availability of data sources on veterans' characteristics and service utilisation, the potential exists in the future for VHC to carry out or commission studies of considerable national significance and rigour to advance a research and development agenda in community care. The care coordination pilots are an example of this can be achieved, given to ability to coordinate the sources of utilisation data available to DVA.

That review of recent literature review and its analysis of the aged care assessment data points to some very useful work by Weissert et al. (2003) which was based a series of studies of home care clients in Michigan in the US. In the wider policy context, the work of Weissert and colleagues (Weissert et al. 2003) represents logical way forward for many of the policy and service delivery problems confronting the VHC program at present.

While the focus of Weissert and his colleagues was on delaying nursing home entry, the paper highlights the role of standardised and modular assessment methods, where the goal of care is related to the type of client, and based on their key characteristics. Ideally in these methods the client class type is related to the costs of the interventions and the methods go beyond the

¹⁷ Information derived from <http://www.abc.net.au/rn/perspective/stories/2007/2055886.htm#transcript>

common type of approach used in community care which is based mainly on targeting for specific services and programs via the use of broad eligibility criteria.

“An alternative is to replace targeting - the idea that a client is in or out, eligible or not, with titrated care: generous in its eligibility, but carefully calibrated in the amount of resources actually allocated to a client. High-risk clients would get more care than current practice, to permit more aggressive treatment of their high risks and to take advantage of their high potential to benefit. Low-risk clients would get less care, enough to meet their satisfaction and to monitor their changing conditions, but not so much care that they have little potential to show marginal benefits equal to their marginal care consumption.” (Weissert et al. 2003 p.121)

These authors point out that this classification approach is required in order to achieve real gains in the longer term as part of a systematic redesign process, where the aim is not just a one-off study with overly ambitious aims, but to build a better *system* that can be progressively improved and fine-tuned over time.

“Such careful titration of care should produce better outcomes because care would be directed at those for whom it would do the most good. Directing it at risks should also produce greater effectiveness. And focusing on risks should also produce better progress markers and useful standards against which to judge and reward high-quality program performance... Care decisions would be based on risks, value, and effectiveness, and as training and knowledge expands of what combinations of care work and how much additional benefit can be expected from additional units of care for a given set of client characteristics, care planning should become more standardized.” (Weissert et al. 2003 p.121)

A more rigorous approach to understanding the variability in the client population is recommended. This should be in terms of their goal of care, level of dependency and the presence or absence of key risks such as carer status, psychosocial problems, presence or absence of wounds, and environmental factors.

“More of the variation in care should be explained by client characteristics. And home care would become part of the solution to how we provide affordable, high quality care to deserving populations of frail elderly people rather than a difficult-to-justify drain on scarce resources.” (Weissert et al. 2003 p.121)

The classification approach has been developed into a casemix system for sub-acute and non-acute care (Eagar et al. 2004, Green and Gordon 2007) and recommended for the HACC program by rigorous classification work in WA (Calver et al. 2004). It has been developed for use in community care in planning for a model to support the Coordinated Care Trials sponsored by the Commonwealth Department of Health and Aged Care (Eagar et al. 2002), but has not yet been more widely implemented in community care in Australia.

The Illawarra Coordinated Care Trial (CCT) commissioned development work on the model of care that used the same classification or ‘titrating’ approach as a means of defining consumer needs, community care interventions and care packages (Centre for Health Service Development 2000). This resulted in a classification for coordinated care clients using six client types, with four levels of case management, and represented by 30 discrete classes, each with its own indicative cost structure. An important feature of the CCT design was that the classification approach allows for levels of case management to be defined in a way that does not imply a full case management approach for all clients, but allows for graded levels of case management activity from navigation support through to more intensive care coordination.

Screening algorithms and telephone triage

The literature search has highlighted current policy and practice trends both internationally and within Australia especially in relation to the development of screening tools for common ‘access points’ as part of *The Way Forward* agenda of the Australian Government. The search revealed a range of documents that addressed ‘assessment’, ‘screening’, ‘intake’, ‘innovation’, ‘evidence based practice’ and ‘policy and practice reform’. The quality of these resources varied from highly complex and technical to policy documents covering a few dot points. In spite of the variability there appears to be an emerging consensus in the literature primarily from English speaking

countries and Scandinavia on what constitutes good practice and a common direction for policy reform.

Lessons for the VHC program that were identified in the literature were that the development of person/client centred services (rather than a focus on particular service types), should be based on the early and broad assessment of individual needs. That early assessment can be phone-based and should be supported by integrated referral networks using common and easily shared information. These referral systems are now rapidly evolving using information and communication technologies.

The predominant view in the literature is that strengthening community-level services and their use of shared information is the key to developing trust between agencies and between the agency and the service user, to allow for regional integrated models to deliver common outcomes to common clients. The development of shared, standardised, tiered and integrated 'screening' and 'assessment' models, using data items and tools, including provision for 'self-assessment' models, is highlighted as important for the development of best practice service models.

Fries et al. (2002) examined data from a number of programs covering the same Michigan population as used by Weissert et al. (2003) and this work is part of the same body of evidence examined by Leutz (1999 and 2005) for his conclusions on the laws of integration. Fries et al. (2002) examined the use of a screening algorithm for ongoing assessment in the state's home and community based services program (called MI Choice) and for determining eligibility for reimbursement for long term care. They conclude

the "screening algorithm can be used both over the telephone to identify clients who will not be fully assessed (as they are unlikely to receive services) and in person to recommend the appropriate (long term care)." (p.462)

This work is technically sophisticated and the key component uses a screening algorithm based on an empirical design and access is organised by individuals requesting a service who call a central phone number or a set of local numbers. The pool of items necessary for the screening algorithm forms the telephone screen instrument. This is essentially the same method and outcome (a screening tool based on a similar data items) used in work on a screening tool developed for the NSW Home Care Service (Stevermuer et al. 2003) and incorporated into the Ongoing Needs Identification tool (Eagar and Owen 2003), and the tools developed for *The Way Forward* (Samsa et al. 2007). A summary paper describing the lessons from this body of project-based work on priority rating for community care has now been published to become part of the more formal Australian peer-reviewed literature (Stevermuer et al. 2007).

Fries et al. (2002) point out that a key attribute of the approach is that the screening system is still being refined as a means of achieving a range of data-driven solutions. They conclude that:

"the availability of an empirically derived screen has laid the foundation for more accurate and appropriate decisions...The MI Choice screening algorithm described here has been adopted by the Department of Veterans' Affairs for nationwide implementation and is being considered for adoption by several other states and nations."

"Michigan has implemented the telephone screen, in-person assessment, and screening algorithm using optical scanning methodology. Hand-completed forms are rapidly scanned in each agency, where errors are resolved and the algorithm computed. Daily, the agency computers upload new assessments to the state data-base, which can then be used to maintain longitudinal records on individuals, to profile participants and agencies, and to perform policy and other research ... The availability of comparable data sets, and scales and algorithms such as the MI Choice screen, enable the development of efficient and effective state-wide long-term care systems." (p. 472-3)

Summary of literature review findings

This final section of the literature review summarises our findings in the area of interventions, service models and ways of organising care, and policy directions for home care, applicable to Australian veterans.

Interventions

In summary, this review found the following on effective interventions in home care applicable to Australian veterans:

- The scientific evidence base on respite care needs to be improved in order to derive reliable guidelines to assist the development of the most effective care practices (Mason et al. 2007, Ingleton et al. 2003)
- Evidence was found which supported the targeted use of preventative health visits for the elderly, usually carried out after a comprehensive assessment (in order to improve the targeting) and with visits by nursing, health visitor or allied health professionals (Stuck et al. 2002).
- There is a lack of specific service-level information in the literature on the effectiveness of domestic assistance services, personal care services, and home and garden maintenance services. The support for these types of services comes from evidence of their effectiveness when subsumed into a care plan as part of a package of care (McCusker and Verdon 2006). A review of identified high quality papers on care packages found the following key concepts described: service intensity, training of other providers in the community, assessment and monitoring, care planning and management, multi-disciplinary teams, care coordination and evaluation, home visiting, telephone contact, equipment and transport, referral to other providers and volunteer agencies, as well as respite services.
- Three major trends were noted from the literature on home care services: (1) the use of technology to improve health care delivery, (2) the rise of programs that address functional independence or restoration, rather than maintenance, and (3) the importance of physical activity or exercise for the elderly
- Key clinical issues for the geriatric population at risk for hospitalisation include: early detection, care coordination, and the integration of information; as well as the need for better targeting of health interventions for older people (Stuck et al. 2002, Lynn and Adamson 2003) and the use of screening algorithms. (Fries et al. 2002)
- In terms of health care integration for the elderly within the OECD, only single-entry point systems with geriatric assessment and case-management / case coordination have been successfully implemented in public health systems. (Johri et al. 2003)

From this examination of the scientific literature on effective interventions, the key findings of relevance for the future development of the VHC program are:

- Develop ways to promote the better integration of services, e.g. a range of care coordination strategies that cover a range of needs, refined screening algorithms for use at the level of the regional single entry points, and use of information technology for linking between a broader range of services for the purposes of referral.
- Look for service development strategies that reflect a better combination of active programs with set goals, e.g. health promotion and falls prevention, exercise programs, that promote independence, rather than a goal of maintenance care. Respite options could be developed that linked with outdoor mobility and socialisation, and personal care linked to health and nursing interventions. (Gitlin et al. 2006)
- An explicit focus on areas such as environmental modification and home safety interventions that linked domestic assistance would be logical, as suggested by the randomised controlled

trial reported by Nikolaus and Bach (2003) where the home based intervention included comprehensive geriatric assessment, assessment of the home for environmental hazards (safety checklist), advice about possible changes, necessary home modifications and education in the use of technical and mobility aids.

- Develop ways for the program to look beyond DVA services to better target a wider range of interventions for veterans with a spectrum of needs, e.g. interventions that are age related, disease-specific, preventive and more proactive.
- Enhance the use of the available assessment, data collection and reporting arrangements to allow assessors and providers to routinely measure outcomes, e.g. improvements in daily functioning.

Service models

Examining specific departmental web-sites, strong evidence was found on the use brokerage models in New Zealand and other countries, especially when backed up by research that was geared to enhancing service models over time (Wainwright 2003). The elements include:

- better coordination and integration of services (including case management for complex cases);
- use of a minimum data set with expenditure information;
- use of a standard assessment tool;
- development of rehabilitation and carer support services;
- examination of the relationship between home care utilisation and hospital admission data;
- examination of health utilisation and cost effectiveness data across the whole aged care sector;
- organisational integration;
- good information systems;
- incentives for GPs;
- development of disease management and prevention programs; and
- consideration of supportive housing options.

It is particularly useful to note how the Veterans Independence Program (VIP) in Canada is evaluating itself by examining hard performance data like nursing home admissions, and how developments in Michigan show the value of adopting an empirical, rather than just policy-driven approach (Fries et al 2002).

The work by Wiener et al. (2004) in the US included a detailed literature review into home care services and using it to develop a research agenda. In terms of the issues relevant to an Australian context, they found that:

- there needs to be further investigation into the role of home care services in reducing the total costs of long term care; and
- that new service approaches using technology, carer support and respite, and consumer self-direction need to be investigated.

Policy development

Common issues identified in the literature were the development of person / client centred services, rather than a focus more supply-side or service-driven responses based on determining eligibility for a narrow band of service types.

Best practice examples of community care policy focused on early and broad assessment of individual needs and models for the assessment of service users that includes their positive potential for improved functioning as well as their levels of functional dependency.

The case for developing programs of 'low-level' support such as the VHC and HACC programs is essentially one of increasing client choice by enabling the substitution of community care interventions for institutional placement, and in particular it is based on the assumption that low levels of care are a preventive intervention to reduce the risks of admission to residential care institutions. The evidence on this assumption is by no means clear cut when assessed in detail by examination of the academic and international literature.

The summary by Johri et al. (2003) (p.223), points to the need for an elaborate and flexible combination of interventions. It points out that internationally, many jurisdictions have attempted to facilitate this by establishing a single entry point system, with case management provided for continuing care in the community and for admissions to long-term care institutions. Reducing fragmentation and improving the use of resources, is hard and significant limitations remain, including the residual barriers between medical and social care, acute and continuing care, and community and institutional care. The problems still remain when each agency continues to function autonomously in its own jurisdiction with its own budget.

The examination of the submissions to the Review of Subsidies and Services gave a useful snapshot view of the major issues for community care, and they include VHC as a contributor to those unresolved issues of fragmentation and confusion for clients and providers. The problems are brought about by a set of programs that are not consistent in how they operate, and create disincentives to making transitions to higher levels of support.

The consensus in the literature and policy-level conclusions is clear enough. The issues of how to develop more common tools and guidelines and improve integration from the point of view of the consumer are commonly understood in the service sector, by State and Territory and non-government organisations and are entirely consistent with what has been summarised from the other practice literature and from the more academic services. They essentially argue for a more flexible model of care than has so far evolved from the combination of all programs operating essentially independently, but with a more or less common understanding of the issues for their shared population of clients.

This literature review is now supplemented with a description of the available resources provided by the Department of Veterans' Affairs into the functioning of the VHC program, in order to further inform the context for this project, its data analyses and the presentation of the options and conclusions.

Table 29 DVA and VHC Literature: program reviews, guidelines and other documents

Reference	Description of findings / comment
Acumen Alliance (2003) <i>Veterans' Home Care Management and Costing Review: Final Report</i> . Canberra: DVA.	A review of the VHC program "to examine whether the current management and organisational practices and VHC fee for service costs are consistent with the broad objectives of the program and sustainable within the budget estimates for the period of the current and subsequent round of agency and service provider contracts" (pp.2). It is found that the program lacks an effective price review mechanism and an effective means of performing fee reviews, which has resulted in fixed assessment and service fees not adequately covering all of the costs of performing assessment or providing services, with cost increases being shouldered by the assessment agencies and service providers. Use of the Health and Community Care Sector Wage Cost Index is recommended as the basis for fee reviews. Revised budget estimates are given for the 4 service areas and also assessment. Other recommendations include a review of the DVA IT system, and also the provision of compensation for extraordinary travel costs in future contracts. Requests by agencies for separate fees for each assessment type, and a separate fee for home assessment, are rejected in this review. The review is informed by analyses of surveys, site visits and cost data.
AC Nielsen (2007)	Survey of community dwelling veterans and dependants entitled to Gold or White Repatriation

Reference	Description of findings / comment
<p>2006 <i>Your Lives Your Needs Survey Report: Volume 2: Carers of Veterans and War Widows(er)s</i>. Canberra: Report for DVA.</p>	<p>Health Cards and those receiving incapacity payments >13 weeks and their carers. Findings include:</p> <p>Most carers are spouses/partners (79%); and female (91%); 35% under 60 years, and 22% over 80 years;</p> <p>Most card holders are male (84%), over 65 (78%) and Gold Card holders (88%);</p> <p>Main type of assistance provided by carers is medication management and wounds (74%) followed by housework, shopping, dressing and meals (69%-66%);</p> <p>Generally positive ratings about their own health, however 61% limited by their health when undertaking moderate activities, and 26% report pain interfering either quite a bit or extremely with normal work activities;</p> <p>Respite care was seen as important or very important for 56% of carers, but only 14% received it in the previous 12 months;</p> <p>Permanent alternative arrangements: 29% would seek help from DVA, and 16% from VHC;</p> <p>Majority (78%) of carers do not feel they need additional help; and</p> <p>Carer support – 12% receive carer payment, while 43% receive Carers Allowance.</p>
<p>Australian Institute of Health and Welfare (2002) <i>Health care usage and costs: A comparison of veterans and war widows and widowers with the rest of the community</i>. Cat no. PHE 42. Canberra: AIHW.</p>	<p>This report identifies factors affecting health care utilisation and expenditure for veterans (those entitled to a Gold Card under the Veterans' Entitlement Act 1986), and war widow(er)s, with these patterns compared to the rest of the community. Three major components of health expenditure by entitled veterans and war widow(er)s are analysed: LMO and GP services; pharmaceuticals; and public and private hospital services. Changes over the period 1997-2000 are examined, as are the policies and issues that have influenced these changes. The report concludes that there is substantial similarity of usage between Gold Card holders and the rest of the community for LMO/GP services, pharmaceuticals and hospital services, after differences in age, service-related disability and marital status are accounted for. Differences in cost per service between Gold Card holders and the rest of the community exist, largely due to policy decisions. For example, "DVA have agreed higher prices with LMOs than the [Medicare] bulk-billing rate" (pp.11).</p>
<p>Australian National Audit Office (ANAO) (2007) <i>Performance Audit. Administration of the Community Aged Care Packages Program, Department of Health and Ageing</i>. Audit Report No 38. 2006-07</p>	<p>The ANAO audit reports on DoHA's administration of the CACP Program, and included consideration of the broader policy and service context, in particular the VHC program. It noted that "DoHA's guidelines do not address the boundary between the CACPs Program and Veterans' Home Care (VHC). Consequently, the ANAO noted considerable variations amongst providers, community organisations and DoHA's State and Territory Offices (STOs) in their understanding as to whether a care recipient who is also a VHC recipient could also be held against a CACP place, and vice versa" (pp.20).</p> <p>It included a specific recommendation regarding clarification of relationship CACPs and VHC – to which DVA agreed: "DVA welcomes the recommendation by ANAO for DoHA to promulgate guidelines for its CACP Program to ensure a consistent approach to veterans as a special needs group in their access to CACPs (<i>Note - Veterans are included as a special needs group under the CACP legislation</i>). The introduction of clear guidelines in this area will significantly assist in the understanding of CACP managers and providers of how the VHC program should interact with the CACP program to the benefit of veterans" (pp.25).</p>
<p>Australian National Audit Office (ANAO) (2005) <i>Performance Audit. Veterans' Home Care</i>. Audit Report no. 43. 2004-05</p>	<p>Aim of the Audit was to "form an opinion about DVA's management of the current and future demand for VHC services" (pp.12). Findings include: the need to develop a comprehensive profile of potential/eligible clients to assist "planning for VHC and ensure that those veterans most in need are receiving VHC services"; "improved coordination ... would assist DVA to achieve an integrated response to caring for veterans"; the assessment form was not effective for more complex cases; there is variations in service levels across regions with no analysis for why these are occurring; and, that DVA hasn't evaluated whether VHC is meeting its aim of enhancing the independence and health outcomes of veterans (pp.13-16). Seven recommendations were made to address these, all of which were agreed to by the Department.</p>
<p>Bowler E and Peut A (2006) <i>Veterans on Community Aged Care Packages: a comparative study</i>. Aged Care Series No.9, Cat Number AGE46. Canberra: Australian Institute of</p>	<p>This study gives a profile of Community Aged Care Package recipients who were DVA cardholders, and examines differences and similarities between this group and other recipients of CACP. The report concludes that: cardholders had significantly lower utilisation rates of CACPs; dependency level of those on CACPs were similar to non-cardholders with the exception of a lower rate of severe or profound communication limitation; type and amount of assistance received from the CACPs were generally similar, although cardholding CACP recipients were more likely to receive assistance from other government programs especially due to their access to assistance from DVA. Utilisation rates depend on many factors including eligibility, accessibility, acceptability and appropriateness. The lower utilisation rate</p>

Reference	Description of findings / comment
Health and Welfare.	in veterans may also be explained by a lack of knowledge about general community programs, a bias in selection of recipients, or possibly a need for higher care levels than is available through CACPs. The study emphasises that a more comprehensive understanding of veterans' use of aged care services requires examination of utilisation rates of veterans in other community care programs (particularly VHC and HACC) and in low and high level residential care.
Bradbury B and Brown J (2004) <i>Veterans' Home Care Cost Effectiveness: Final Report</i> . University of NSW: Social Policy Research Centre.	<p>Supplement to Posner et al (2003) <i>Veterans' Home Care Evaluation Final Report</i> (below). This report sought to determine whether there is evidence the VHC program has had an impact on expenditure on and usage of health-related services (hospitals, local medical officer visits, community nursing, allied health service); and admissions to residential care. Based on administrative data: trend analysis and comparison group analysis.</p> <p>"While the trend and comparative analyses did not find any clear evidence that the VHC program led to reductions in service use, it is important to emphasise that the modest size of the VHC program and the inherent limitations of non-experimental methodology may mean that it is quite possible that these methods have been unable to identify any impact that may exist ... VHC program has been effective in targeting those most in need of additional support" (pp. vi). It is shown that veterans have an increased ability to remain in their homes and entry into residential care has been delayed, although similar trends have also occurred in the general community.</p>
Brooke E, Gardner I, et al (1999) <i>Veterans' stories: Case studies from the Improving Social Networks study</i> . DVA	This report gives case studies from the sample used in the report by Gardner I, Brooke E, et al (1999) <i>Improving health and social isolation in the Australian Veteran Community</i> . The 26 stories include: 6 Vietnam and Younger Veterans, 10 World War II veterans, 7 war widows, and 3 carers.
Deloitte (2006) <i>Independent review of payments for in-home respite services</i> . Canberra: DVA.	This review aimed to determine how DVA's payments for the purchase of in-home respite services compare with the rest of the industry. The DVA in-home respite hourly fee of \$27.90 was compared with costs of delivering in-home respite services by VHC and non-VHC providers, and the DVA respite fee was benchmarked with the price other purchasers pay. In relation to provider costs, it was found that DVA's fixed fee is insufficient to cover the costs of providers. Also, labour was found to be the main cost input for respite care, and labour rates were variable between states and within states, which meant that DVA's fixed fee generates larger profits or losses for providers delivering the same service but operating in different locations. This review was unable to distinguish VHC from non-VHC providers due to a lack of respondents that do not provide VHC services. In relation to purchaser rates, it was found that no common price for the provision of in-home respite services exists.
Department of Veterans' Affairs (2004) <i>Targeting Veterans with Higher Needs – Pilot Study</i> . Canberra: DVA.	This PowerPoint presentation summarises the 'informal' high needs pilot program of 2004. The objectives of the pilot was to test the capacity of the VHC to meet the requirements of higher need clients, and to gain a better understanding of the clients with higher needs. The results suggest that the needs of veterans are largely being met, however, more investigation is required into understanding and assessing needs of veterans, especially allowing for State and regional differences.
Department of Veterans' Affairs (2004) <i>Veterans' Home Care (VHC) Program – Final Evaluation Report</i> : Departmental Response. Canberra: DVA.	Response to the SPRC final evaluation report (Posner et al 2003, below). Changes include incorporating high level fees into contracts; removal of some inconsistencies in the assessment process and the provision of services; communication strategy targeting broader community care sector regarding the role and capabilities of VHC; and IT issues addressed as part of broader DVA IT upgrades.
Ernst and Young (2005) <i>Department of Veterans' Affairs – Quality Assurance Review of Veteran's Home Care and Community Nursing</i> . Main Report: 1-41. Canberra: DVA.	<p>Review of the quality assurance processes of VHC and Community Nursing (CN) programs, based on desktop research, an online survey for contractors, interviews with State Offices and consultation with selected contractors. In regards to existing quality assurance process for the 2 programs, it was found that CN had quite an extensive quality assurance program involving detailed audits of all their service providers which was too rigid for the needs of DVA. VHC, on the other hand, was found to not have a formal, consistent quality assurance framework nationally, which has resulted in a high degree of variability of application of practices and processes.</p> <p>Recommendations include consolidating similarities between the two programs while still recognising the individual objectives of each. Actions to minimise fraud are also recommended, including the establishment of a Potential Fraud Identification Register. Quality assurance tools are explored, for instance the Contractor Assessment Summary tool, and the Audit Program Framework.</p>

Reference	Description of findings / comment
<p>Gardner I, Brooke E, et al (1999) <i>Improving health and social isolation in the Australian Veteran Community: Research findings from the Improving Social Networks Study</i>. DVA.</p>	<p>The 1994 Baume Report, <i>A Fair Go</i>, identified social isolation as a priority concern for the veteran community. As people grow older they are more likely to experience social isolation as a result of frailty, mobility problems, and losses of friends and family. In response, the Department of Veterans' Affairs (DVA) commissioned research into the causes and effects on health of social isolation, in order to inform the development of comprehensive interventions to enhance social networks and overcome social isolation. This national study focused on individuals who experience social isolation and the service providers and community groups who can address their needs.</p> <p>Overall, approximately 10% were classified as socially isolated and another 12% were at risk: Vietnam and younger veterans were more likely to be isolated (20%) than the other client groups, and a further 8% were at risk of isolation; Among World War II veterans 10% were isolated and 14% at risk of isolation; and War widows had the lowest level of isolation (5%) and at risk of isolation (8%), but they were more likely to report loneliness, boredom, or unhappiness (20%). Among those at risk of isolation, war widows were most likely to be categorised as depressed. These figures correspond closely to those reported in the results of the DVA's 1997 Survey of Entitled Veterans, War Widows and Carers.</p>
<p>ORIMA Research (2006) <i>Veterans' Satisfaction Survey – June 2006: Health Card Holders</i>. Report for DVA.</p>	<p>Summary of results of Veterans' Satisfaction Survey, examining veterans' overall satisfaction with DVA, satisfaction with recent contact with DVA, DVA information material, DVA internet services, DVA's health care arrangements, and discharge planning. Generally, levels of satisfaction had increased from previous surveys. 30% of respondents (N=477) had received some VHC services during the previous 6 months, with 92% of these respondents being satisfied with VHC and 86% saying it was 'very important' in assisting them to continue living in their home independently. 92% of those who had received VHC services were satisfied with the amount of services received, and 92% were also satisfied with the quality of services received. 34% of respondents who were VHC recipients had contacted the 1300 550 450 telephone service in the previous 6 months, and 89% of these respondents were satisfied with the telephone service.</p>
<p>ORIMA Research (2006) <i>A Report on the June 2006 Veterans' Satisfaction Survey (Cycle 11)</i>. Report for DVA.</p>	<p>Detailed analysis of the results of the June 2006 Veterans' Satisfaction Survey, which looked at health card holders, income support pension claimants, and disability compensation claimants. Focus was on a number of elements of DVA, including VHC. Findings regarding Health Card Holders' satisfaction with VHC included in summary (above).</p>
<p>Posner N, Powell-Davies G, et al (2003) <i>Final Report of Evaluation of Veteran's Home Care</i>. Social Policy Research Centre and Centre for General Practice Integration Studies: University of NSW.</p>	<p>Report on VHC Program implementation, impact and outcomes. Cost effectiveness analysis followed in subsequent report by Bradbury and Brown (see above). Report concluded that there has been increased access to low level home care services for veterans and war widow(er)s and freeing of HACC hours for use by members of the general community on HACC waiting lists (<i>service provider perspective only</i>). There is potential for further integration and coordination with other programs (within and outside DVA) and for care and support to take more flexible forms than the 4 service types. Also, acknowledges the "need to balance efficient provision of services with meeting user needs and coordinating services that are flexible and maximises individual outcomes. DVA will benefit from ongoing consultation with stakeholders in achieving this balance" (pp viii – ix).</p>
<p>DVA (2007) <i>Veterans' Home Care Annual Statistical Summary 2005-2006</i>. Canberra: DVA.</p>	<p>The objective of the Annual Statistical Summary is "to highlight the patterns and characteristics of recipients and their usage of the VHC program, as well as the main features of assessment and service provision for these recipients" (p.1). The Summary analyses statistics from the VHC operational database and the VHC data mart. Trends in assessments since the commencement of the program (2001) and activities are examined, as well as the program's activities during the 2005-06 financial year, which includes summaries of: the number and type of VHC services approved; demographic characteristics of VHC recipients; service provision and those who require multiple service types; and State and Territory variations.</p> <p>Findings include:</p> <p>of the 77,216 veterans assessed in the 2005-06 period 96.2% were aged 70 years and over, and those aged between 80 to 89 made up 71.9% of the total number of veterans assessed.</p> <p>75.5% of service hours were for domestic assistance, 19.1% respite, 3.1% personal care, & 2.2% home and garden maintenance.</p> <p>3% increase in assessments and service hours from 2004-05.</p> <p>Approximately 5000 assessed for respite care only.</p> <p>Approximately 17% of total hours approved for core (non-respite) services were <i>not</i> used.</p>

Reference	Description of findings / comment
	<p>Transitional veterans (those transferred from HACC prior to 1 Nov 2002 = 13% of VHC clients) used 42.9 hours p.a. of core service, compared to 29.6 hours for non-transitional veterans.</p> <p>77% receive only one type of VHC service, and 0.1% use all four types.</p> <p>Patterns of service provision varied between States and Territories – ranging from 53.3 hours p.a. in ACT to 31.8 in SA.</p> <p>Differences between State and Territory service provision are examined, showing that the ACT had the highest average level of service provision during 2005-06.</p>
VHC Program Reviews - Methodological papers	
AC Nielson (2003) <i>Survey of Veterans, War Widows and their Carers: Methodology Report</i> . Report for DVA.	Methodology behind the survey of 'Card holding' veterans and war widows and carers, which aimed to inform the future development and review of health related programs for DVA clients and their carers. The most recent study before this regarding provision of services was in 1997. Content includes questionnaire and survey procedures; data processing; auditing and quality control; and, copies of initial mail outs/letters, survey questionnaires, introductory letters
DADHC (2006) <i>Project brief – Evaluation of DVA and COPS brokerage project</i> . NSW DADHC.	This project is exploring the use of case management services for identified veterans from VHC with higher levels of need. The evaluation of the project is due for completion in early 2008. In late 2006, Age Communications conducted eight focus groups for the evaluation of the Veterans Brokerage Project. An On-line Survey has been conducted and consultations were held in Sydney (4 sessions) and in each non-metropolitan DADHC region (Newcastle, Tweed Heads, Nowra and Albury). Participants were asked to reflect on their VBP experience to date. Data collection using the COPS assessment tool (ONI) will supplement the qualitative data from the consultation component and the results of the On-line Survey.
ORIMA Research (2006) <i>Appendix A: Questionnaires - Veterans' Satisfaction Survey. Cycle 11</i> . Report for DVA.	Questionnaires related to veterans' satisfaction (which were used to obtain the results presented in <i>ORIMA Research (2006) Veterans' Satisfaction Survey – June 2006: Health Care Holders</i>) (above). It includes the Health Card Holders survey, Income Support survey, and Disability Compensation survey. The questionnaires were used as guide by the Centre for Health Service Development (CHSD) when developing their Veterans' Home Care Questionnaire, for instance the format and style.
VHC Program Documents – Guidelines etc.	
Annual Reports 2005-2006: <i>Repatriation Commission, Department of Veterans' Affairs, and National Treatment Monitoring Committee</i> . Canberra: DVA.	Annual Report to the Australian Parliament by the Department. In relation to the VHC, the Report details expenditure (more than \$385 million in VHC funding since 2001, including \$91.4 million in 2005-06), as well as \$16.1m to State and Territory governments to assist veterans' access to broader community care services; client statistics, including demographics, number of assessments, and service usage; and the new contract management and quality assurance framework for community nursing and VHC providers. In addition, the Report notes the review of payments for in-home respite services, prompted by the VHC Reference Group. The Reference Group was established in 2004 to advise the Department on issues relevant to the VHC program, and comprises representatives from VHC assessment agencies, service providers and the Department of Health and Ageing (DoHA). Aged and Community Services Australia joined the group in late 2005. Issues discussed during the year included quality assurance, re-contracting, client outcomes, the interface with the DoHA <i>Community Care Review – The Way Forward</i> , new deeds of agreements with state and territory governments to support access to services through the Home and Community Care program and specific concerns from assessment agencies and service providers.
DVA (2000) <i>DVA Human Research Ethics Committee Administrative Guidelines Version 2.0</i> . Canberra: DVA.	Report used to prepare the CHSD submission to the Ethics Committee of DVA to approve the VHC Review methodology.
National Program Guidelines for the Home and Community Care (HACC) Program (2007)	<p>This document consists of three tables comparing services provided by HACC to those provided by the VHC program, and other services provided by DVA. Brief descriptive comments are given on each service, with similarities and differences between comparable services noted.</p> <p><i>Comparison of HACC services and other DVA services available to veterans compared to the services available to veterans eligible for VHC.</i></p>

Reference	Description of findings / comment
Veterans' Home Care (2006) <i>Veterans' Home Care Guidelines</i> . Canberra: DVA.	Guidelines for VHC program, includes: Background, aims, objectives and strategies Eligibility guidelines Types of VHC services Access to services Assessment and coordination Service provision Account payment arrangements Veteran Co-payment arrangements Continuity of service following the death/ill health of a veteran Accountability and standards Operational issues 12 attachments A-L including forms, assessment guidelines, protocols etc.
Veterans' Home Care (2006) <i>Veterans' Home Care Guidelines Attachment K – Assessment Agency Regional Assessor and Coordinator Application Manual</i> . Version 6.1. Canberra: DVA.	The Assessment Agency Application is designed to assist contracted assessors and coordinators assess the needs for, and approve services, under the DVA VHC program. This manual has been designed to assist in the training of new users and as a reference guide for existing users of the Assessment Agency Application. The manual considers functions that relate to both assessors and coordinators, and also includes additional processes for specific circumstances.
Veterans' Home Care (2005) <i>Veterans' Home Care Guidelines Attachment L: Service Provider Application Manual</i> . Canberra: DVA.	Application is designed to assist contracted service providers under the DVA VHC program. This manual has been designed to assist in the providers to apply and as a reference guide for existing providers to inform veterans of the service delivery guidelines. The manual also includes additional processes for specific circumstances. These VHC were guidelines used by the review to interpret the findings of the consultations in the field.
Veterans' Home Care (2007) <i>Section 2 – Eligibility. Guidelines – March 2007</i> . Canberra: DVA.	Access to VHC is not automatic, with veterans needing to be assessed as eligible before they can receive assistance. Section 2 outlines: Eligibility for assessment Using a repatriation Health Care do identify an eligible veteran or war widow/widower Eligibility for respite care Eligibility for veterans living in boarding houses and supported accommodation
Veterans' Home Care (2007) <i>VHC Bulletin for Assessment Agencies and Service Providers</i> . 13 th April 2007. Canberra: DVA.	The purpose of this bulletin is to: Advise of the Departments intention to convene a forum of all 16 VHC assessment agencies to meet on a regular basis to discuss and resolve issues affecting the VHC program Invite each VHC assessment agency to nominate a representative to attend the forum

Current practice and policy - submissions to the Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs

The submissions to the Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs (carried out to complement *The Way Forward*) were reviewed for comments relevant to VHC.

They indicate that the integration of programs and local services remains a paramount concern to the community care sector including VHC service providers. The variation in access to services provided under the various program types is significant and clients and their carers may receive an amount of care that is not commensurate with their levels of need.

The submissions did not identify any efficient or effective way to reform the community care system to ensure that the clients of all types of programs will benefit in a consistent and equitable way. They noted that the provision of 'basic' services is not the same as a client having basic needs, as basic services are commonly needed and used by those clients of greater complexity and have to be part of a more complex service response.

Table 30 Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs

Organisation / theme	Comments and recommendations
<p>Aged and Community Services Association</p> <p><i>Duplication of systems and reporting requirements</i></p>	<p>An organisation providing all of the following: CACP; EACH; EACHD; HACC/COPS, NRCP (Respite House and in-home respite); TCP; DTC; DVA Nursing; VHC - has to deal with the following:</p> <p>9 different Guidelines; 6 different Standards; 6 different quality reporting/monitoring processes; 6 different referral and assessment processes; 8 different review and assessment processes; 9 different financial reporting requirements, incorporating various periodic returns; 9 different data reporting requirements; 4 different software requirements; 4 different processes for provision of equipment.</p> <p>Red tape can be reduced without Government and the industry losing appropriate and transparent accountability processes and information essential for the ongoing planning and delivery of quality care. The Review must streamline these requirements.</p>
<p>Aged Care Assessment Services, Victoria</p> <p><i>Lack of flexibility and limited scope and intensity of services</i></p> <p><i>Access to higher levels of services without case management</i></p>	<p>The services that matter the most in keeping people in the community:</p> <p>Allied Health services for preventative and restorative care to attain and retain independence.</p> <p>Inpatient rehabilitation and geriatric evaluation and management inpatient services which provide older clients with the opportunity to receive assessment, treatment and therapy to restore function and maximize independence</p> <p>Planned Activity Groups (PAG) that stimulate clients socially, increase and maintain their functional independence, and provide carers with the respite required to assist maintain clients at home ...</p> <p>Funded transport available to and from services such as PAG, slow stream rehabilitation is significant in encouraging clients/carers to both initially access and continue attendance at these services</p> <p>Flexible and responsive in-home respite and residential respite to enable carers to be able to access a reasonable break from their caring role. Carers often respond better to respite services that are flexible in their nature and also provide culturally appropriate workers. Respite is often only able to be provided at times dictated by the service providers which are not always when the carer requires the break.</p> <p>Access to services such as personal care, home nursing and domestic supports which are able to respond to fluctuating care needs.</p> <p>Access to higher levels of services without case management. Many clients with complex care needs are able to arrange their own services or have carers who can do this on their behalf and do not require a case manager however currently access to higher levels of services is only available with case management. Case management delivered in a timely manner can also be the key in assisting clients who require this component to remain at home. The support of a case manager who is able to work with clients and families and negotiate services to be more responsive to a clients care needs can be essential for some clients.</p> <p>Access to affordable gardening and home maintenance services to ensure not only a safe but also</p>

Organisation / theme	Comments and recommendations
	<p>pleasurable environment for older clients ... access to these services is not available or extremely limited.</p> <p>Medication monitoring and dispensing particularly for clients with dementia. Access to Registered Nurses Div 1 to ensure safe and skilled management of more complex clients ... and often results in a lack of early detection and resolution to clinical issues.</p> <p>Aids and Equipment funding to enable timely assess can make the difference between a client remaining in their current environment or having to move to residential care.</p> <p>Clients entering the community care system should be able to move seamlessly through the levels of service without the stress of having to change service providers with each progression. Similarly planning processes for the allocation of services need to fully take into account the needs as seen in and by the sector delivering the services in addition to statistical input. This could be achieved with more flexible use of service funding in service delivery.</p>
<p>Australian Institute of Health and Welfare</p> <p><i>Gaps in the evidence base</i></p>	<p>Recommendations: One continuous care package program</p> <p>New clients would require ACAT assessment to take up a package at any level. Existing clients could (for example) move from a lower to higher level of service at the discretion of the service provider but, on remaining at a high level of service for a specified period of time, an ACAT appraisal to continue at that level of care could be required. (Alternatively, provider decisions about higher patterns of service provision could be subjected to a random audit program). The advantages of a single care package program include:</p> <p>A more flexible system of care provision for clients responsive to changing client need over time</p> <p>Improved continuity of care for clients</p> <p>Removal of disincentives for providers to assist clients who fall into the 'gaps' between the two programs</p> <p>Encouraging (and enabling) service providers to manage their own risk in relation to their overall client care need profile (potentially devices such as targets specifying a nominated percentage of high need clients would ensure a range of services were offered)</p> <p>A single care package program could have the capacity to deliver any type of assistance for any level of care within the scope of the entire program. Thus access to nursing care is provided to two groups of CACP clients who must currently go to another program for assistance: (a) low-care needs clients who may require it on an episodic basis, and (b) high and complex need clients where the availability of informal care means that while total hours required are low, skilled nursing assistance is nonetheless required.</p> <p>Access to nursing, allied health care and mobility services</p> <p>Our findings in recent years have emphasized the importance of nursing and allied health care services to frail older people living in the community. They have also emphasized the increasing importance of mobility limitations in premature admission to residential aged care services and in poorer quality of life and capacity for self care among older people living in the community.</p> <p>It is recommended that consideration could be given to:</p> <p>improving access to nursing and allied health care to community care clients;</p> <p>developing the capacity of aged care programs to offer low impact physical therapy to older people in their homes and group exercise settings; the aim being to encourage physical activity in age-friendly environments</p> <p>While a single continuous care program facilitates the provision of these services to a wider group of clients, it may be beneficial to establish greater linkages between health and social services to maximise the effectiveness of annual voluntary health assessments of people aged 75 and over under Medicare Enhanced Primary Care. Care package recipients could be assisted by their care package provider to respond to those recommendations, be they advice for preventative physiotherapy or occupational therapy recommendations.</p> <p>Significant gaps in available data ... constrain the value of the Review at the present time and this inadequate evidence base may adversely affect the efficacy of reforms that flow from the Review.</p>
<p>Carers Australia</p> <p><i>Gaps and overlaps and needs in the future</i></p>	<p>Fragmentation of the services system in most states and territories, together with complexity of targeting, eligibility requirements and the services that can be delivered within different programs makes the services system difficult both to understand and to access for most carers and consumers.</p> <p>Consideration of means for consolidating the services system beyond the common arrangements. This requires progressive reductions in the development of separately targeted small funding</p>

Organisation / theme	Comments and recommendations
	<p>programs and in the distribution of small amounts of program funding to a wide variety of agencies.</p> <p>Some carers are reluctant to transfer to CACPs due to possible reduced services and higher fees than those being received under the HACC program. Consolidation of eligibility and needs assessment for the packaged care tier, currently underway.</p> <p>Improved continuity of care between basic CACPs and HACC, as some carers may be reluctant to transfer from HACC to CACPs because of loss of trusted care workers.</p> <p>The development of common reporting data across Commonwealth programs and the increasing comparison of data systems across programs using common client identifiers are essential to future planning.</p>
<p>Catholic Health Care</p> <p><i>Coordination across a continuum of care</i></p>	<p>Veterans' Home Care was implemented January 2001. This program offers veterans and war widows the same types of home care support services, respite, transport and social support as HACC. Access to the program is via an eligibility assessment, and co-payments are required. Whilst this program is targeted at a specific client group, it represents another program option for older people which, from a consumer and provider perspective, could be seen to duplicate and further fragment the existing community care programs.</p> <p>Community care should be preventive, therapeutic, and restorative or supportive; and services which support older people include services which support carers to maintain their caring role.</p> <p>Primary care and health promotion, Restorative/therapeutic services, and Information, assessment and care coordination are available and accessible to older people at all levels of dependency.</p> <p>Services are designed in such way as to promote a continuum of care particularly across the community and acute/sub-acute sectors and the community and primary care sector.</p> <p>At higher levels of dependency, older people can move into and out of residential care. Options for care delivery (i.e. either in community based or residential settings) occurs through a permeable interface or care substitutions between the residential and community sectors.</p>
<p>Department of Health and Human Services Tasmania</p> <p><i>Service gaps and overlaps</i></p>	<p>In theory, each program has its own discrete role. ... basic level support services to maintain an individual's independence (HACC), higher level of community care for individuals who would otherwise require low or high level residential aged care (CACP and EACH packages). Other Australian Government programs (i.e. NRCP and residential respite) then aim to provide separate but complementary services.</p> <p>However in practice, both anecdotal and formal reports show that service gaps and overlaps are common. The variation in services provided under the various program types is so significant that clients ultimately receive an amount of care that can range from one to 50 hours per week</p>
<p>Department of Families and Communities</p> <p>South Australia</p> <p><i>Service gaps and overlaps - reduce the number of discrete programs, promote common access, assessment and referral arrangements</i></p>	<p>It is the responsibility of State and Territory Governments to provide rehabilitative services. The Australian Government's concern to ensure that the jurisdictions accept this responsibility and that cost shifting does not occur has resulted in a focus and culture of maintenance and support in community care. Opportunities for prevention and early intervention which would improve the quality of people's lives, and a significant saving to Governments have not been taken advantage of.</p> <p>Whilst maintaining the integrity of community as distinct from rehabilitative care, a revitalisation of an approach promoting independence is in the interests of all. There is a clear role, for example, in home modification and equipment (often very basic) provision in setting the person and their family up to be able to manage independently, or at least with less formal support. An increased focus on allied health assessment and prescription and short term intervention would assist.</p> <p>Social isolation is a critical factor in well-being. The more connected a person is to their community, both the more likely they are to receive informal care and the less likely they are to have unnecessarily inflated care needs. Services which link people to their communities are therefore of strategic importance, and not the 'soft' service which they are often seen to be.</p> <p>Of immediate concern is the number of different programs providing respite, the variation and overlap between them, and the lack of a system to assess relative need and equity of service provided... Some programs currently have caps, but there is no system to identify cross program usage ... The need for respite is more related to carer circumstances than to the level of caree needs. Assessment for respite provision needs to be based around the carers' needs, although the needs of the caree are central in determining how the care should be provided.</p> <p>Case management and care coordination have a vital role in ensuring an effective and coordinated service response. Unfortunately, increasingly large amounts of community care resources are being employed in this manner due to the complexity of funding programs and the service sector. Reform in these areas by reducing the number of discrete programs, common access, assessment and referral arrangements are clear ways forward, and the outcome will be more timely and</p>

Organisation / theme	Comments and recommendations
	<p>efficient responses with increased resources for service provision.</p> <p>Links to services other than community care are also vital, including and especially health. For example, if medication is not appropriately managed, the amount of community care required will increase and the benefit a person receives will be compromised. Again it is the service system design, including transfer of assessment information and a smooth referral process which is critical. Arrangements may vary from jurisdiction to jurisdiction, but the principle is important in the design of all community care.</p>
<p>Queensland Health</p> <p><i>Reduce service gaps and overlaps, promote access to nursing and allied health interventions, education and training for carers</i></p>	<p>Research informs us that specific allied health intervention in community care settings contribute to more positive health outcomes for older people. CACPs therefore need to be able to facilitate movement across the care continuum from low to high community care and not just provide support with low level care services</p> <p>Amalgamate the programs for respite such as the National Respite for Carers Program and respite through the HACC Program, into one program that offers a range of respite options that can be delivered by a variety of service providers operating at the local level.</p> <p>In amalgamating respite programs ... there should be recognition of those programs which also provide respite to carers of people with a disability...should ensure these carers are not disadvantaged.</p> <p>Consolidate CACPs, EACH and EACHD into one community care program that provides a clear, logical and easily accessible continuum of community care that is adjustable to the level of community care required and able to respond seamlessly to the assessed need of individual clients. This will reduce duplication and gaps in service delivery, make the system less complex and enhance workforce options and service viability.</p> <p>Introduce clear entry and exit strategies for those moving between HACC and other community care programs.</p> <p>Include nursing and allied health services in Community Aged Care Packages (CACPs) to make the program more responsive to the needs of clients at the lower end of the packaged care continuum in order to adequately meet all their needs and to remove the reliance on other programs to access the required services.</p> <p>Education and Training for Carers to access appropriate information, advice and support ... that have a preventive / restorative function and are not limited to tertiary interventions are required ...through the establishment of an education/training program to inform carers of the progression of certain conditions (e.g. dementia); healthy ageing programs; self advocacy programs, and community and primary health options.</p>
<p>Silver Chain WA</p> <p><i>Consolidated access, flexibility and early intervention to promote independence</i></p>	<p>From our experience in providing services to this client group we also know the importance of:</p> <p>A well managed point of access that is able to provide information on availability of services, determine eligibility, establish an electronic client record and schedule the first appointment with the appropriate provider (Silver Chain currently operates this way through a centrally based customer centre).</p> <p>Early intervention independence programs for all referrals prior to long term utilisation of services, to raise the level of independence for the client. This program also ensures appropriate levels of service provision and significantly reduces demand on long term service provision. Silver Chain can demonstrate the effectiveness of this type of intervention through the Home Independence Program (HIP).</p> <p>A provider needs to be able to respond to the changing needs of a client. In the absence of this the client is often required to change their provider to access appropriate services. Such changes are not wanted by the client nor are they in the client's best interest.</p> <p>Packages of care that could be increased with higher care needs would be ideal, providing the flexibility to meet the needs of the client without major disruption to their life.</p> <p>This simple arrangement would address the issues of gaps and continuity of care for the client, and reduce some of the administrative and coordination issues for the provider.</p> <p>Being able to provide home care to residents currently in a residential care facility, wishing to return to the community for weekends or short stay would be of great value to residents and families.</p>
<p>Uniting Care Ageing NSW and ACT</p> <p><i>Importance of residential respite</i></p>	<p>The range of service types currently available within the Basic Care Tier is reasonably adequate, although there could be a better planning focus on and linkage with preventive and/or health promotion type services such as healthy ageing centres and men's sheds and the like.</p> <p>The main problem with the Basic Care Tier is its fragmentation, being funded and regulated under too many different programs and different government departments eg HACC, NRCP, VHC. We</p>

Organisation / theme	Comments and recommendations
<i>and anomalies in costs</i>	<p>appreciate that this review is focused more on older Australians with complex care needs and their carers (Packaged Care Tier), but this fragmentation is an obvious, well-documented issue that contributes to program boundary problems both within and across all of the tiers in the system.</p> <p>The importance of residential respite should not be underestimated ... over 50% of residential respite users are also accessing community care programs, such as HACC and CACPs.</p> <p>This single quality accountability system could cover all Department of Health and Ageing community care programs, all DVA community care programs and the HACC program. The validating or “standards” agency could be funded either outright by the Commonwealth, or on a pro-rata basis by the relevant funding bodies from efficiencies/savings by eliminating the current duplication.</p> <p>The reduction in red-tape and efficiencies to be gained by providers from such a proposal are obvious, plus its implementation would enable more resources to be redirected back into direct care.</p>
<p>Victorian Department of Human Services</p> <p><i>Improve access to restorative services within an active service model and simplify the system</i></p>	<p>The underlying principle that Victoria has been using in its own reforms is that care should be delivered in the right place at the right time. In practice, this means that integrated and clearly graduated care that meets people’s needs, that is delivered in a timely way, and is located close to where people live and work, will produce better outcomes and is a more efficient way to use the resources available.</p> <p>Victoria has a preference for a community care system built around organisations that have sufficient infrastructure and scale to deploy the required resources and skilled personnel, and that have good connections to primary healthcare services. The present system in Victoria has some of these characteristics (particularly the strong role of local government home-care services, robust community health services across the State, a metropolitan-wide home nursing service, innovations in small rural health services, and the service coordination agenda promoted by the Primary Care Partnerships Strategy).</p> <p>‘Basic’ does not imply that clients are mainly low dependency. The evidence shows that many low-dependency people receive no formal assistance, while many quite dependent people make only limited use of one or two basic services; these basic services are critical to supporting them and their carers in the community.</p> <p>Victoria’s developmental work on an Active Service Model in the HACC Program (is towards) a capacity-building model where interventions focus on the restoration of function (e.g. learning how to manage the housework or self care after a health setback) rather than simply providing an ongoing substitution for the person’s incapacity. Central to this approach is a commitment to enabling the client to be more actively involved in the planning and delivery of the intervention.</p> <p>One aim of this developmental work is to establish whether short-term interventions are able to increase independence and reduce ongoing reliance on formal services. One such group may be entrants into home care who could benefit from a mix of new equipment for housekeeping and short-term instruction by occupational therapists or physiotherapists. Silver Chain in Western Australia has done substantial work on this approach</p> <p>At this stage, it is not possible to predict the net impact on demand for HACC services or the average cost per client, but a guiding principle is that interventions should be relatively low cost and low intensity in keeping with the overall pattern of resource distribution currently evident in the HACC program.</p> <p>Reducing complexity for clients and carers by simplifying the system rather than requiring case management to navigate the complexities of the system.</p>

Appendix 3

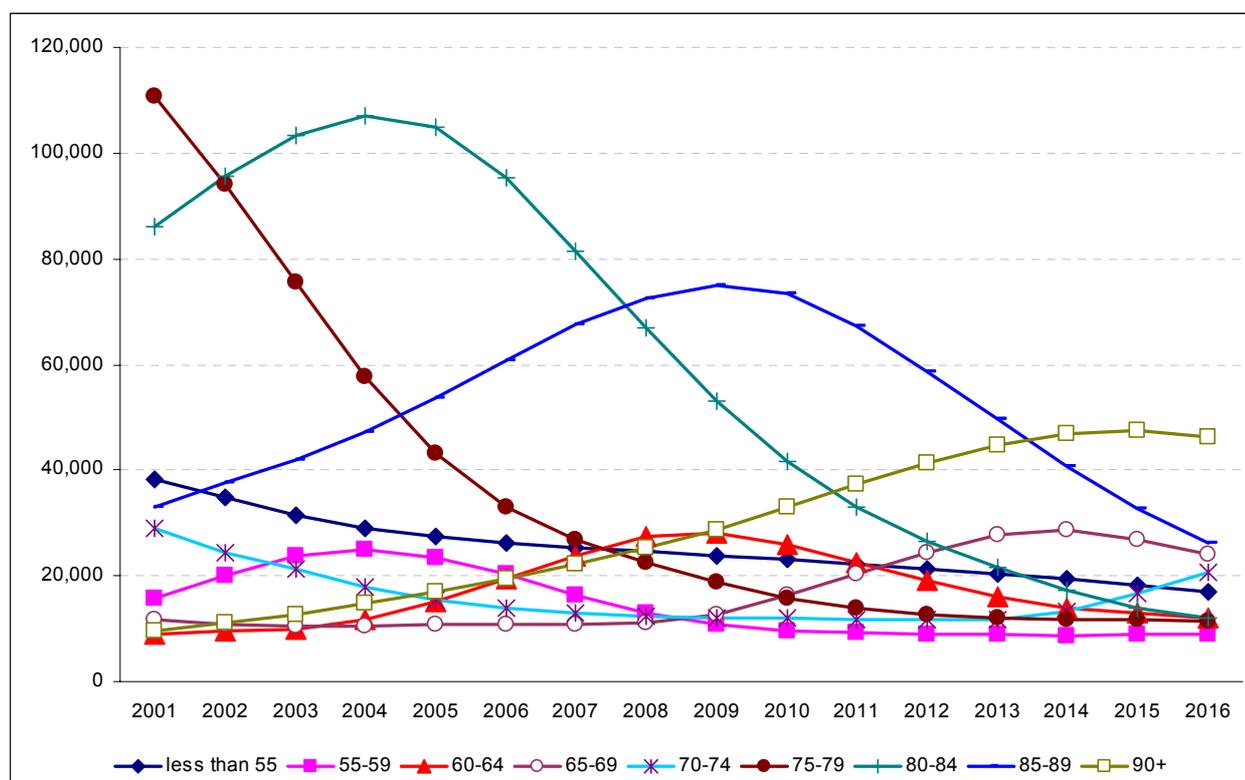
Methods and assumptions in projections

This attachment describes the methods used to compile the projections reported in the body of the report. Care has been taken to make the assumptions explicit.

DVA population projections

Existing projections of the population of DVA gold and white card holders are the starting point in the projection of VHC services. DVA compiles projections of the DVA population by age and sex. Data inputs include projected ex-service survivor populations by conflict, DVA grant rates, internal transition rates and DVA-specific mortality rates. All of these data are internal to the DVA, and we believe that there is no need to replicate these processes. For each future year, the DVA projections include the number of people by age and sex. They also project the number of gold and white card holders by age and sex (denote this population 1). Figure 31 summarises these projections by showing the number of gold or white Card holders by age group at December. The actual data provided by DVA were for June of each year (actual data up to June 2007; projected values from June 2008 onwards). The December figures are linear interpolations of the June figures.

Figure 31 Actual and projected number of DVA gold or white card holders by age at December



VHC service projection model

Let $C_{s,a}^i$ denote the projected number of (gold and white) card holders in year i by sex: $s \in (m, f)$ and age: $a \in (<65 \text{ years}; 65-70; 70-75; 75-80; 80-85; 85-90; 90+)$

Consideration was given to model the proportion of card holders who are not residing in residential aged care by age/sex. Since people in residential aged care are unlikely to benefit from VHC

services, this would form the population of people who receive the vast majority of VHC services. However, the proportion of gold or white card holders who are in residential aged care is small (8.5% in 2006) and the quality of the residential aged care data item has been in question. Thus it does not seem feasible to explicitly model this proportion. However, this should not greatly affect the quality of projections.¹⁸

Projecting the proportion of gold and white card holders assessed for VHC services

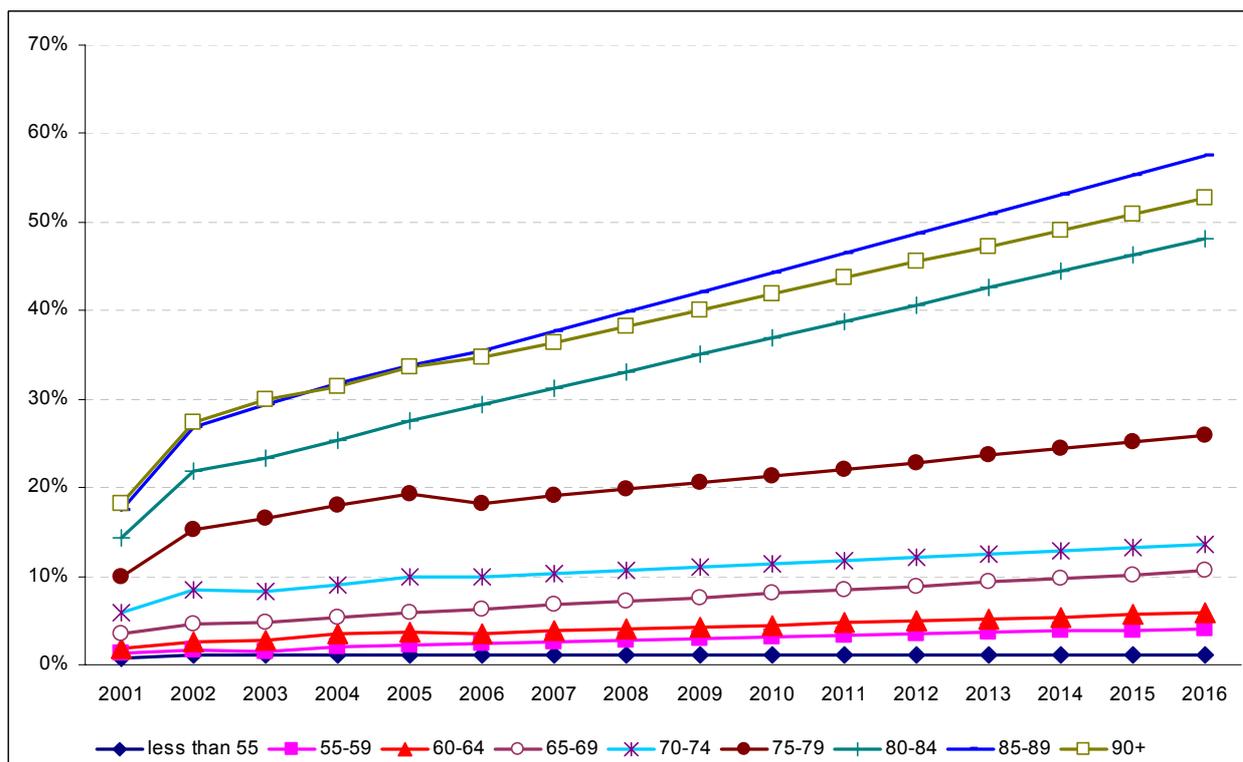
The first step is to project the proportion of Population 1 who apply for VHC services by age and sex. Denote $p_{s,a}^i$ as the proportion of people in Population 1 projected to be assessed for VHC in year i , by age (a) and sex (s).

Population 2 is the set of people (projected to) be assessed for VHC In year i :

$$\text{Population 2} = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i)$$

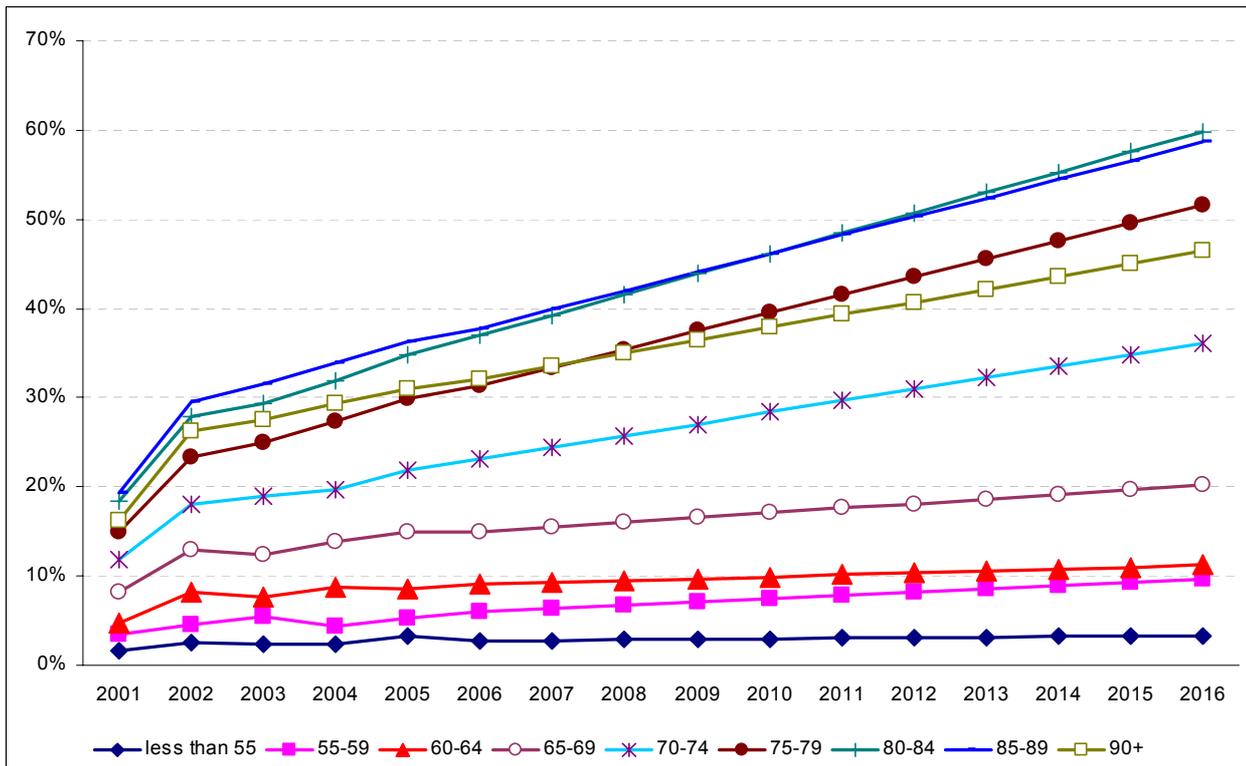
In general, this percentage is highest for older age groups, although females aged 90+ have lower rates than immediately younger females. In recent years, this percentage has increased considerably within each age-sex group. We assume that these trends will continue, by linearly extrapolating the change in these proportions. Specifically, we assume that the average annual increase in this proportion for each group between 2002 and 2006 will continue to 2016. This is illustrated in Figure 32 for males and Figure 33 for females.

Figure 32 Actual and projected proportion of male DVA gold or white card holders who are assessed for VHC services by age at December



¹⁸ The main consequence of this omission is that the model will not be able to explicitly consider ‘what-if’ scenarios which consider different future utilisation of residential aged care.

Figure 33 Actual and projected proportion of female DVA gold or white card holders who are assessed for VHC services by age at December



Projecting the proportions of Population 2 who receive each VHC service

The second step is to project the proportion of Population 2 (by age and sex) who receive each of the five service types (domestic assistance, personal care, respite in home, respite emergency, home and garden).

Let $q_{s,a,DA}^i$ denote the proportion of people in Population 2 projected to receive domestic assistance in year i , by age (a) and sex (s).

Similarly, let $q_{s,a,PC}^i$, $q_{s,a,RIH}^i$, $q_{s,a,RE}^i$, $q_{s,a,HG}^i$ refer to the corresponding percentages for personal care, respite in home, respite emergency and home and garden, respectively.

Thus the projected number of people receiving any domestic assistance in year i is given by:

$$PDA^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,DA}^i)$$

Note that PDA does not represent the projected number of people receiving domestic assistance at a point in time. It represents the projected number of people who receive any domestic assistance in year i . Some may receive it only at the beginning of the year, others at the end. This is sufficient for the projection methodology. But it should not be misinterpreted.

Similarly for personal care:

$$PPC^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,PC}^i)$$

Similarly for in home respite:

$$PRIH^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a.RIH}^i)$$

Similarly for emergency respite:

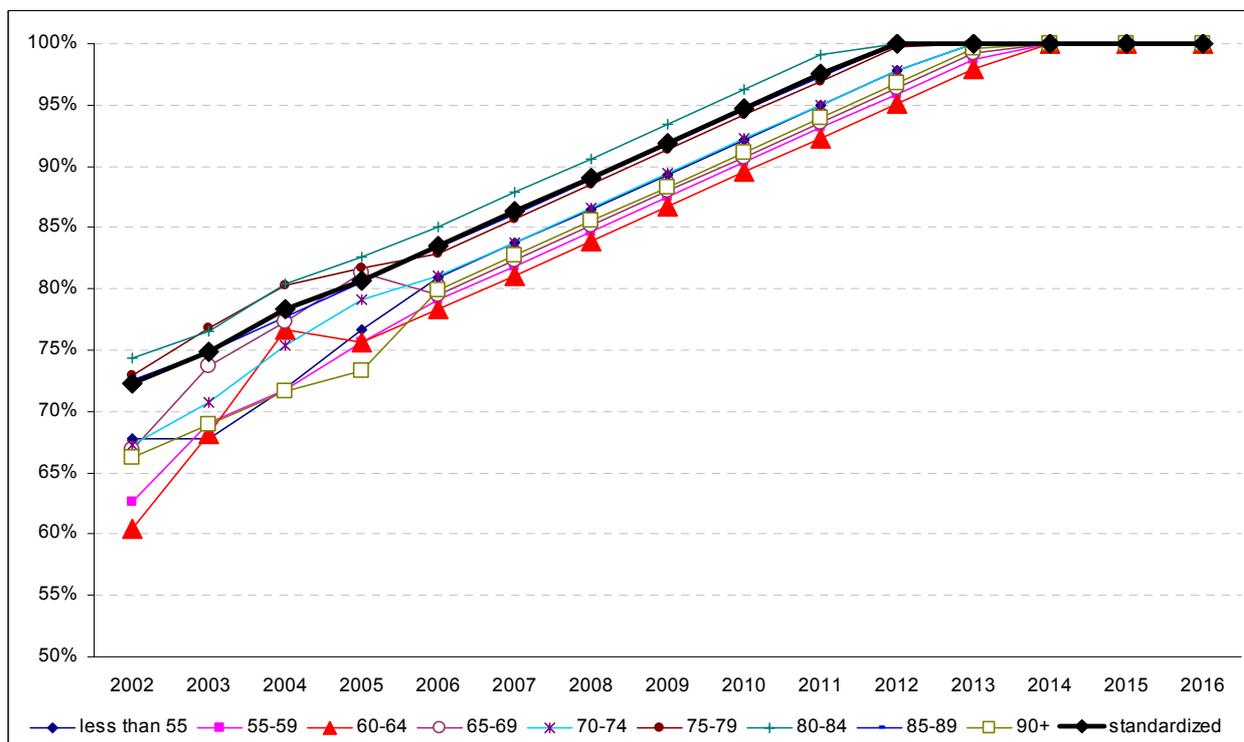
$$PRE^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a.RE}^i)$$

Similarly for home and garden:

$$PHG^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a.HG}^i)$$

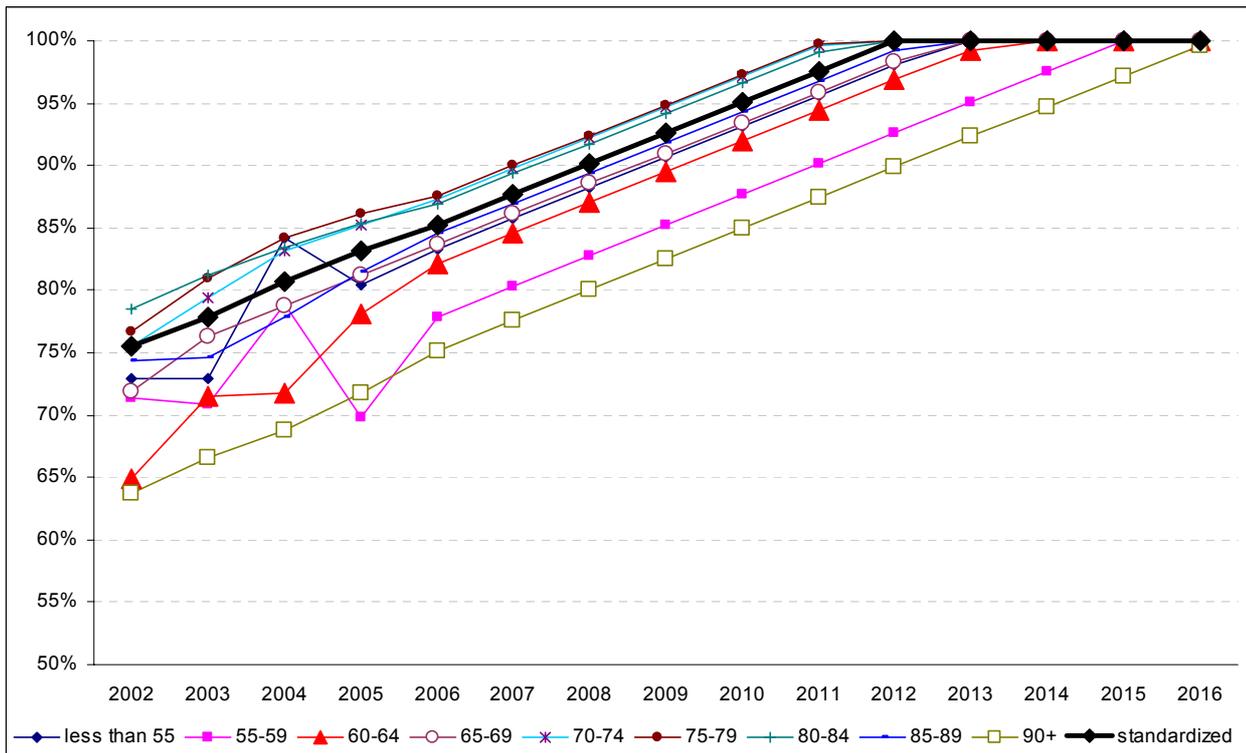
The proportions of assessed people who receive domestic assistance have increased considerably in recent years. On an age standardised basis¹⁹ this percentage has increased very steadily for males from 72% in 2002 to 83% in 2006. For females, the corresponding increase was from 75% to 85%. We assume that the trend in the standardized rate will increase linearly for each age group. Specifically, we assume that the average annual increase in the standardized proportion for each sex between 2002 and 2006 will continue for each age group to 2016. For most groups, this results in a projected proportion of 100% in about 2012, which is subsequently assumed to stay constant. This is illustrated in Figure 34 for males and Figure 35 for females.

Figure 34 Actual and projected proportion of males assessed for VHC who receive domestic assistance by age at December



¹⁹ Directly standardised to the population of people assessed for VHC services in 2006.

Figure 35 Actual and projected proportion of females assessed for VHC who receive domestic assistance by age at December



The proportions of assessed people who receive in home respite have decreased in recent years. As a conservative measure, we do not assume a continuation of this trend. Instead, we assume that the 2006 proportions will stay constant in future years for each group. This is illustrated in Figure 36 for males and Figure 37 for females.

Figure 36 Actual and projected proportion of males assessed for VHC who receive in home respite by age at December

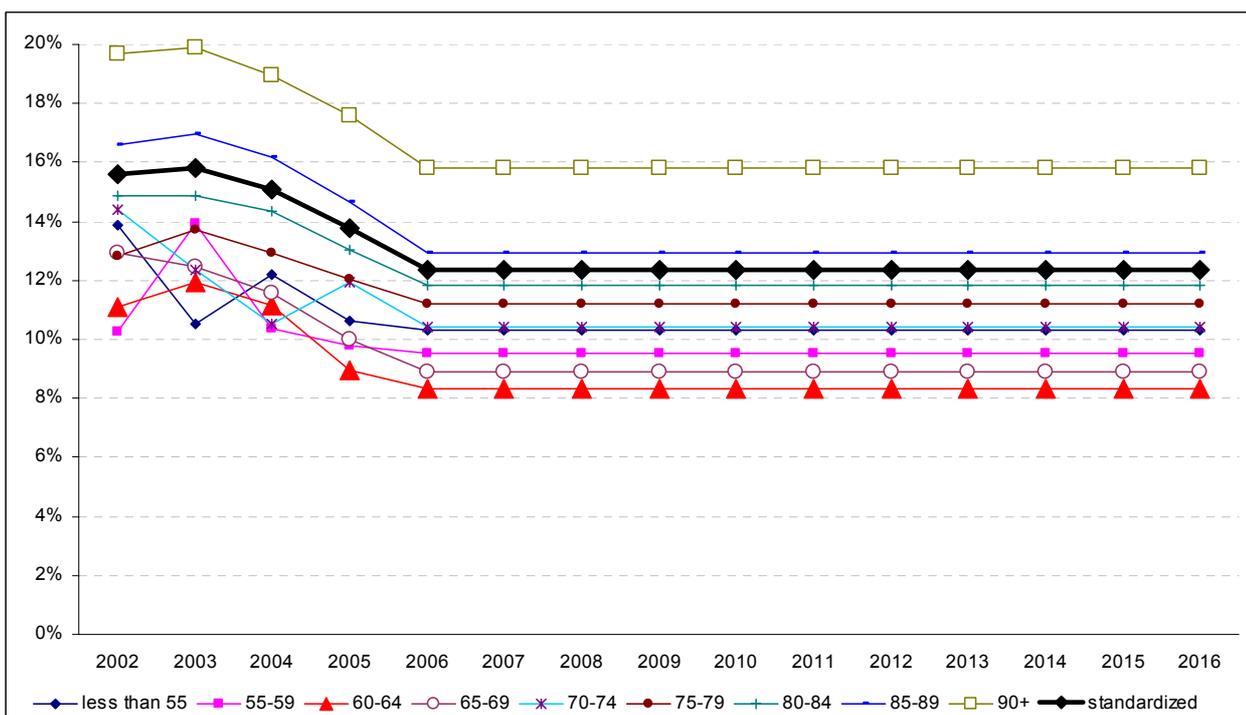
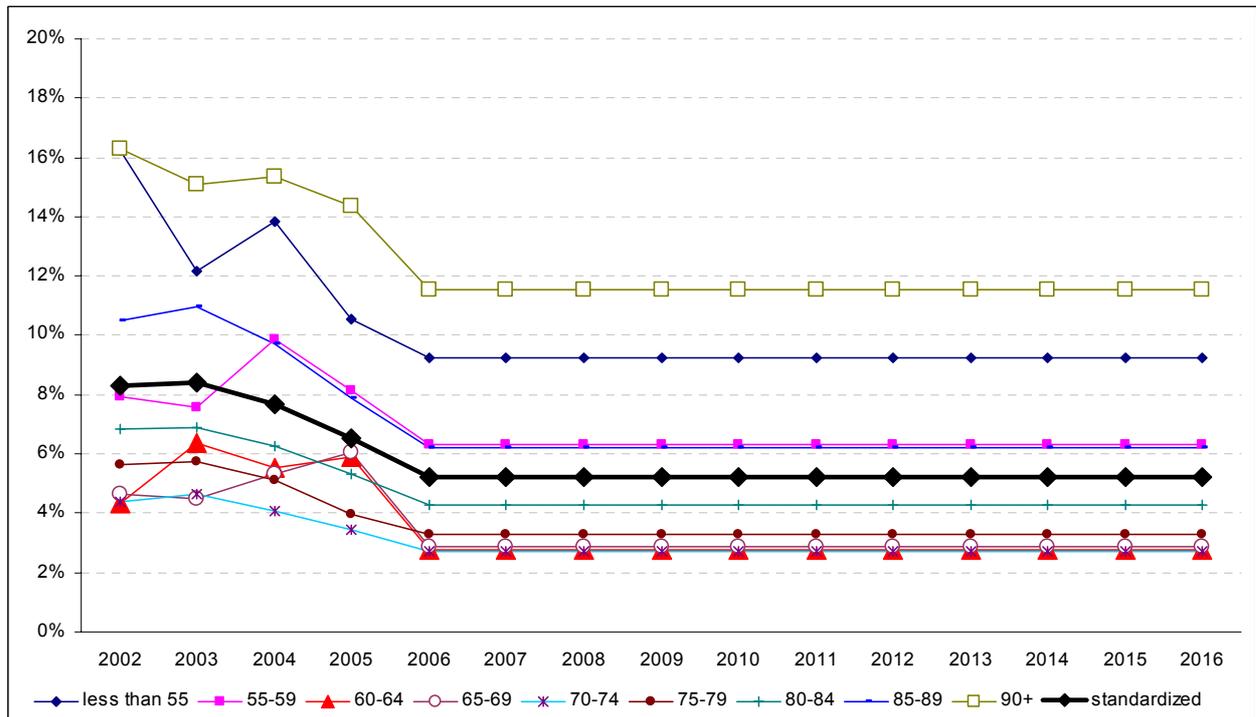


Figure 37 Actual and projected proportion of females assessed for VHC who receive in home respite by age at December



The proportion of assessed males who receive personal care has been steady between 2004 and 2006, though it has decreased slightly for females. We assume that the 2006 proportions will stay constant in future years for each group. This is illustrated in Figure 38 for males and Figure 39 for females.

Figure 38 Actual and projected proportion of males assessed for VHC who receive personal care by age at December

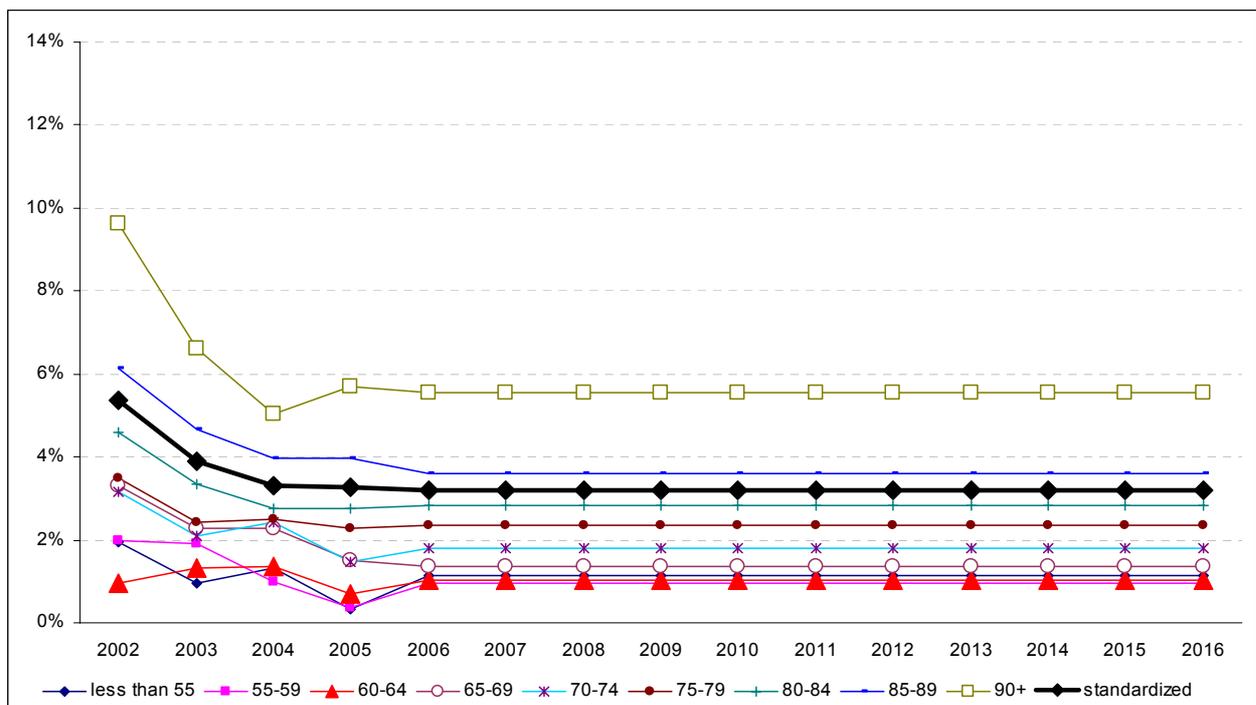
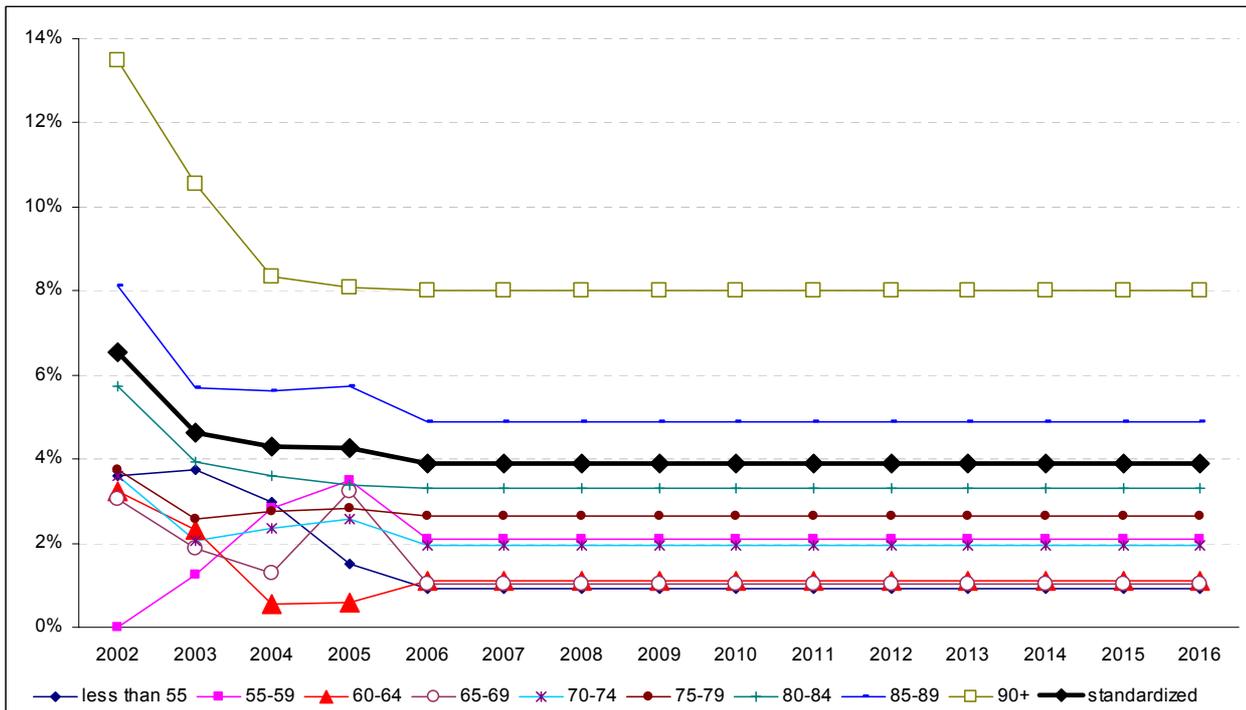


Figure 39 Actual and projected proportion of females assessed for VHC who receive personal care by age at December



The proportions of assessed people who receive home & garden maintenance have fluctuated considerably in recent years, although they did not change greatly between 2005 and 2006. We assume that the 2006 proportions will stay constant in future years for each group. This is illustrated in Figure 40 for males and Figure 41 for females.

Figure 40 Actual and projected proportion of males assessed for VHC who receive home & garden maintenance by age at December

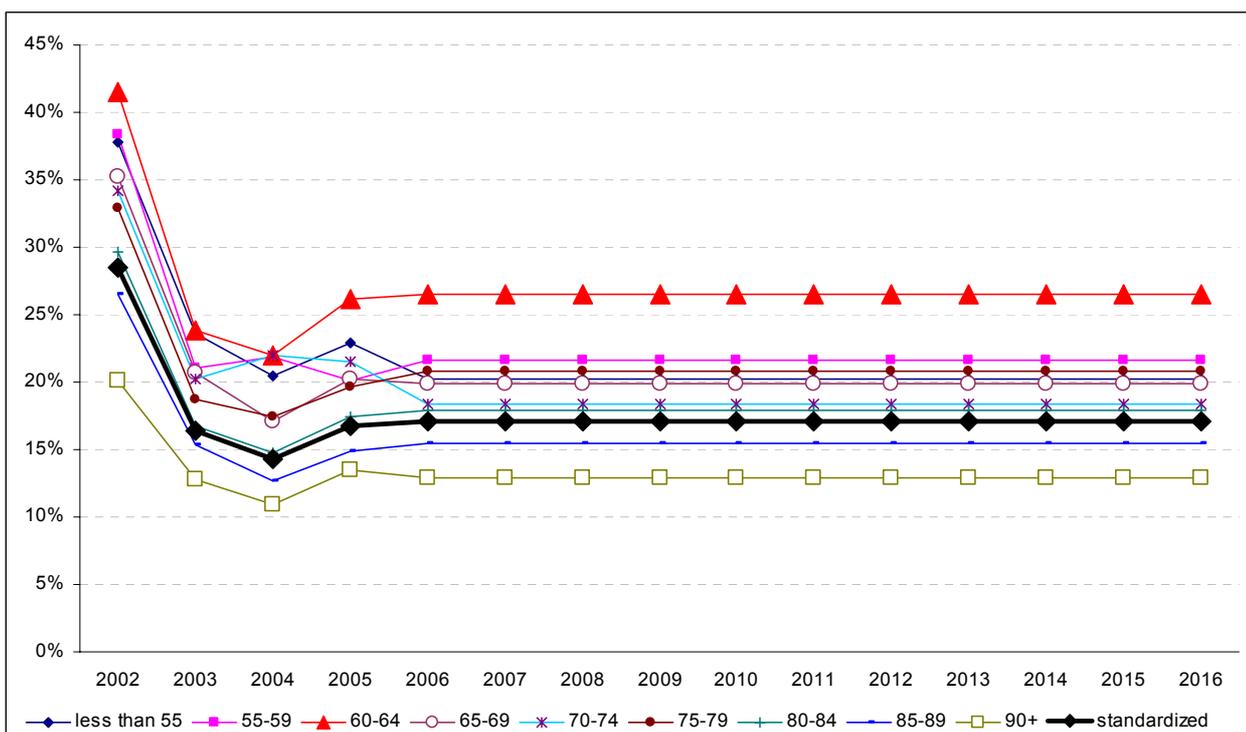
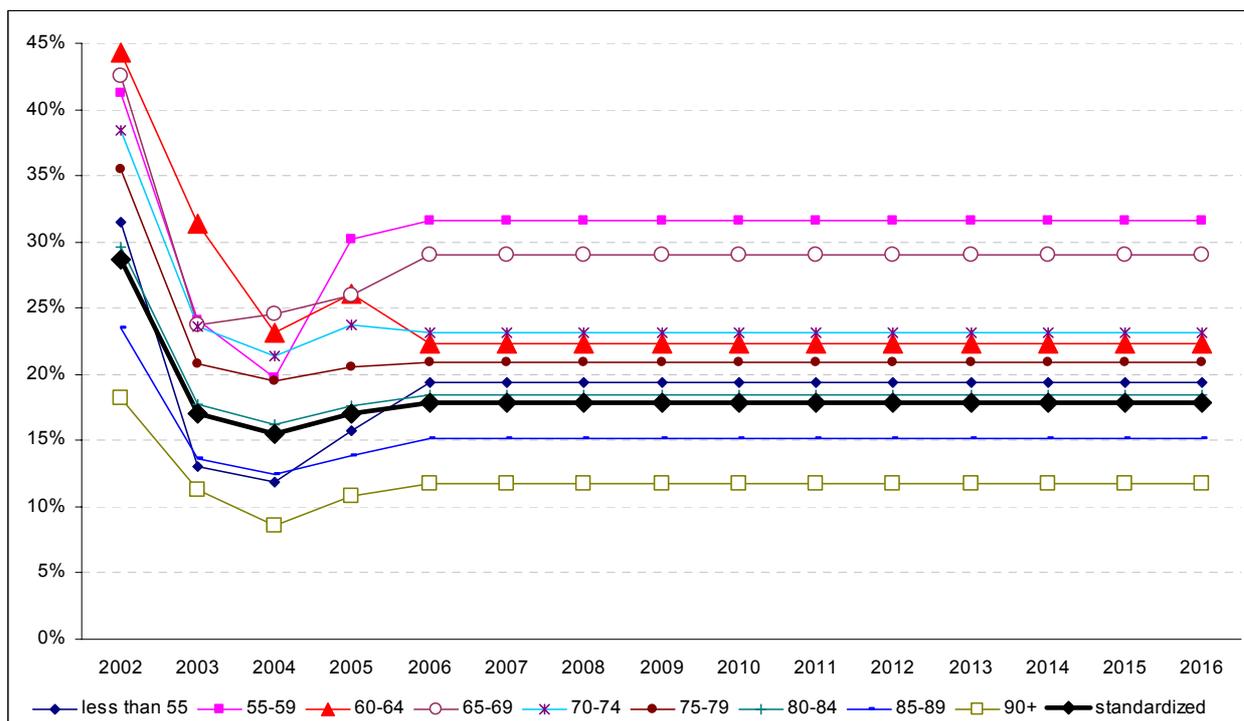


Figure 41 Actual and projected proportion of females assessed for VHC who receive home & garden maintenance by age at December



The proportions of assessed people who receive VHC emergency respite are very small and fluctuate wildly between years for most age groups. The age standardised proportions have decreased in recent years. However, we do not assume a continuation of this decline. Instead, we assume that the age standardised proportion for 2006 will apply for all age groups in future years. This is illustrated in Figure 42 for males and Figure 43 for females.

Figure 42 Actual and projected proportion of males assessed for VHC who receive emergency respite by age at December

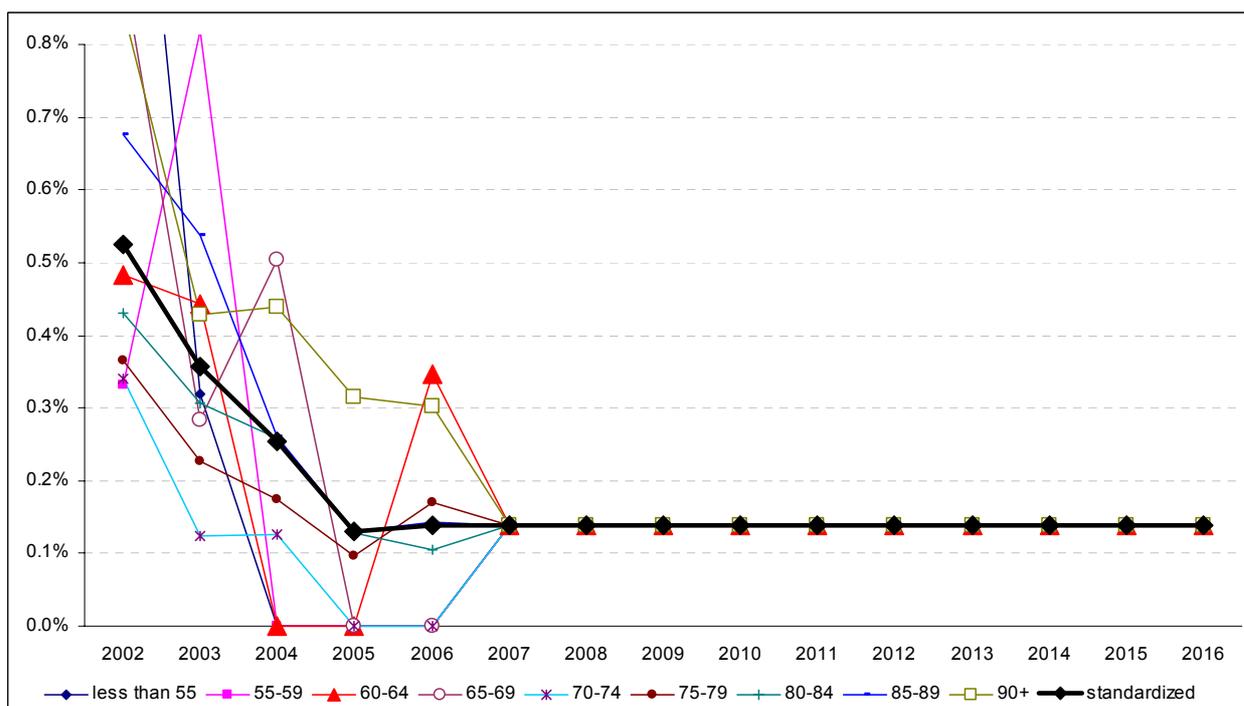
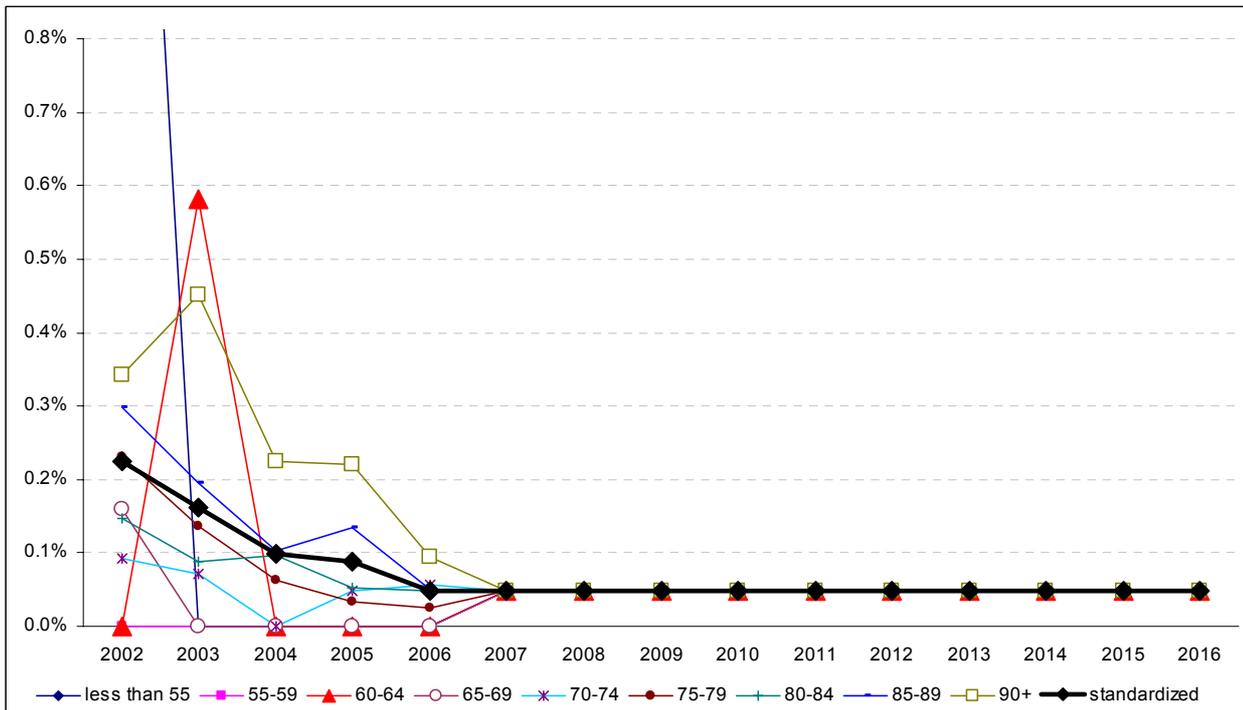


Figure 43 Actual and projected proportion of females assessed for VHC who receive emergency respite by age at December



Projecting the average number of occasions of each VHC service for those who receive such a service

The third step is to project the average annual number of occasions for each service type amongst those who receive services (by age and sex).

Let $N_{s,a,DA}^i$ denote the projected average number of occasions of domestic assistance received in year i , by age (a) and sex (s), amongst people who receive any domestic assistance in that year.

Note that $N_{s,a,DA}^i$ does not refer to the average number of occasions of people who receive the service for the full year. It is calculated for all people who received any such services in that year. This is sufficient for the projection methodology. But it should not be misinterpreted.

Similarly, let $N_{s,a,PC}^i$, $N_{s,a,RIH}^i$, $N_{s,a,RE}^i$, $N_{s,a,HG}^i$ refer to the corresponding averages for personal care, respite in home, respite emergency and home and garden, respectively.

Thus the projected number of occasions of domestic assistance to be received in year i is given by:

$$NDA^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,DA}^i \times N_{s,a,DA}^i)$$

Similarly for personal care:

$$NPC^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,PC}^i \times N_{s,a,PC}^i)$$

Similarly for in home respite:

$$NRIH^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,RIH}^i \times N_{s,a,RIH}^i)$$

Similarly for emergency respite:

$$NRE^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a.RE}^i \times N_{s,a.RE}^i)$$

Similarly for home and garden:

$$NHG^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a.HG}^i \times N_{s,a.HG}^i)$$

For domestic assistance, home & garden maintenance and in home respite, the number of occasions of service is assumed to stay constant at 2006 levels for each group. For personal care and emergency respite, the average number of occasions for future years is assumed to equal the *standardised* 2006 average. This decision reflects the paucity of data within most age groups for these service types. These assumptions are illustrated in the following ten figures.

Figure 44 Actual and projected average annual occasions of domestic assistance for males who receive any domestic assistance in that year by age at December

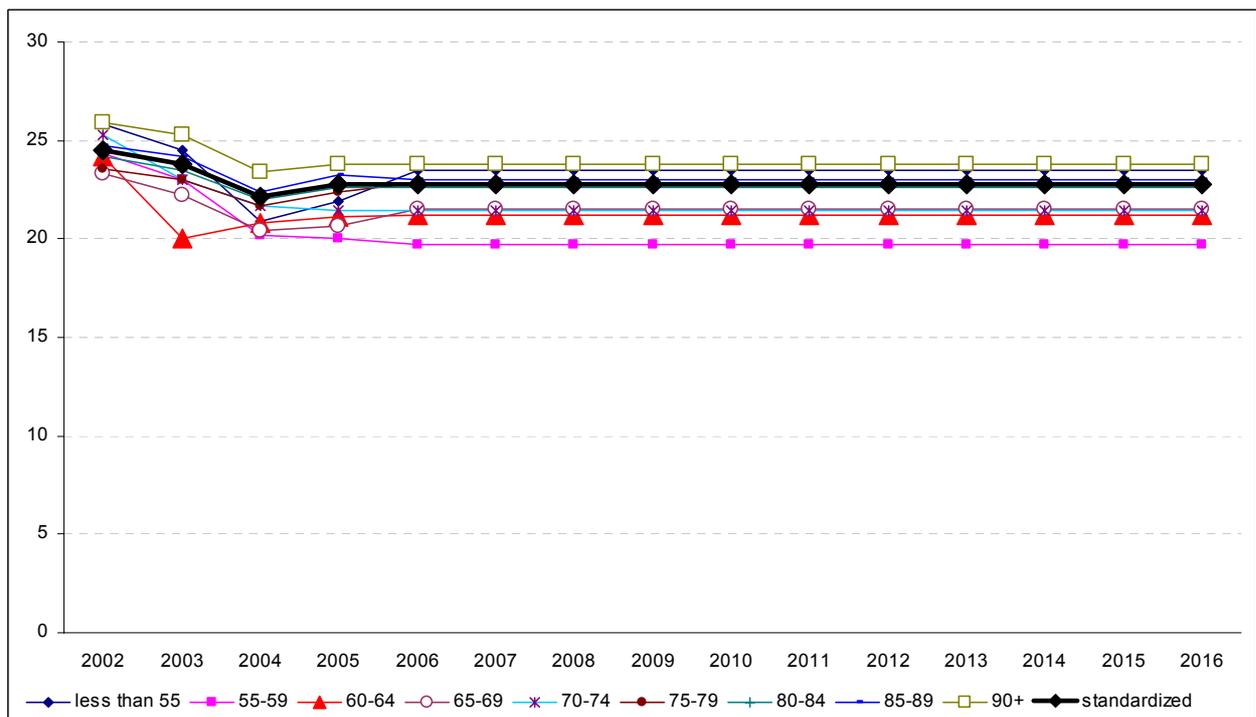


Figure 45 Actual and projected average annual occasions of domestic assistance for females who receive any domestic assistance in that year by age at December

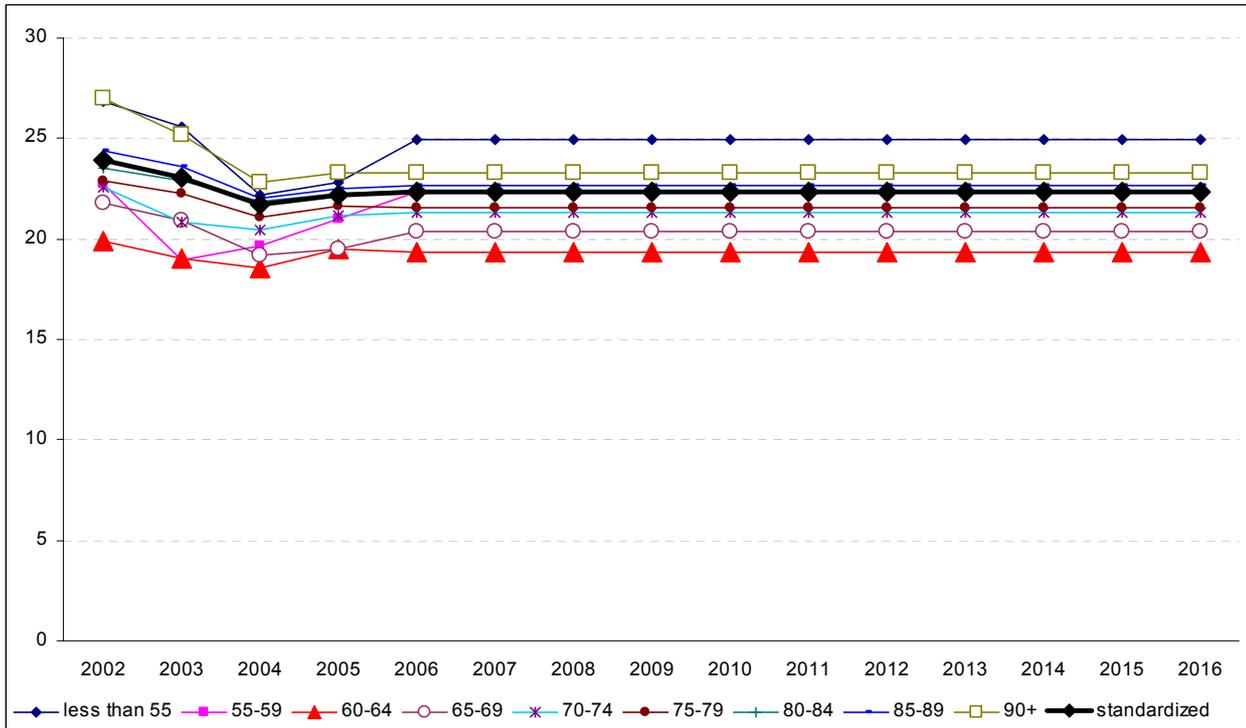


Figure 46 Actual and projected average annual occasions of in home respite for males who receive any in home respite in that year by age at December

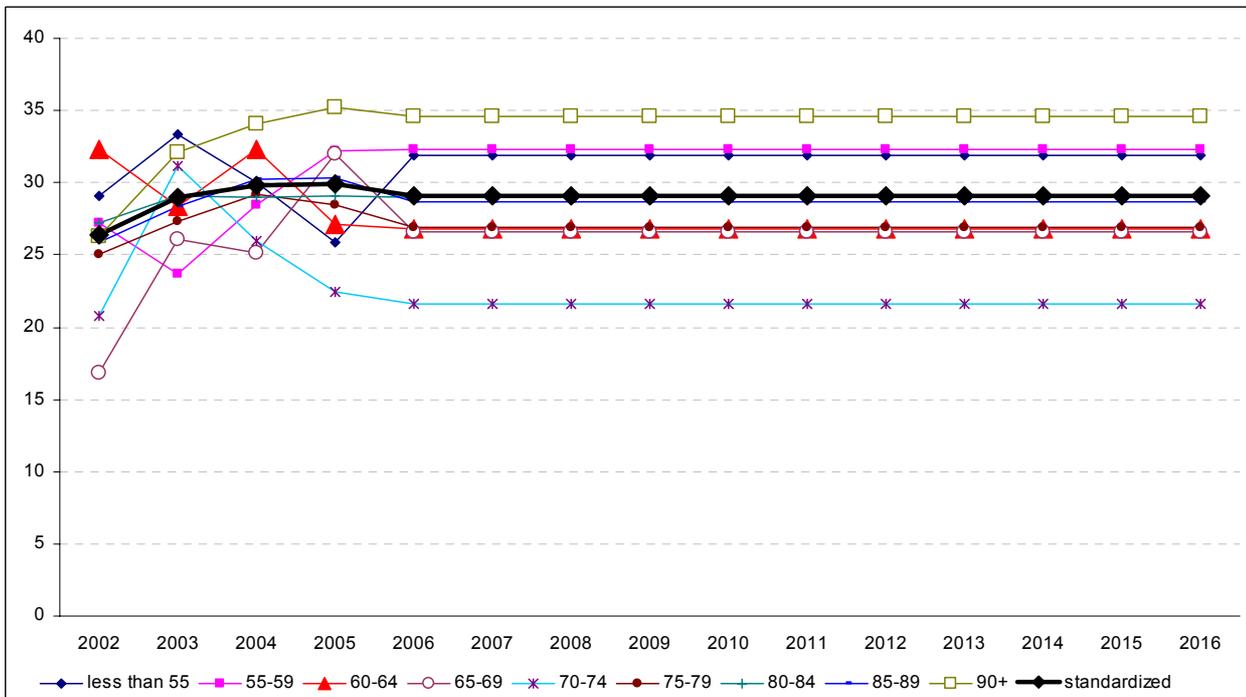


Figure 47 Actual and projected average annual occasions of in home respite for females who receive any in home respite in that year by age at December

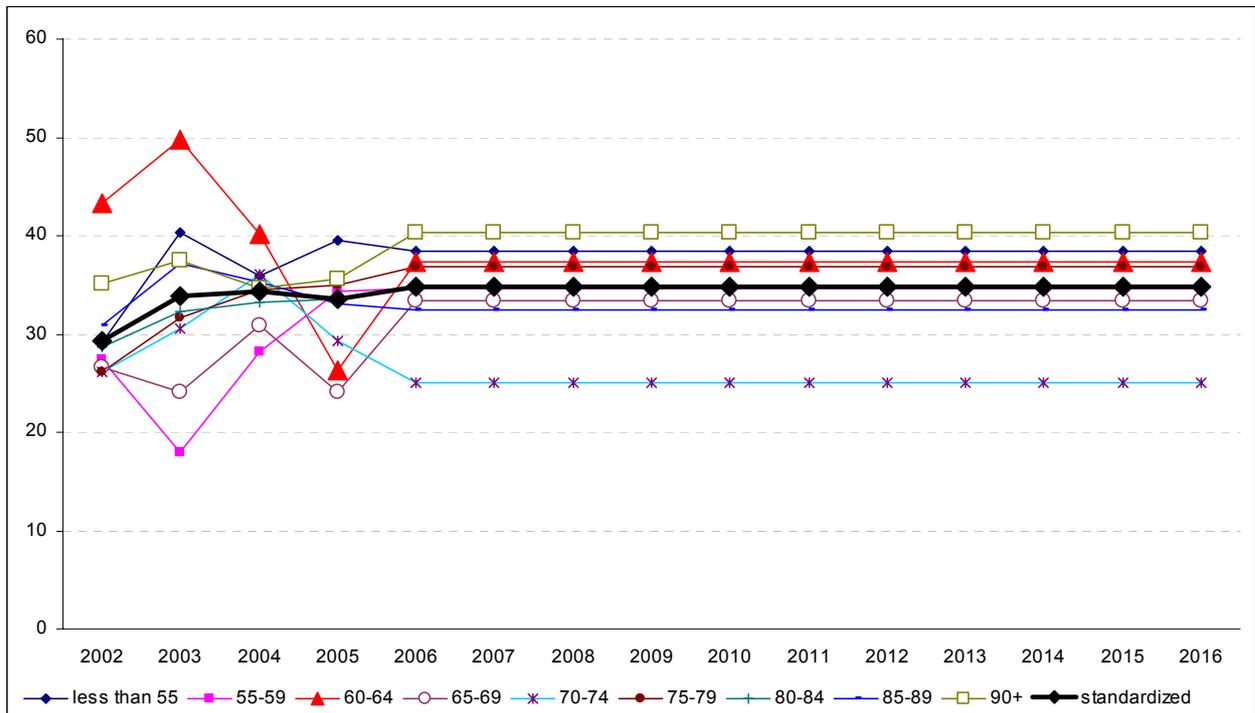


Figure 48 Actual and projected average annual occasions of personal care for males who receive any personal care in that year by age at December

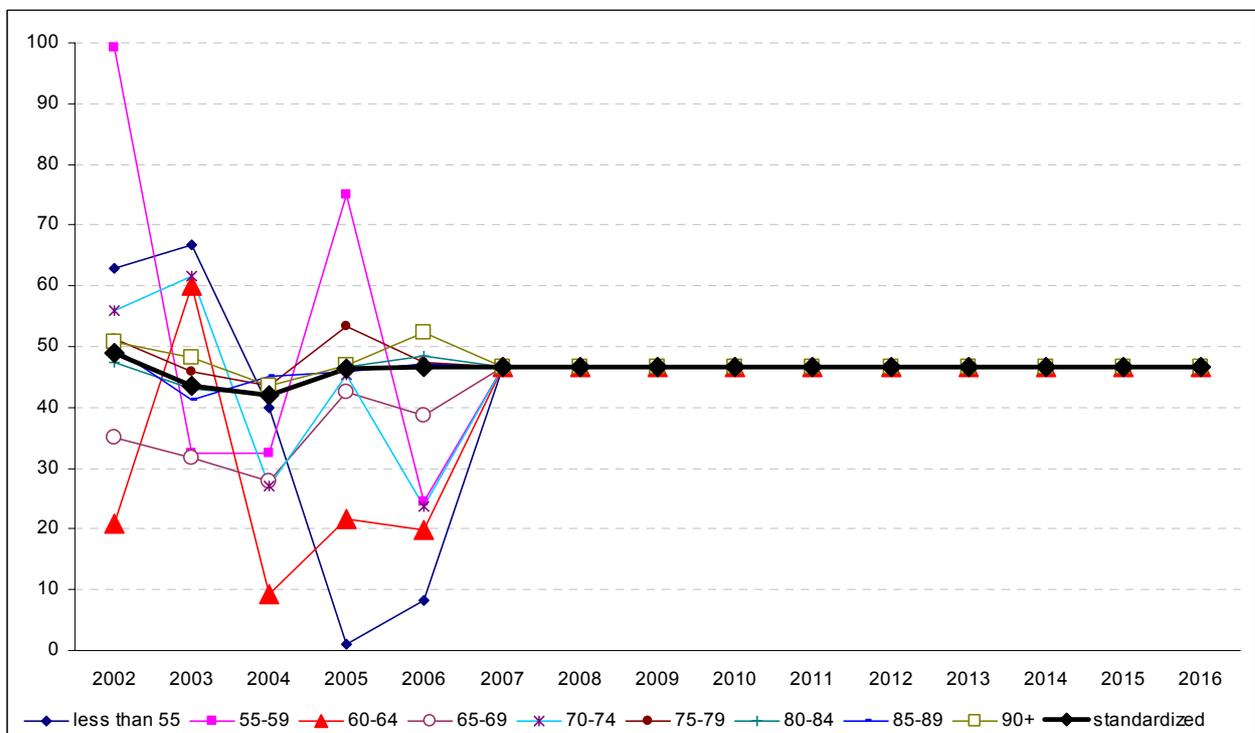


Figure 49 Actual and projected average annual occasions of personal care for females who receive any personal care in that year by age at December

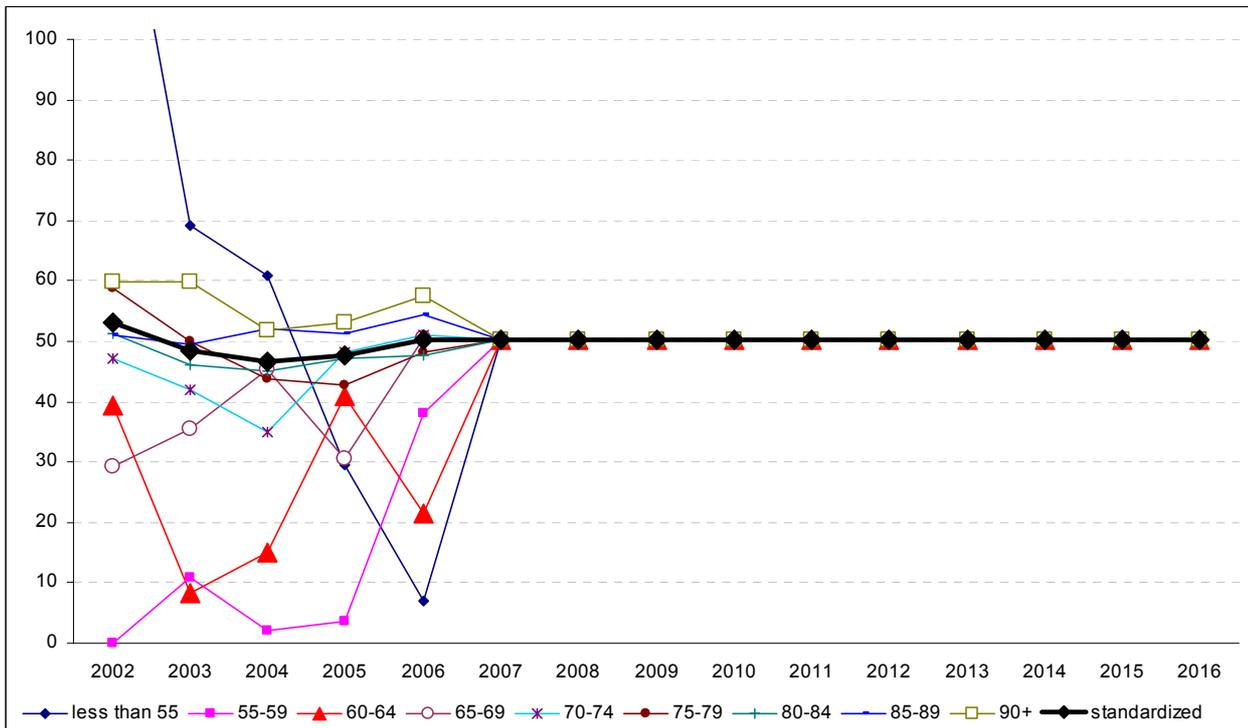


Figure 50 Actual and projected average annual occasions of home & garden maintenance for males who receive any home & garden maintenance in that year by age at December

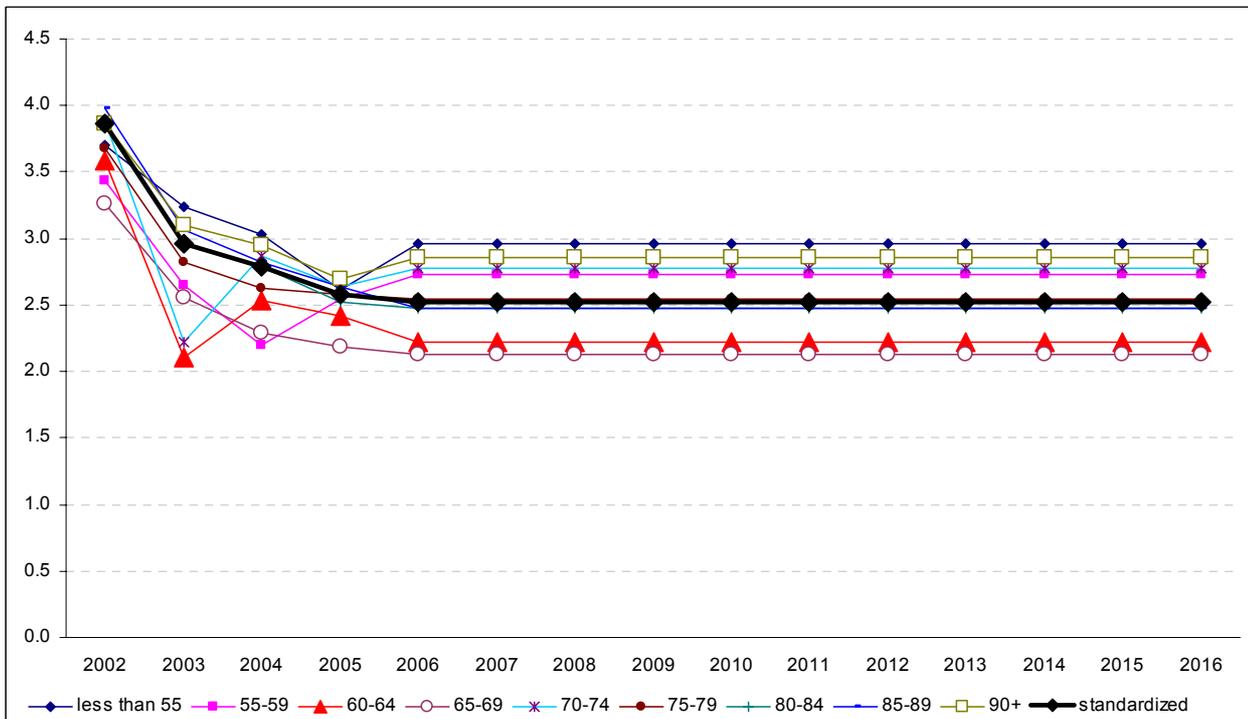


Figure 51 Actual and projected average annual occasions of home & garden maintenance for females who receive any home & garden maintenance in that year by age at December

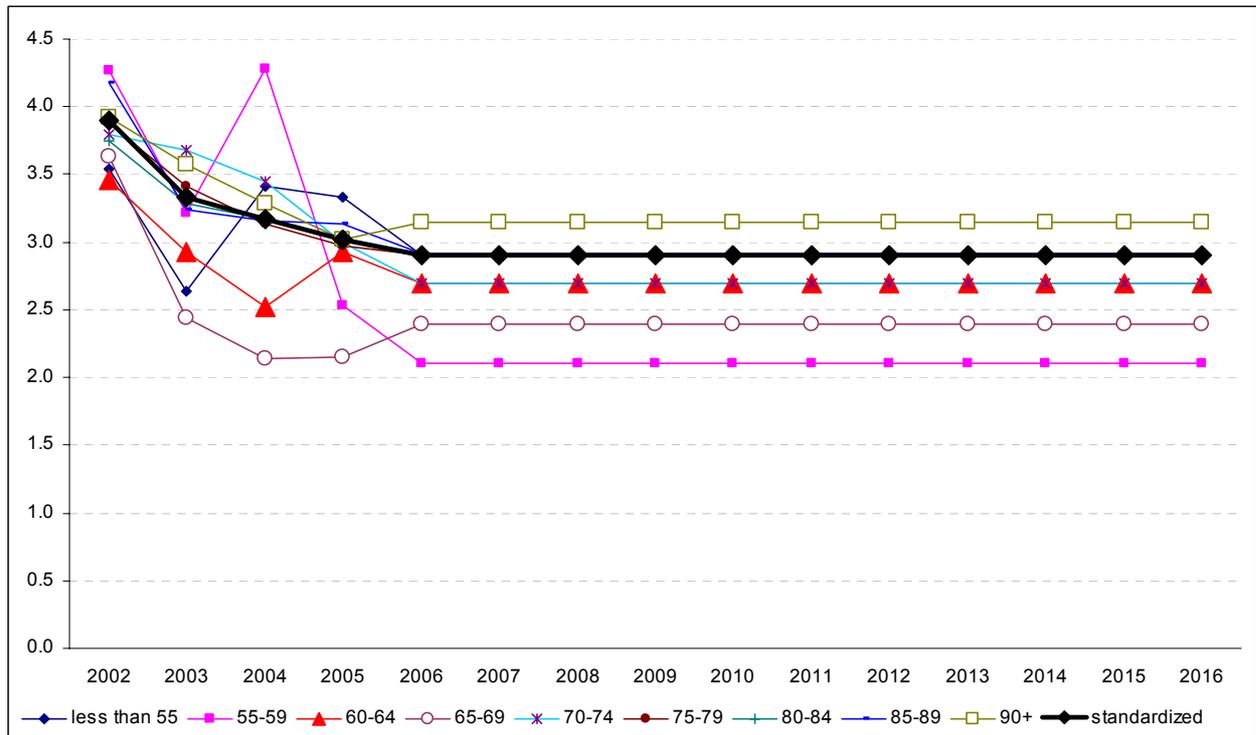


Figure 52 Actual and projected average annual occasions of emergency respite for males who receive any emergency respite in that year by age at December

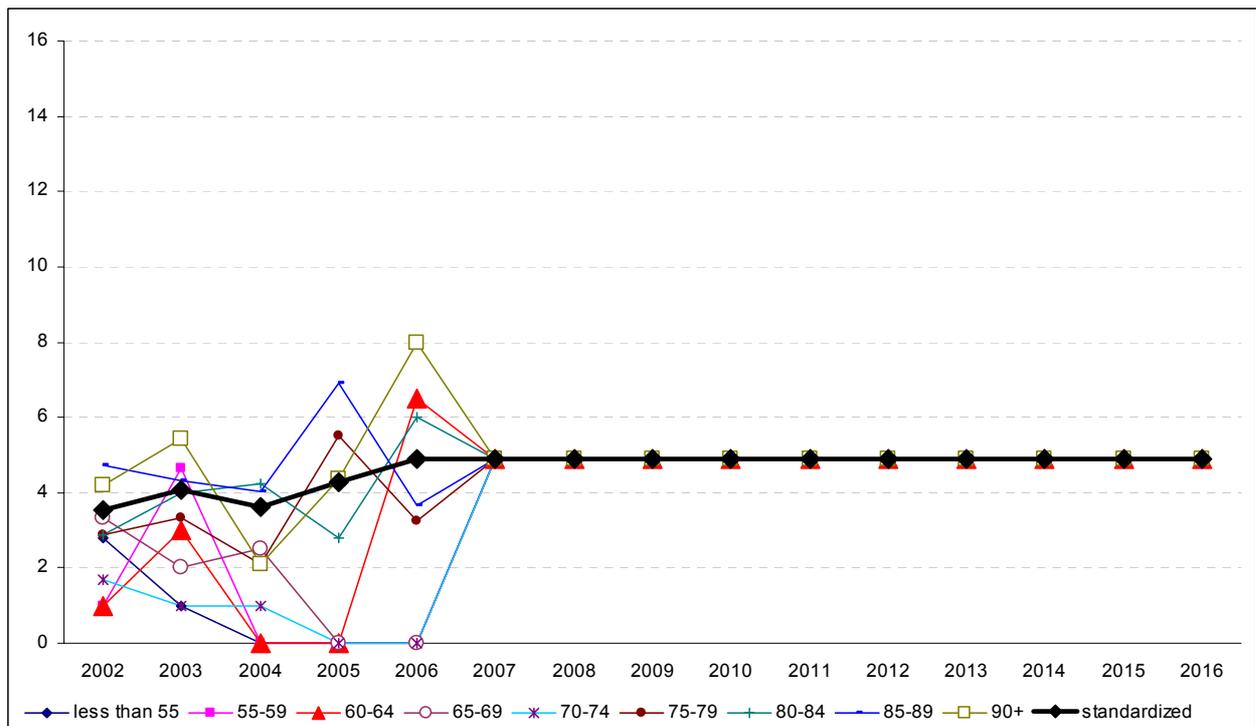
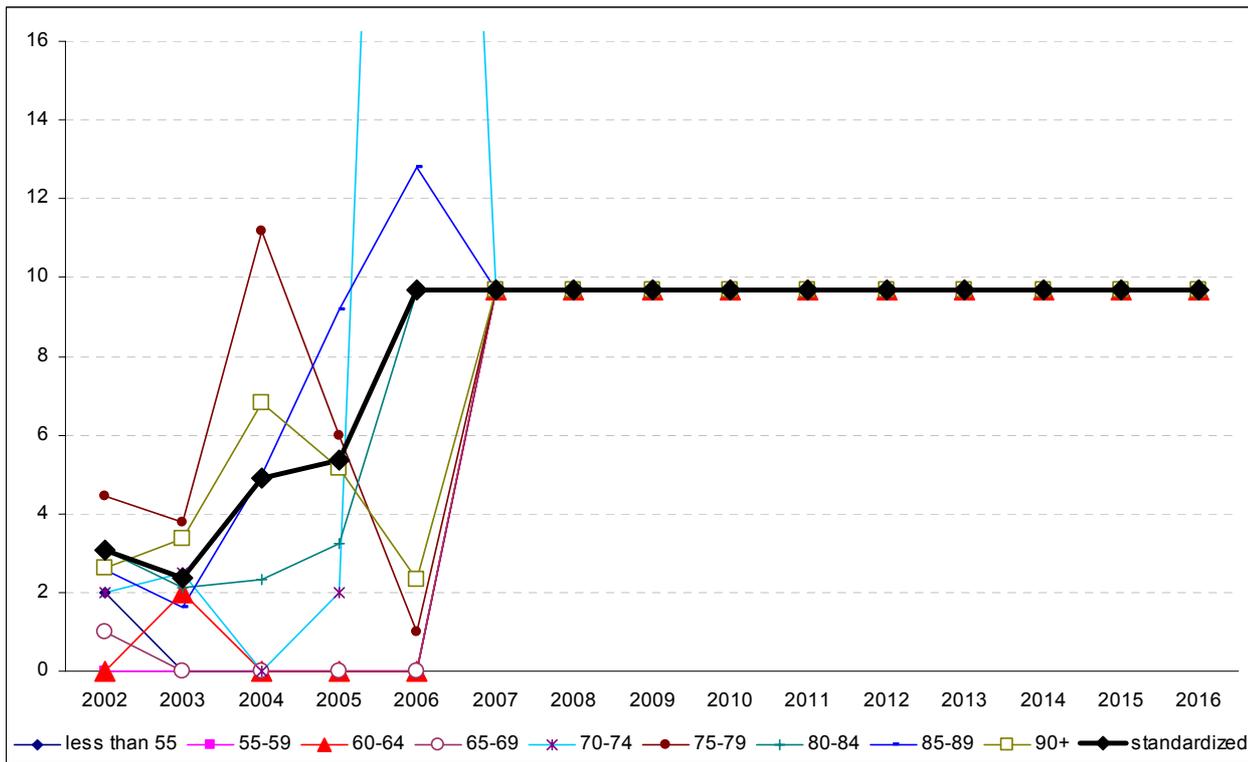


Figure 53 Actual and projected average annual occasions of emergency respite for females who receive any emergency respite in that year by age at December



Projecting the average number of hours per occasion of service

The fourth step is to project the average number of hours per occasion of service for each service type (by age and sex).

Let $H_{s,a,DA}^i$ denote the projected average number of hours per occasion of domestic assistance received in year i , by age (a) and sex (s).

Similarly, let $H_{s,a,PC}^i$, $H_{s,a,RIH}^i$, $H_{s,a,RE}^i$, $H_{s,a,HG}^i$ refer to the corresponding averages for personal care, in home respite, emergency respite and home and garden, respectively.

Thus the projected number of hours of domestic assistance to be received in year i is given by:

$$HDA^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,DA}^i \times N_{s,a,DA}^i \times H_{s,a,DA}^i)$$

Similarly for personal care:

$$HPC^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,PC}^i \times N_{s,a,PC}^i \times H_{s,a,PC}^i)$$

Similarly for in home respite:

$$HRIH^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,RIH}^i \times N_{s,a,RIH}^i \times H_{s,a,RIH}^i)$$

Similarly for emergency respite:

$$HRE^i = \sum_{s,a} (C_{s,a}^i \times p_{s,a}^i \times q_{s,a,RE}^i \times N_{s,a,RE}^i \times H_{s,a,RE}^i)$$

Similarly for home and garden:

$$HHG^i = \sum_{s,a} (C_{s,a}^i \times P_{s,a}^i \times q_{s,a.HG}^i \times N_{s,a.HG}^i \times H_{s,a.HG}^i)$$

DVA can use the projected number of hours to derive the projected total cost of the program.

Finally, the total projected hours of VHC services received in year i is given by:

$$HT^i = HDA^i + HPC^i + HDA^i$$

For domestic assistance and in home respite, the average hours per occasion of service is assumed to stay constant at 2006 levels for each group. For home & garden maintenance the average number of hours has increased in recent years. The average annual increase between 2002 and 2006 is assumed to continue for each age group in future years. For personal care and emergency respite, the average per occasion of service for future years is assumed to equal the *standardised* 2006 average. This decision reflects the paucity of data within most age groups for these service types. These assumptions are illustrated in the following ten figures.

Figure 54 Actual and projected average hours per occasion of domestic assistance for males by age at December

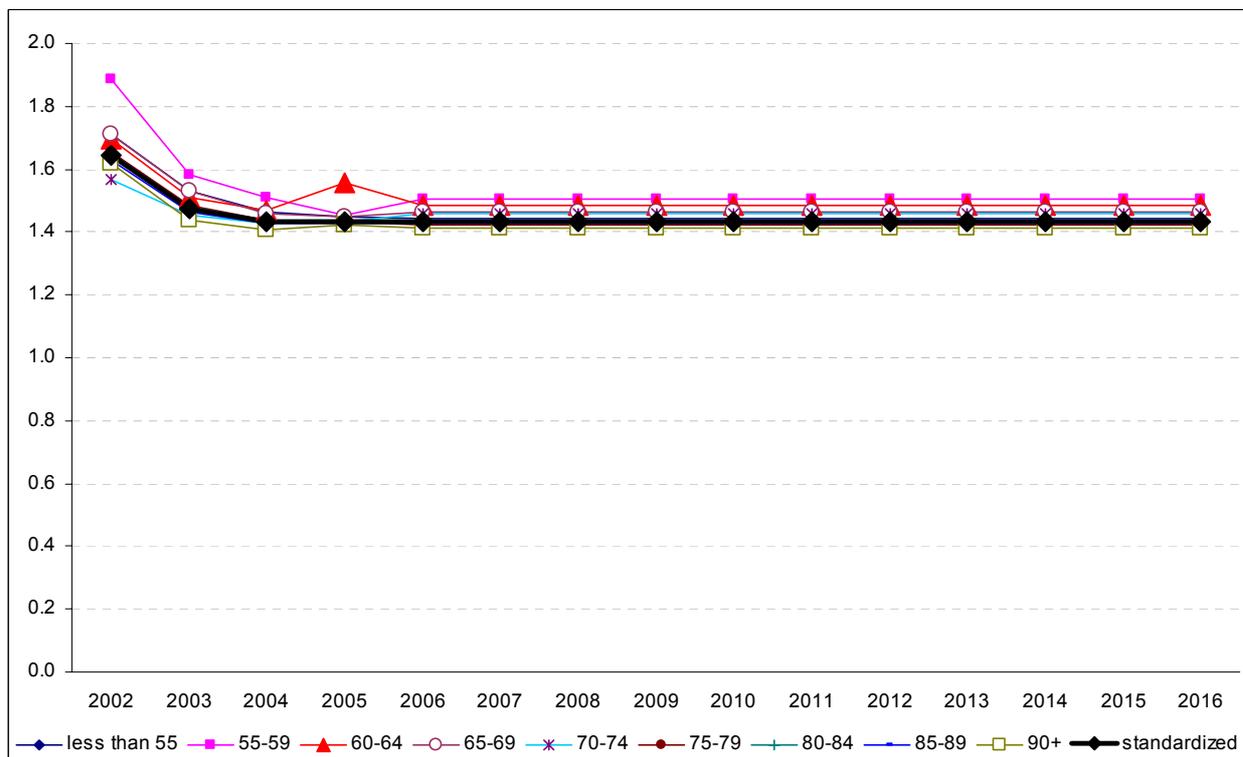


Figure 55 Actual and projected average hours per occasion of domestic assistance for females by age at December

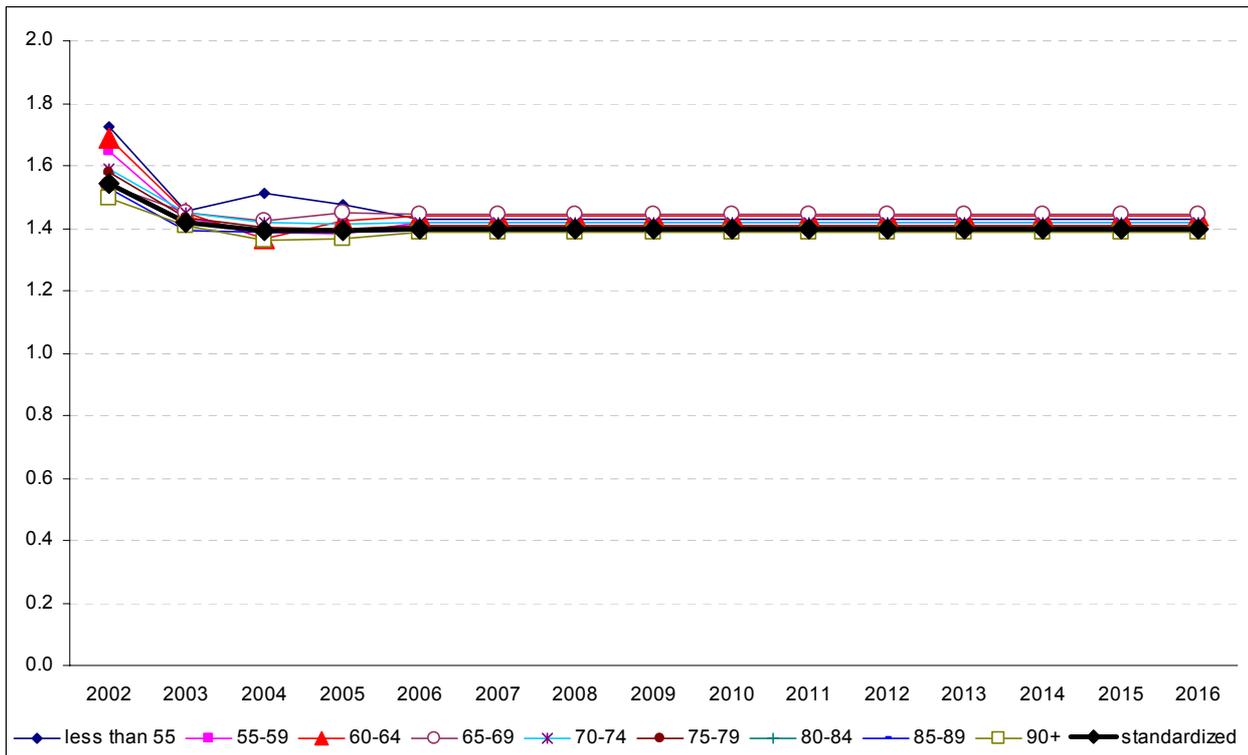


Figure 56 Actual and projected average hours per occasion of in home respite for males by age at December

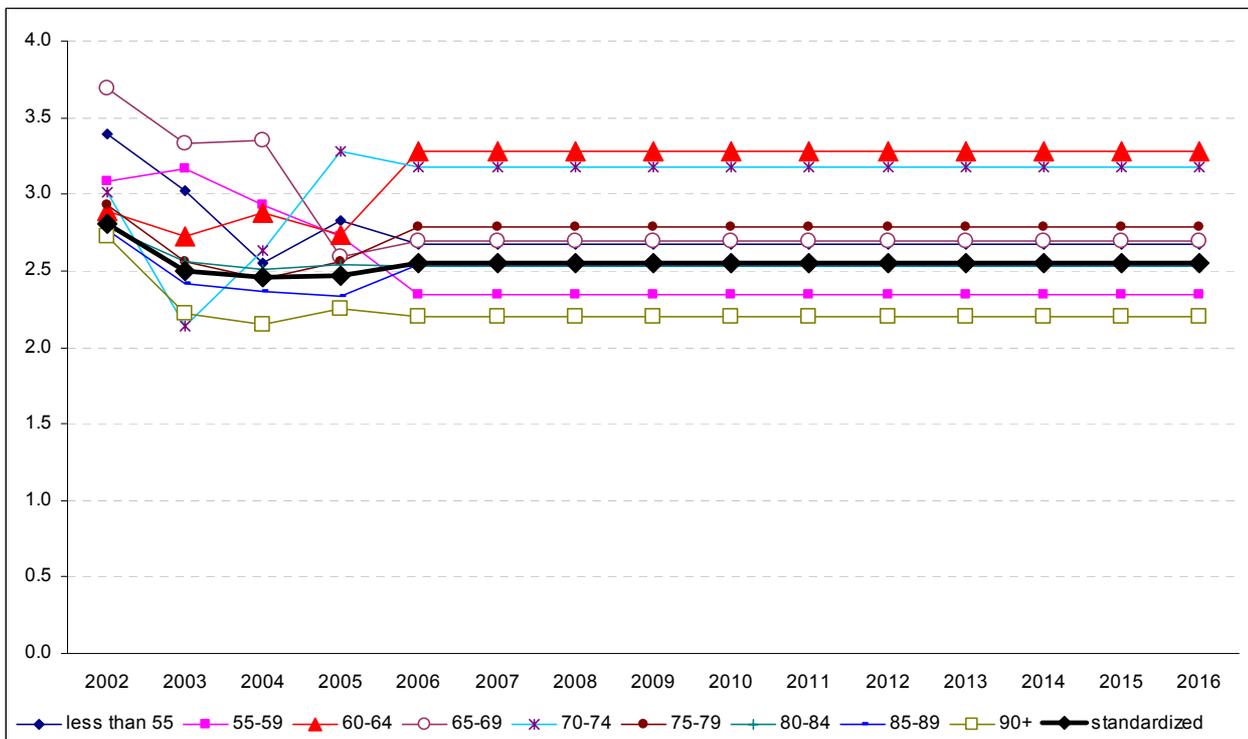


Figure 57 Actual and projected average hours per occasion of in home respite for females by age at December

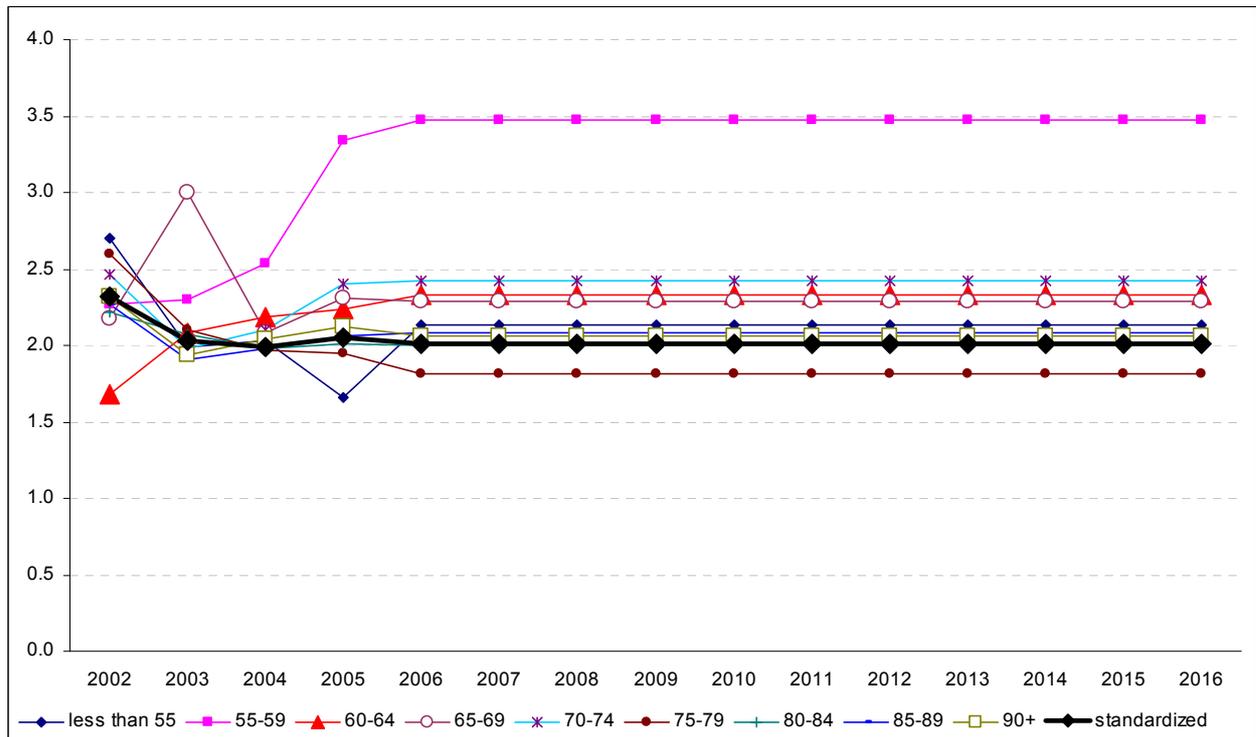


Figure 58 Actual and projected average hours per occasion of personal care for males by age at December

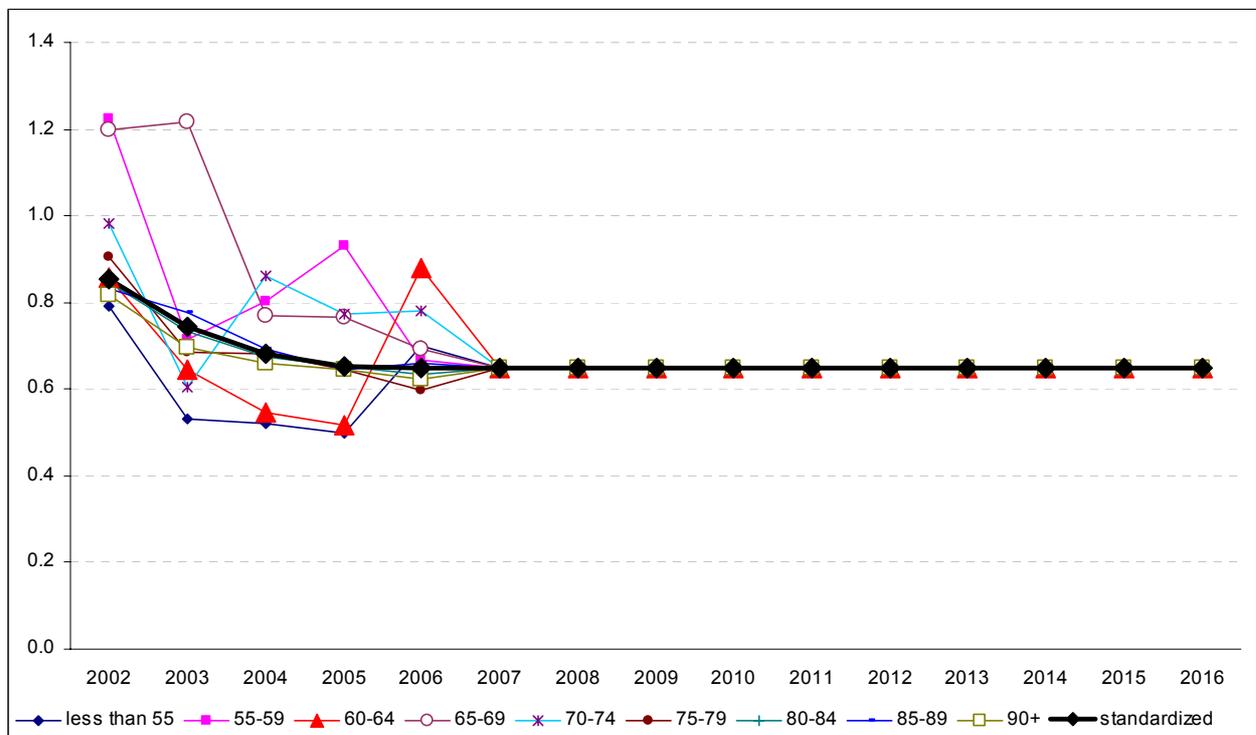


Figure 59 Actual and projected average hours per occasion of personal care for females by age at December

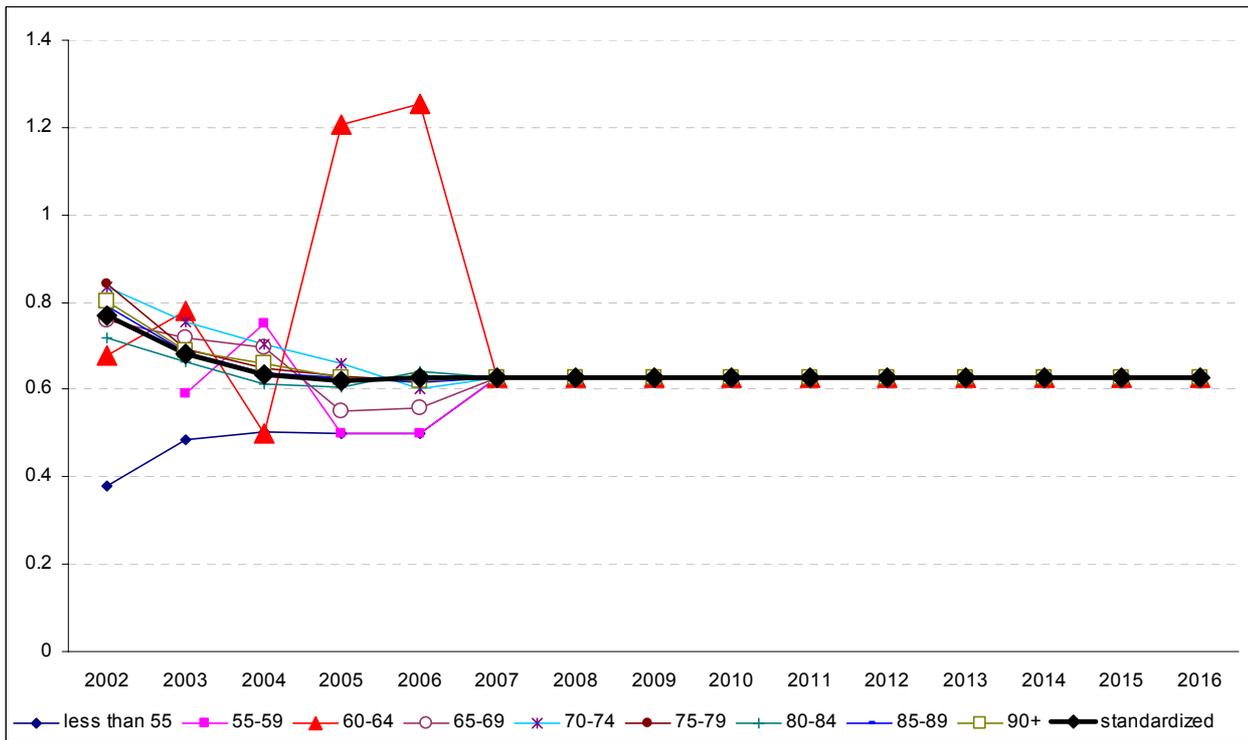


Figure 60 Actual and projected average hours per occasion of home & garden maintenance for males by age at December

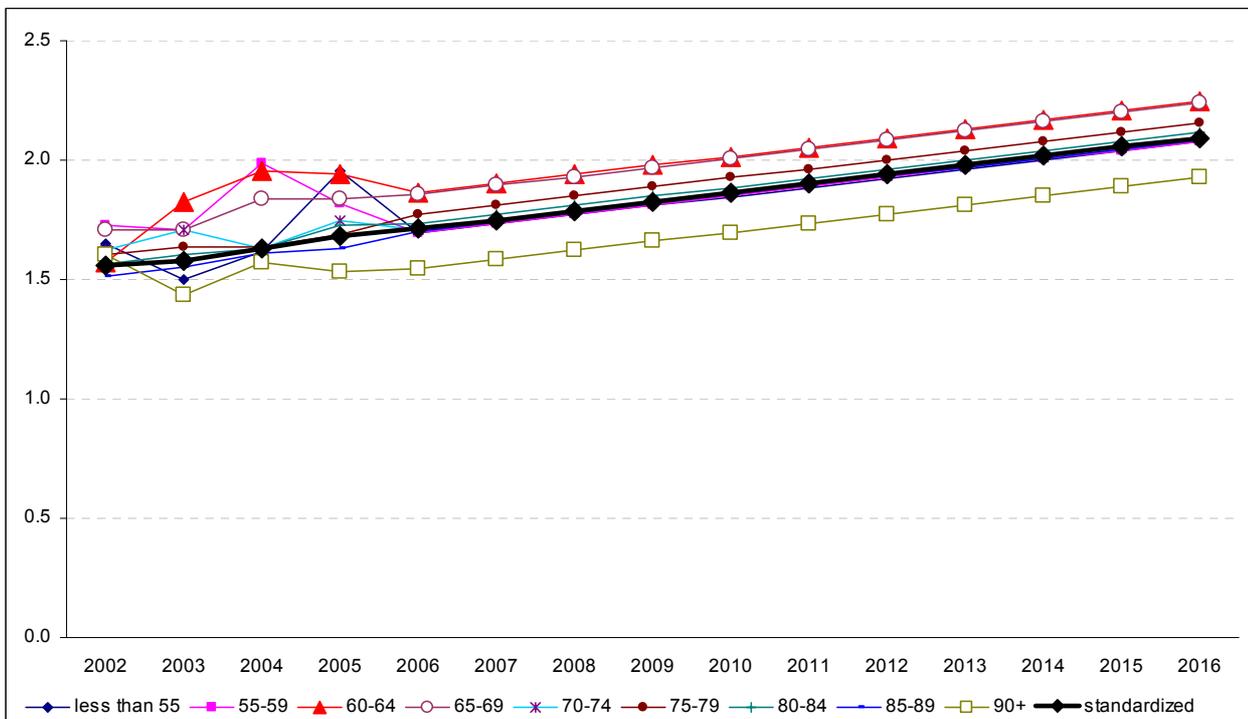


Figure 61 Actual and projected average hours per occasion of home & garden maintenance for females by age at December

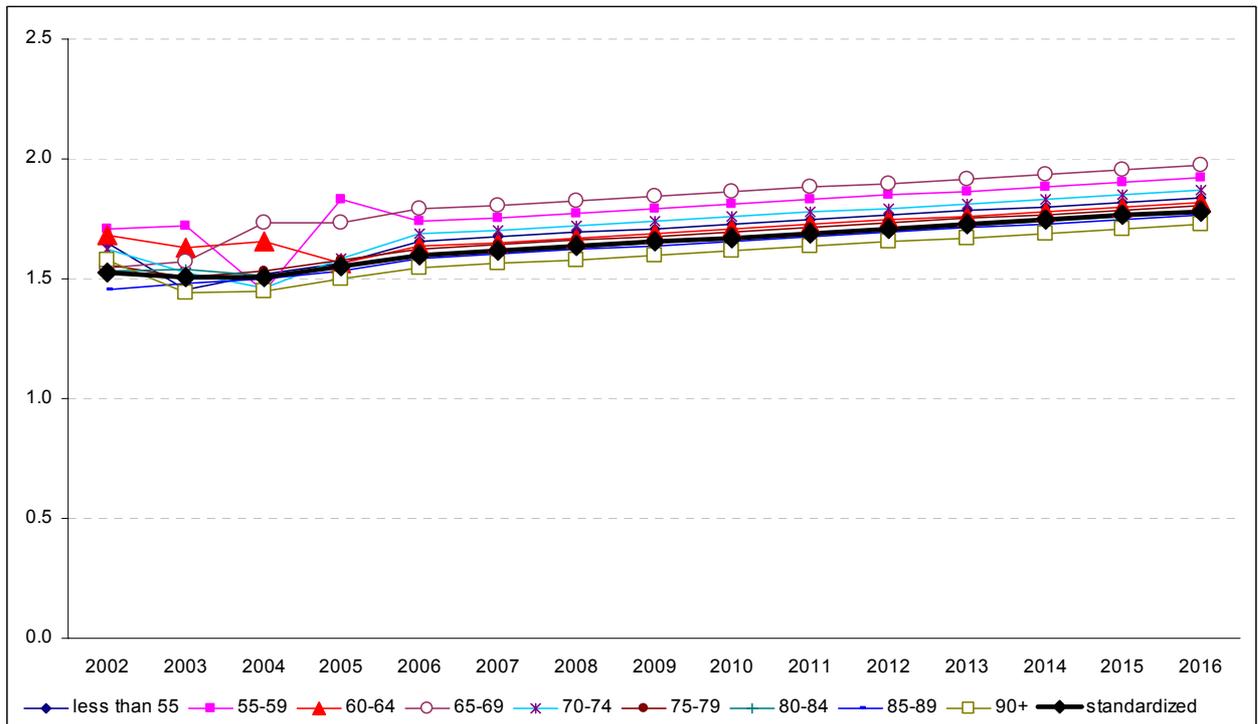


Figure 62 Actual and projected average hours per occasion of emergency respite for males by age at December

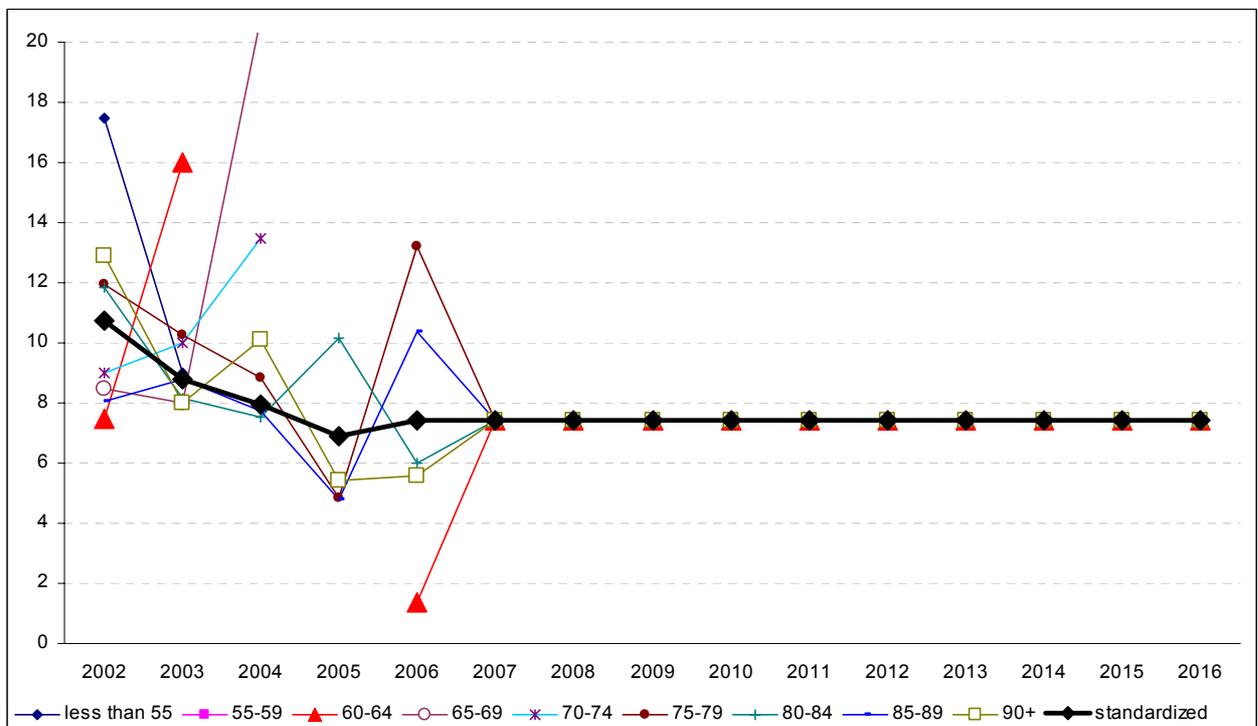
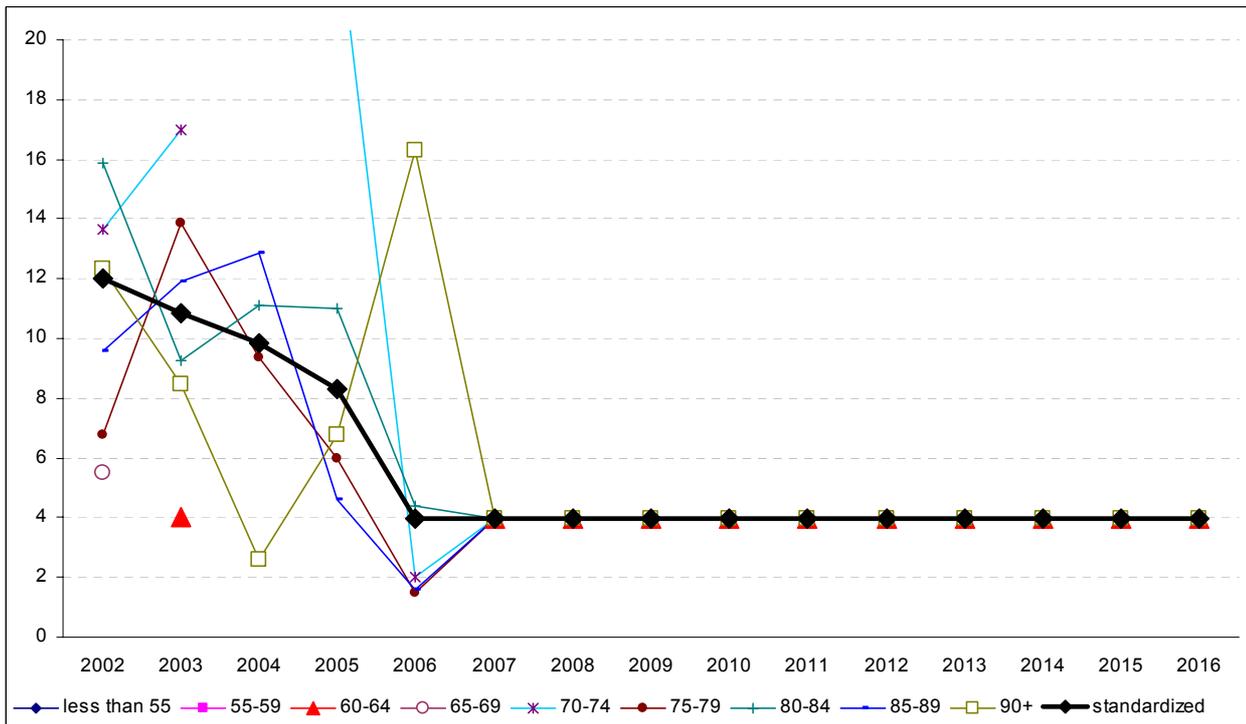


Figure 63 Actual and projected average hours per occasion of emergency respite for females by age at December



Adjustment

When the projection methodology outlined above is applied to the years that have already occurred, the resulting total hours of services falls 6% short of the actual hours provided. The main reason for this is that the methodology assumes that the only people who can receive VHC services in a given year are those people who have a gold or white card at the *end* of that year. This is driven by the nature of the data we have obtained. Several options were considered to address this shortfall. One option was to duplicate the entire process outlined above for the set of people who did not have a gold or white card at the end of each given year, but did have such a card at the start of the year. This approach would reduce the shortfall, but it still would not account for those people who had a card at some point during the year but not at either endpoint. Such people are not identifiable in the data and they include those who die shortly after receiving the card.

The second option (which has been adopted) was to include a manual adjustment to the total figures for each year. This is justified by the observation that the shortfall across service types has stayed constant at 6% for all years from 2002 to 2006. There is also no obvious time trend in this percentage for any service type. The percentage does vary slightly between service types. Domestic assistance hours have been adjusted for an assumed 6.2% undercount. The corresponding percentages for the other service types are 6.8% (home & garden maintenance), 6.3% (in home respite), 3.8% (personal care) and 5.0% (emergency respite).

Appendix 4

Results of the veteran and war widow survey

Random samples of veterans were drawn from three cohorts – veterans who receive services from VHC, veterans who applied for VHC but were not approved for services and veterans who had never applied for VHC. Because of the differences in the contact with VHC, there were slight differences between the cohorts' surveys. The essential information obtained, however, was the same.

Table 31 sets out the total number of surveys posted, and the total possible response after subtracting veterans to whom surveys were posted prior to DVA's notice of their death, and veterans who declined to answer the survey.

Table 31 Potential survey response

	Number	%
Surveys posted	1852	100%
Deaths	27	1.5%
Declined to answer	78	4.2%
Total possible response	1747	94.5%

In total 1047 responses were received, 906 from veterans receiving VHC services, 57 from veterans assessed but not approved for VHC and 84 from veterans who had not applied for VHC. Table 32 indicates the number of responses received and the response rate per survey cohort, and shows that, as was expected, the highest response was from veterans receiving VHC services in 2006 and 2007.

Table 32 Actual survey response

	Surveys posted	%	Surveys received	Response rate (%)
Receiving VHC	1562	84.3%	906	58%
Not approved for VHC	115	6.2%	57	50%
Not applied for VHC	175	9.5%	84	48%
TOTAL	1852	100%	1047	57%

Analysis of survey responses

The survey was well-answered with an average response rate to all items of 79%.

One section had a considerably lower response rate. This section concerned respite for people whom veterans regarded as their main carer. About half of those who responded to the survey indicated that they had a carer, but only about a third of these indicated that their carer sometimes had respite from their normal caring role. Of these, only small numbers of veterans were able to provide information about the type of respite care accessed, and/or the frequency, cost and organisations involved in that respite care. As a result, the analysis does not include detailed information about respite for people who care for veterans.

Survey respondents had an opportunity to provide additional general comments at the end of the survey. In particular, comments from veterans receiving VHC services supplement their responses to questions about satisfaction with these services.

VHC population profile

The survey population was drawn from the 2006 VHC population consisting of men (48.3%) and women (51.7%) who were either veterans or classified as a dependant (e.g. spouse).

Members of the 2006 VHC population were further classified by:

- age (5 year age groups from 55-59 until 90+, with a further group for veterans aged less than 55)
- most recent conflict
- Card type (Gold Card holders or veterans with overseas service comprise 97.8% of the population, with the remainder being White Cardholders)
- state of residence
- ABS remoteness index
- whether in residential aged care (and level of care)
- whether TPI (95.1% were not classified as TPI)
- service utilisation (items received in 2006 (Yes/No), that is, mental health services, medical treatment items, allied health items, pharmacy items, community nursing items, private hospital episodes and other TAS (transport assistance scheme) items)
- history of assessments for services
- history of claims for VHC services (by type, that is, domestic assistance, personal care, home and garden services and respite care)
- history of approved hours for VHC services (by type)
- history of claimed hours for VHC services (by type)
- history of card entitlement.

Profile of respondents

The random sample (1852 veterans) generated a survey population that closely mirrored the 2006 VHC population on all demographic, VHC and other identifiers including age, sex, state of residence, card type and service utilisation, with minor differences relating to history of VHC claims and services. In turn, the respondents to the survey (1047 veterans) also mirrored the VHC population with minor differences mostly relating to assessment history, claims history and medical service utilisation. More substantive differences related to state of residence and, to a lesser degree, age group representation.

Proportionally more veterans from NSW (5.9% more) and proportionally fewer veterans from Queensland (4.7% fewer) responded to the survey, relative to the proportions of veterans sampled in these states and the VHC population resident in NSW and Qld. Fewer veterans aged 85 years or more (4.4% fewer) and a slightly smaller proportion of veterans aged between 60 and 70 (0.5%) responded, but this was balanced with a greater response from veterans aged between 70 and 85 relative to the proportions sampled and in the VHC population as a whole.

Veterans who responded indicated small differences in usage of some medical services (up to a maximum of 3% more or 3% less usage) from the sample and the VHC population as a whole. The differences tend to offset each other, with fewer pharmacy, allied health and medical treatment items balanced against more private hospital episodes, community nursing and TAS usage.

A minor difference in assessment history can be seen between those responding and the VHC population. Of the veterans who responded, 4% fewer were recorded as being assessed once

only in 2007, while 3.3% more of these veterans were recorded as having two assessments in 2007.

The differences in VHC claims history and service utilisation in those responding are due partly to a difference in these indicators between the sample population and the VHC population as a whole. Consistently higher numbers of claims, approved hours and claimed hours for domestic assistance (4.5% increase), home and garden services (1.1% increase) and personal care (1.3% increase) can be seen in the sample population compared with the VHC population as a whole. Those responding indicate an even larger increase in domestic assistance claims and services (6.3%) and home and garden claims and services (between 3.3-4%) compared with the VHC population as a whole, but a reduced number of claims and services for personal care (0.9% increase relative to VHC population).

In summary, the sample and respondent populations appear to be representative of the VHC population so that the survey findings can be attributed to the VHC population as a whole. The small differences between the populations, while not significant in terms of bias, should be taken into account when considering the survey findings.

Gender

In the cohort of VHC recipients, slightly more responses were received from women (470 or 52.4%) than men (423 or 47.6%) and this resulted in a slightly higher response to the survey overall from women than men - 533 responses (or 50.9%) from women and 499 responses (or 47.7%) from men. This difference in response rate between the genders reflects the difference in gender in the VHC population as a whole, that is, 51.7% women and 48.3% men. A small number of responses (15) were received from persons of unknown gender.

Table 33 shows the response rate by gender from each survey cohort.

Table 33 Survey response by gender

	Female	Male	Unknown	Total
Veterans receiving VHC	52%	47%	1%	100%
Veterans not approved for VHC	42%	56%	2%	100%
Veterans not applied for VHC	46%	52%	1%	100%
Total	51%	48%	1%	100%

Living status

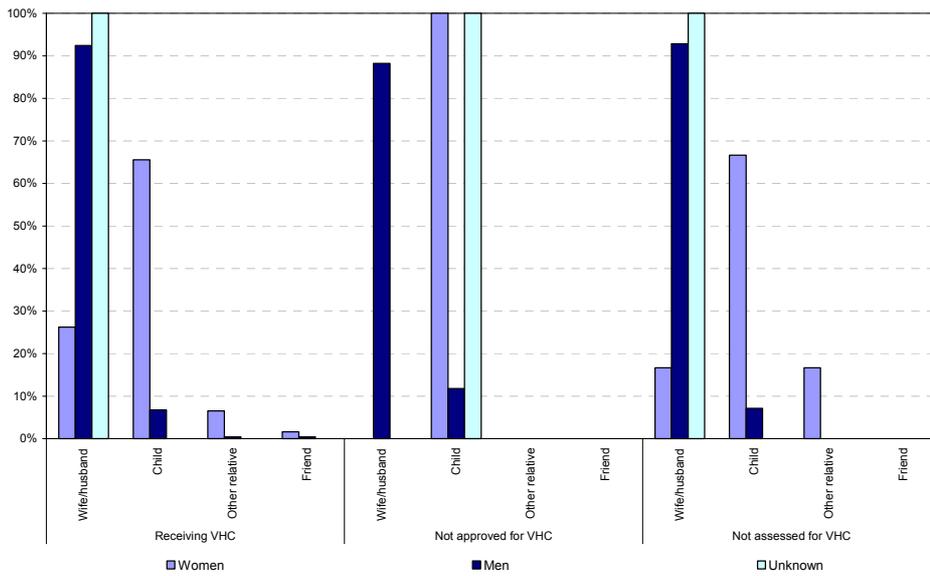
Almost all veterans responding (98%) indicated whether they lived alone or with someone else. On average, 57% of respondents lived alone, but more veterans receiving VHC services lived alone (62%) than veterans not approved for VHC (51%) or veterans who had not applied for VHC (56%).

Many more war widows live alone (average 79%) than men (average 37%).

About 31% of veterans provided information about those with whom they lived – most responses were received from men (76%), almost all of whom (91%) lived with their wives/female partners. By contrast, almost all women veterans living with another person lived with a daughter or a son.

Figure 64 indicates the relationship to veterans of the people with whom they lived.

Figure 64 People with whom veterans live

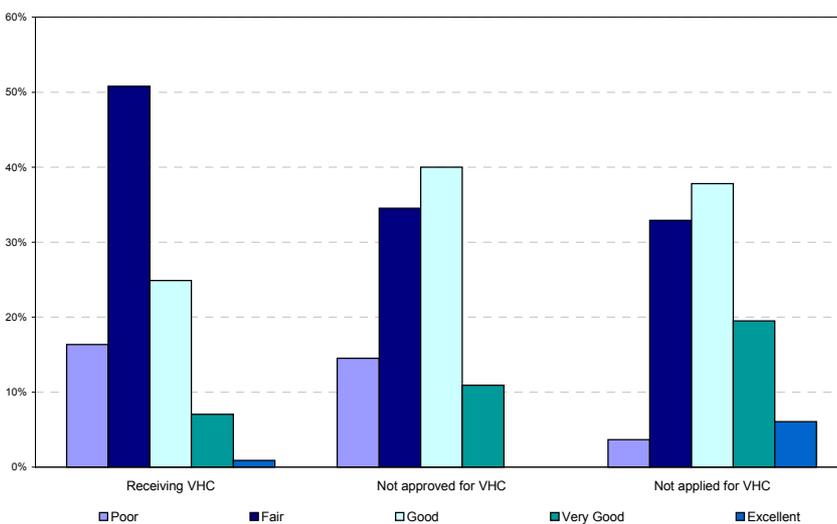


Health status

Almost all respondents provided information about their health (95%). Veterans receiving VHC services reported the worst health status, while those who had not applied for VHC reporting the best health status.

Figure 65 indicates general health status as reported by each survey cohort. Most veterans receiving VHC services described their health as ‘fair’ (51%) with only 8% stating it was ‘very good’ or ‘excellent’. By contrast, more veterans in the other cohorts described their health as ‘good’ or better.

Figure 65 General health of veterans



Veterans receiving VHC reported relatively more intense bodily pain during the last 4 weeks than veterans in the other survey cohorts, with 72% reporting pain of moderate or greater intensity in this period compared with 51% and 52% in the other two cohorts. No instance of ‘very severe’ bodily pain was reported by any veteran in either of the second or third survey cohort, while 28 (3%) of veterans receiving VHC services reported ‘very severe’ bodily pain in the last 4 weeks.

More veterans receiving VHC services also reported that their health had interfered ‘quite a bit’ with their normal activities than veterans in the cohorts (44% of veterans receiving VHC, compared

with 29% and 23% for veterans in the second and third cohorts respectively). More veterans who had not applied for VHC (31%) reported 'slight' interference with normal activities than any other degree of interference.

About 63% of veterans overall reported having had a fall in the past 6 months, but veterans receiving VHC services reported a higher prevalence of falls (38%) than those in the other two cohorts (33% and 24%).

Most veterans reported having fallen either once or twice, but veterans who had not applied for VHC reported a relatively high number of single falls compared with other veterans (63% compared with 42% for veterans receiving VHC services and 24% for veterans not approved for VHC).

We compared this survey's health items to available and comparable normative data for the general population in Australia, aged 75 years or more. We found that the percentage of veterans receiving VHC services in this sample (aged 75 years or more) who responded that their health was either "fair" or "poor" (Question 2) was 76% and 59% for men and women respectively. This suggests that, overall, veterans receiving VHC services aged 75 years or more in this sample self-report that their general health is much worse than people of this age living in the community (Normative Data: Males aged 75 years or more: 36.5% – 34.0%; Females aged 75 years or more: 33.5% – 30.2%) (NSW Health 2000a and NSW Health 2000b). It should be noted that both the NSW Health Surveys were based on telephone interviews.

People caring for veterans

About 96% of veterans reported on whether they needed a carer and whether they received care from others. The survey indicated a difference between veterans' views on whether they needed a carer, and whether they already had someone whom they regarded as their 'main carer'. Similar proportions of veterans in each of the three survey cohorts indicated that they had someone whom they regarded as their main carer (51% on average), but more than 50% of veterans in each cohort reported that they did not need a carer (58% of veterans receiving VHC services, rising to 77% of veterans who had not applied for VHC).

About 50% of veterans provided information about the identity of their carer, nearly all of whom (99%) were relatives or friends rather than paid carers (see Table 34).

Table 34 People caring for veterans

Main carer	Veterans receiving VHC services		Veterans not approved for VHC		Veterans not applied for VHC	
	Count	Percent	Count	Percent	Count	Percent
Wife/female partner	171	42%	11	50%	18	47%
Husband/male partner	11	3%	0	0%	0	0%
Daughter	144	35%	5	23%	13	34%
Son	40	10%	2	9%	5	13%
Daughter-in-law	7	2%	1	5%	1	3%
Son-in-law	1	0%	0	0%	0	0%
Other relative	10	2%	1	5%	1	3%
Friend/neighbour	25	6%	2	9%	0	0%

Many veterans commented that, without their spouse, they would not be able to cope, and noted their concern for the future in light of the age or health status of their spouse.

At present my wife who is 81 looks after me. Without her there is no doubt I would be in a nursing home. How long she can carry on remains to be seen.

The answers provided will change greatly if my wife becomes incapacitated as we now co-operate on doing most things.

My wife is seriously ill. This makes assessing the future difficult.

As the wife of the veteran concerned, I am reasonably able to care for my husband. However, he has Parkinson's disease and will become progressively more disabled and it may be that my health will determine the future.

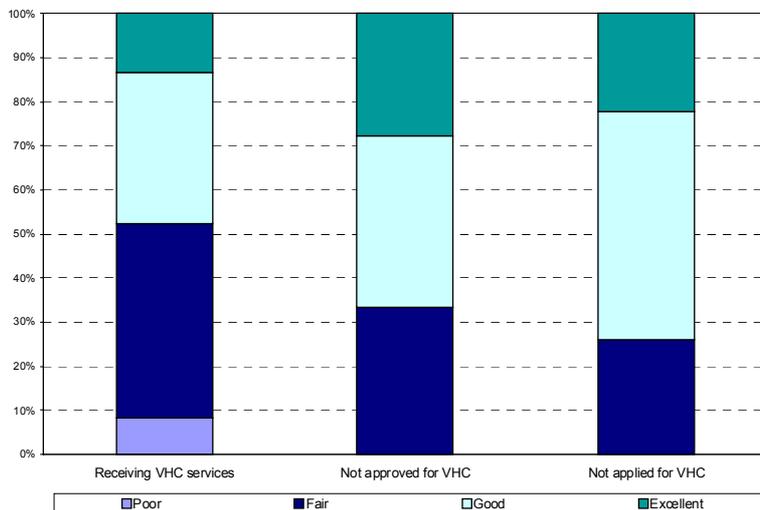
Others noted their reliance on family members for care.

I only have sons flat out with their own families. I try very hard to be independent.

I don't know how long my son and his wife can continue to help us. They may need to move, they have their own lives to lead.

About 72% of veterans provided information about the health of their carers. Figure 66 shows that carers of veterans receiving VHC services are reported as having worse health than carers of other veterans.

Figure 66 Carers' health



Of the 78% of veterans who indicated whether their carers received breaks from their normal caring role, about 70% indicated that their carers did not receive any breaks at all, possibly because carers are almost always family members.

Only about 5% of veterans were able to provide information about carer respite arrangements. As noted above, this information is not reported here. While many veterans expressed appreciation for their carers and understood the need for respite, others were concerned at how they would cope without them.

I am not at all acquainted with what to do if my carer (spouse) needs a break from 24 hour attention to me.

More veterans (91%) indicated who cared for them the last time that they were ill, with care being provided either by a relative or friend (73% overall) or by no one. The majority of veterans falling ill were cared for by their partners or, much less often, by a son or daughter.

Veterans as carers

About 91% of veterans provided information about whether they cared for another person. The majority of veterans surveyed were not caring for another person. Substantially fewer veterans receiving VHC services were caring for someone than other veterans (8% compared with 18% and 21% respectively).

Only 9% of veterans indicated whom they cared for, and, as might be expected, most were caring for their spouse/partner, with proportionally fewer veterans receiving VHC caring for a daughter, son or other relative compared with veterans in the other cohorts (11% compared with 22% in the other two cohorts). It is not surprising that the majority of veterans caring for their spouse indicated that that person could not cope without their help (71%), while 50% of veterans who had not been approved for VHC services and only 18% of veterans who had not applied for VHC indicated that the person being cared for could not cope without their help.

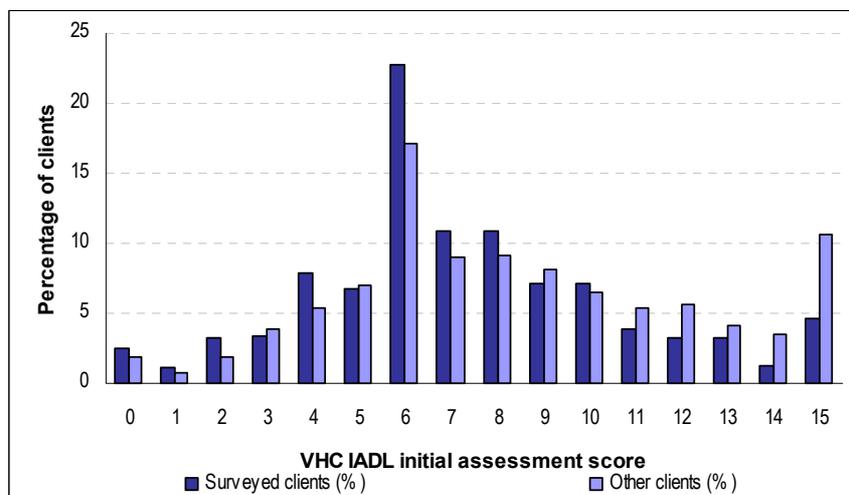
A number of veterans who cared for their spouses indicated the need for more assistance so that they could be free to care for their spouse fulltime. Others mentioned the inequity of wives becoming ineligible for VHC services if their husband, the Card holder, entered residential care or died.

I would like to see spouses of veterans receive the same benefits as veterans.

Comparison of the functional ability of the VHC total population and those who completed the veteran and war widow survey

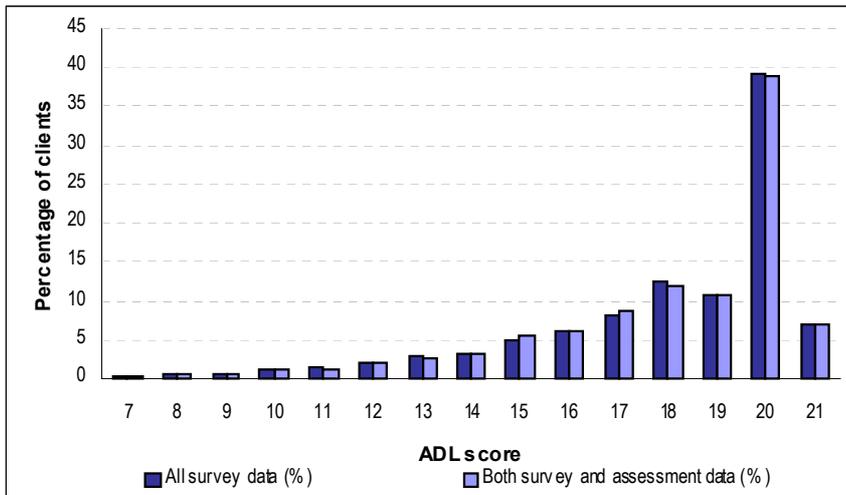
DVA provided ADL and IADL assessment data for just over 82,000 VHC assessments. Figure 67 compares those VHC clients included in the postal survey with those not included in the postal survey in terms of their ability to manage instrumental activities of daily living. Compared to the overall VHC population, those surveyed had slightly lower total scores, indicating they were slightly more dependent than those not surveyed. Questions about ADL functioning were well answered with an average 96% response across all questions.

Figure 67 VHC IADL total score – comparison of surveyed VHC clients & other VHC clients



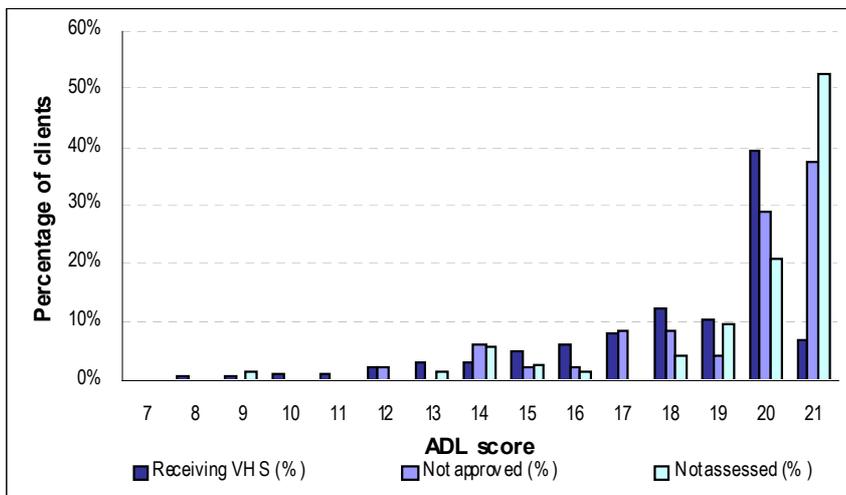
Not all surveyed clients had been assessed by VHC. However, there was no difference between these two groups with respect to the HACC functional screen total score from the survey (Figure 68).

Figure 68 Functional screen total score – comparison of those VHC clients surveyed with and without VHC assessment data



As would be expected, those in the survey cohorts who were not approved or had not applied had higher functional screen scores (were more independent) than those receiving VHC services (Figure 69). However, there was a small percentage of people in both cohorts with low functional ability.

Figure 69 Functional screen total score by survey cohort



For all measures except domestic activity, more veterans report that they are independent than not. However, the number of veterans reporting that they can undertake daily activities without help varied between measures and between survey cohorts.

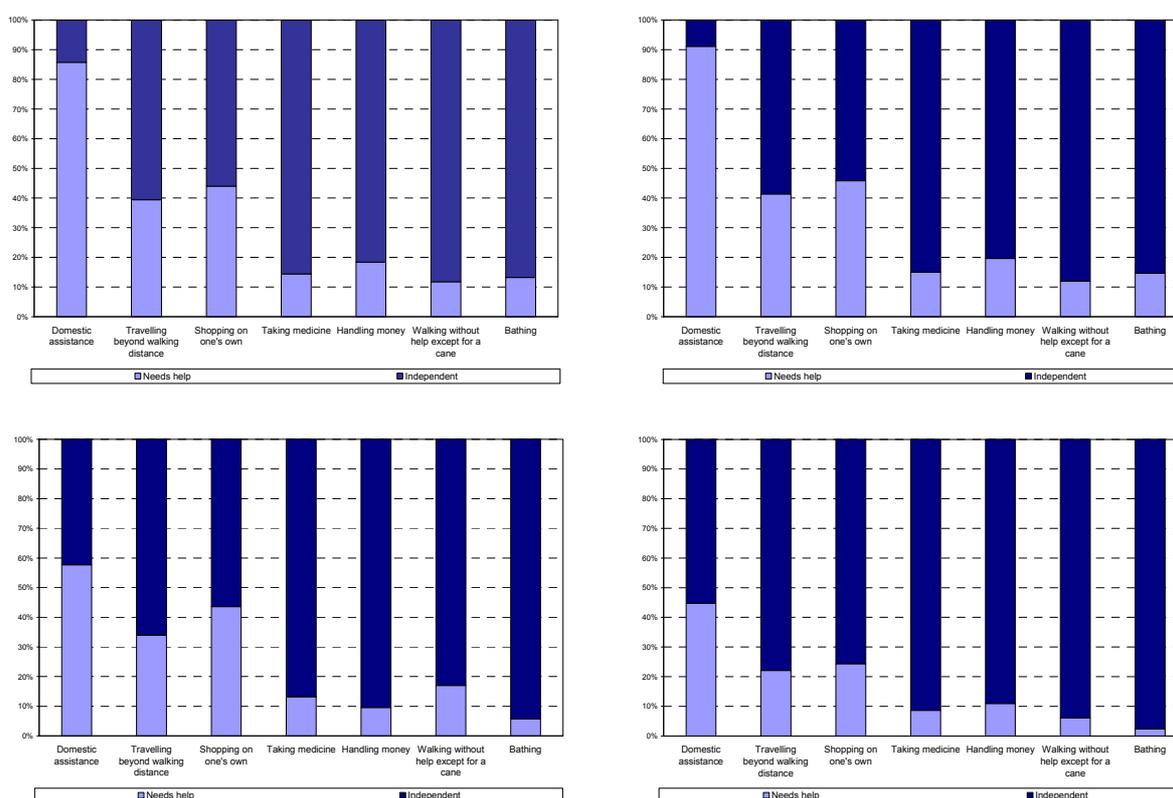
Table 35 shows the functional profile for veterans in each survey cohort. With the exception of walking without help, veterans receiving VHC services are more dependent on others for help than veterans in the other two cohorts. Veterans not approved for VHC were slightly more dependent than veterans receiving VHC in terms of walking (17% of the former needed help compared with 12% of the latter). Veterans who had not applied for VHC were the most independent across all measures.

Table 35 Functional profile: all veterans

Ability	Receiving VHC		Not approved for VHC		Not applied for VHC	
	Needs help	Independent	Needs help	Independent	Needs help	Independent
Housework	91%	9%	58%	42%	45%	55%
Travelling beyond walking distance	41%	59%	34%	66%	22%	78%
Shopping on one's own	46%	54%	44%	56%	24%	76%
Taking medicine	15%	85%	13%	87%	9%	91%
Handling money	20%	80%	10%	90%	11%	89%
Walking without help except for a cane	12%	88%	17%	83%	6%	94%
Bathing	15%	85%	6%	94%	2%	98%

Figure 70 illustrates functional screen scores for each measure for the survey population as a whole, and for each cohort separately.

Figure 70 Functional profiles of each cohort in the survey



The figure shows that all veterans reported significantly higher levels of independence for four measures - taking medicine, handling money, walking without help (except for a cane) and bathing (85%, 89% and 93% independent functioning on average across the four measures for each group).

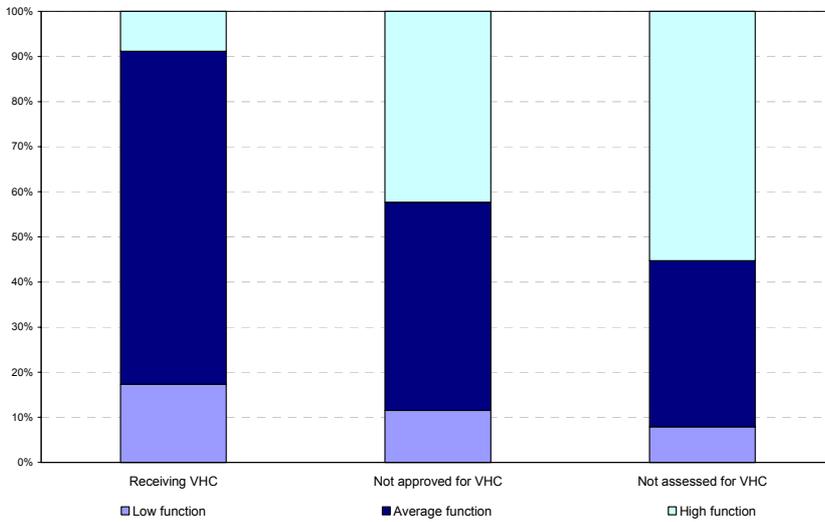
Most independence was reported with regard to bathing (92% on average).

Domestic functioning

The largest differences between the three survey cohorts concerned domestic tasks. Figure 71 shows that a much larger proportion of veterans receiving VHC need help with domestic tasks

than veterans not approved for VHC or those had not applied for VHC. The figure shows that most veterans receiving VHC had average functioning for domestic tasks, while about 42% of veterans not approved for VHC, and 55% of those who had not applied, scored highly for this measure.

Figure 71 Domestic assistance functional profile



Travelling, shopping functioning

Veterans receiving VHC also reported the need for more help than other veterans with regard to travelling to places beyond walking distance, and shopping independently (see Figure 72 and Figure 73). About 59% of veterans receiving VHC indicated they could travel independently (compared with 66% and 78% of veterans in the other cohorts) while 54% indicated they could shop for clothes or groceries on their own (compared with 56% and 76% in the other cohorts).

Figure 72 Travelling to places beyond walking distance: functional profile

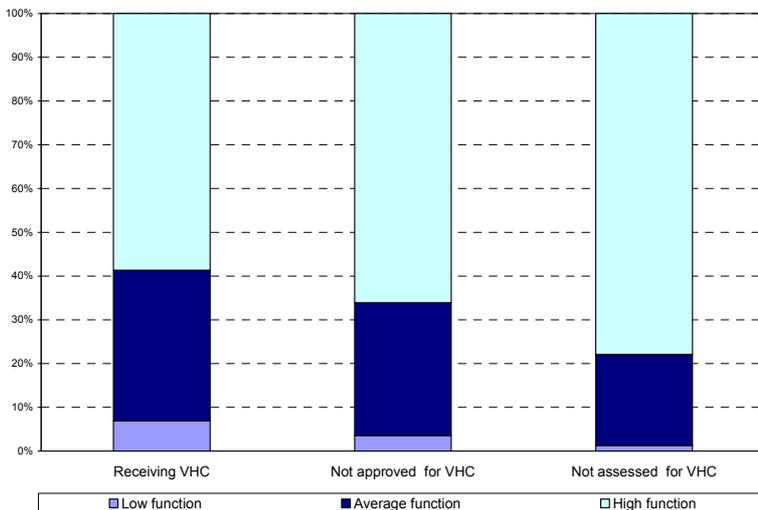
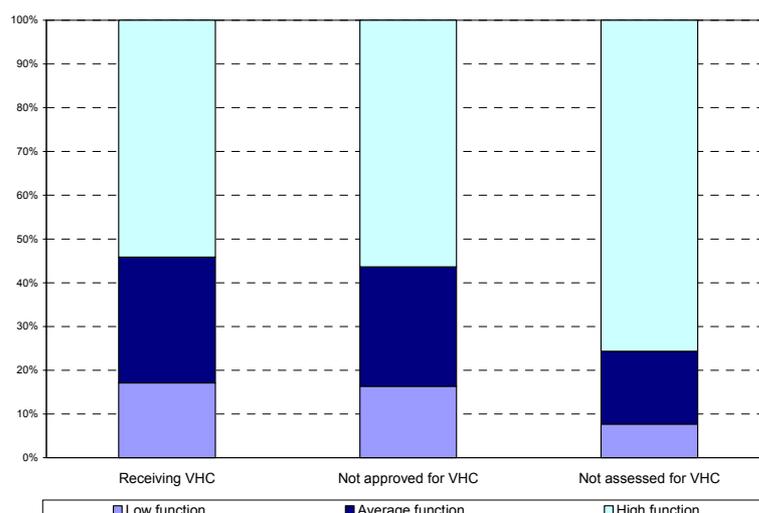


Figure 73 Shopping on one's own: functional profile

Assistance with daily living

Domestic help was most often provided by Community Service Providers (61% on average across all veterans), and assistance with bathing was provided most often by Community Nurses (48%) followed by spouses (35%). For all other daily living activities, help was provided most often by spouses or relatives.

Services received by veterans

Another major component of the survey concerned services received by veterans, both services provided by Veterans' Home Care and other DVA services for which veterans are eligible, and services that veterans might be receiving in addition to these. Veterans were asked whether they received any from amongst a range of services and, if so, the frequency, number of hours and the cost of services received. In particular, veterans were asked about the following services:

- domestic assistance;
- personal care;
- nursing services;
- home and garden maintenance;
- delivered meals; and
- other services to help veterans live at home.

Most veterans (96%) indicated whether they received any of the services listed above. Table 36 indicates that the largest demand is for domestic assistance and home and garden services. The table shows that a significant number of veterans not receiving VHC obtain domestic assistance and home and garden services from elsewhere. Veterans who have not applied for VHC receive fewer services than other veterans, reflecting their better health status and greater independence.

Table 36 Proportion of veterans receiving each service

	Domestic assistance	Personal care	Home and garden services	Nursing services	Delivered meals	Other services
Receiving VHC	90%	11%	48%	13%	16%	22%
Not approved for VHC	38%	4%	44%	9%	15%	12%
Not applied for VHC	25%	4%	22%	4%	5%	10%

	Domestic assistance	Personal care	Home and garden services	Nursing services	Delivered meals	Other services
Total	82%	10%	45%	12%	15%	20%

In response to questions about providers of domestic assistance, most veterans receiving VHC nominated VHC as their provider. However, 147 (or 16%) of VHC recipients nominated other providers. Just over 50% of these veterans received domestic assistance services from non-profit organisations, with 27% receiving services from private providers and a further 22% from other government sources, for example, the Home and Community Care (HACC) program.

Given the demand for assistance with domestic tasks, it is not surprising that this was a common theme in veterans' comments. Some veterans were very critical of the VHC service, describing the cleaning staff as inexperienced and untrained. The time allowed per VHC service (1.5 hours) was criticised by many as too short and the inability to be able to book set days or times as well as the irregularity of the service were also raised. Some veterans based their requests for more service time on the cost-effectiveness of assistance to stay at home relative to residential care.

At 87 years I feel I could stand another 3 hours (of domestic assistance) per week to stay out of Gov. Res.

In addition to complaints about the quality of cleaning in general, some veterans noted that quality checks would be useful. Others made the point that constraints imposed under the program limited the service provided and some had cancelled VHC and arranged private cleaners as a result.

Domestic assistance is a bit awkward at times because of the health and safety rules about some work (which is often what we cannot do and need help with!)

Home care is not allowed to move furniture etc, so only the middle of the rooms is cleaned.

Some veterans criticised the fact that some service providers expected them to prepare for their visits. Veterans receiving VHC services were also more likely to receive nursing services when compared to veterans in the other cohorts. While again reflecting their lesser health status, this finding also relates to the policy that provides for veterans receiving VHC who require more than 1.5 hours of personal care per week to be referred to DVA Community Nursing for services and assistance.

Other Services

About 73% of veterans indicated that they received 'other services' to assist them to live at home but most responses were from veterans receiving VHC. Some of these veterans indicated why they needed more help than the program provided:

VHC (is) not what it should be. No help showering husband, charge for cleaning, lifting almost killed wife.

Table 37 Proportion of veterans receiving 'other services'

	Receiving VHC (n=133)	Not approved for VHC (n=4)	Not applied for VHC (n=6)	Total
Allied Health	4%	0%	0%	3%
Transport medical	3%	25%	0%	3%
Home cleaning	20%	25%	0%	19%
Window cleaning	9%	0%	17%	9%
Transport	4%	0%	0%	3%

	Receiving VHC (n=133)	Not approved for VHC (n=4)	Not applied for VHC (n=6)	Total
Counselling	2%	0%	0%	1%
Gardening	32%	0%	17%	30%
Food services/meals	2%	0%	0%	1%
Home maintenance, handyman general	13%	25%	33%	14%
Shopping (including banking)	5%	0%	17%	6%
Nursing, medical, medications, telehealth services	6%	25%	17%	7%
Respite	2%	0%	0%	2%
Total	100%	100%	100%	100%

Table 37 shows that the most common types of other services received are domestic help, including window cleaning, gardening and home maintenance.

VHC recipients made a number of complaints about the constraints on home and garden services provided under VHC, with some stating that lawn and garden maintenance was their biggest problem. Many veterans requested that VHC provide lawn mowing, weeding and bush cutting.

I have no doubt that many veterans like myself who opted to continue living in their own home would welcome some increase in the garden assistance. I personally can no longer perform even the smallest of tasks....'

Some veterans noted that it was important for them to have a tidy garden, while others linked cleaning the outside of the home and the garden to safety issues and the ability to stay living at home.

Tree pruning access to the back of the house. Back steps unsafe for me to use as there is only one rail to hang on to. No access to clothes line.

The frequency and length of services provided was also an issue.

Gardening services are very sparse and take months to eventuate.

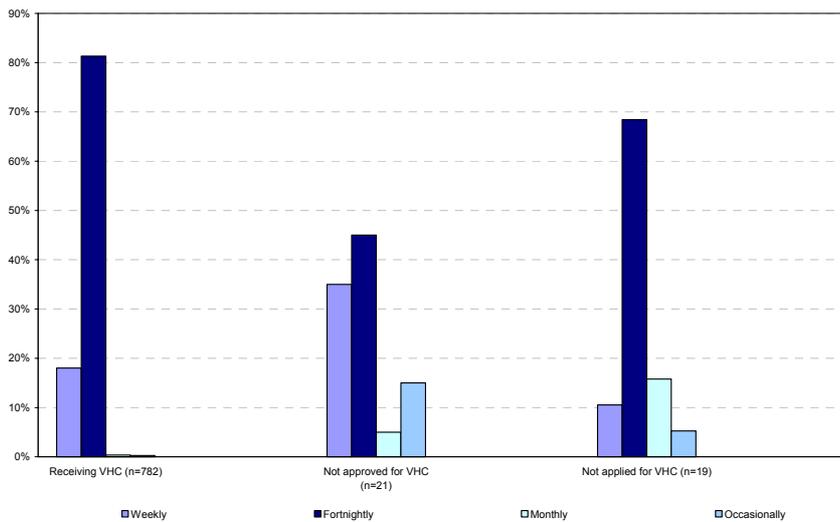
Many veterans indicated a need for services of a heavier nature such as window and carpet cleaning, washing curtains and light shades, changing light globes and 'anything to do with ladders'. There were also requests for washing of floors and walls and cleaning places that are 'out-of-reach'.

Costs and frequency of services received

Veterans not in receipt of VHC provided few details about the cost and frequency of services received. That is, the vast majority of veterans who provided details about the cost, frequency and origin of services were receiving VHC. However, because some of these veterans are also receiving services from other providers, it is not surprising that the information reported did not always reflect the VHC 'benchmark' for services.

Thus, about 70% of veterans provided details of the cost and frequency of domestic assistance received, and responses ranged from reports of 1.5 hours of domestic assistance per month (3 veterans) to more than 5 hours per week (5 veterans). Figure 74 shows that the VHC benchmark of fortnightly assistance is received by just over 80% of these veterans, and the responses also indicated that about 19% of veterans receive more than the VHC benchmark of approximately 1.5 hours of domestic assistance per fortnight. These figures are in line with the finding noted above, that about 16% of veterans receiving VHC receive domestic assistance from other providers.

Figure 74 Frequency of domestic assistance



About 547 (or 60%) of VHC recipients indicated that they received home and garden services from providers other than through VHC. About 76% of these services were from private providers, with 15% from non-profit organisations and less than 10% from other government sources.

About 35% of VHC recipients who provided more details regarding home and garden services report receipt of VHC benchmark service hours (up to 15 hours per year). Responses ranged from up to an hour daily (6 veterans) to up to an hour monthly (11 veterans). Given that about 60% of VHC recipients receive home and garden services from other providers, it is not surprising that 65% report more than the VHC benchmark in terms of service hours received.

Regarding the cost of services, Figure 75 indicates that around 25% of veterans receiving VHC are paying more than the benchmark for domestic assistance, but that other veterans pay considerably more than that (about 45% of veterans not approved for VHC and 55% of veterans not applying for VHC pay between \$10 and \$30 per service). This figure is slightly higher than the finding that about 16% of these veterans receive domestic assistance from elsewhere. It may be that some veterans are receiving more than the benchmark service from VHC service providers.

Figure 75 Cost of domestic assistance (\$ per visit)

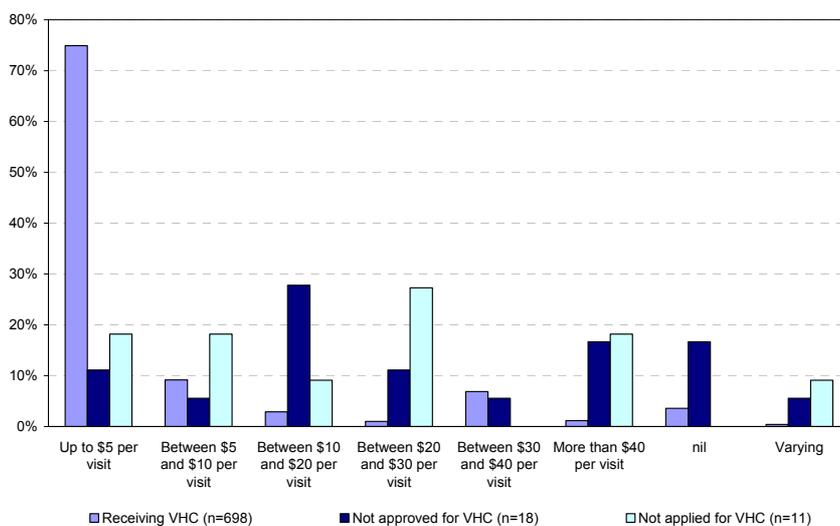


Figure 76 Cost home and garden services (\$ per service)

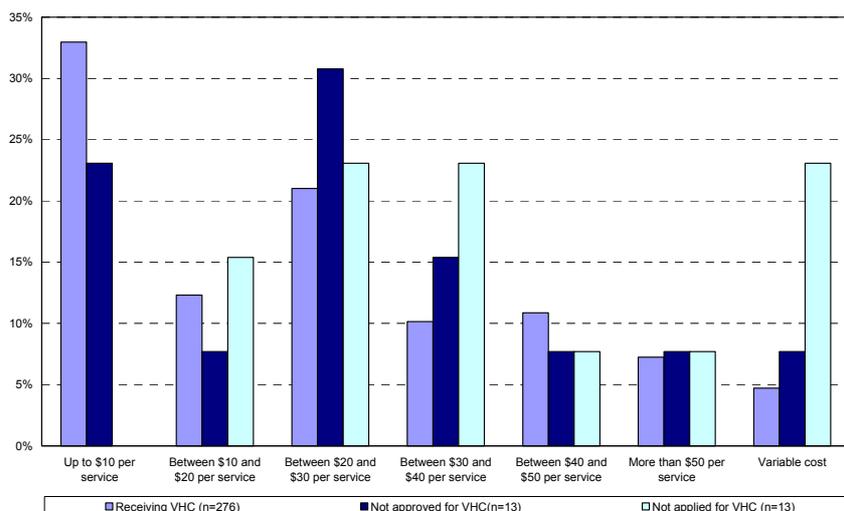


Figure 76 shows that most veterans receiving VHC pay relatively low amounts for home and garden services, compared with other veterans.

Only 71 veterans receiving VHC services provided details of personal care received – about 33% of these veterans received daily care, while the remainder received the VHC benchmark of 1.5 hours per week. This suggests that the responses reflect the provision of Community Nursing Care to these veterans.

Where nursing services and delivered meals were reported as services received, they were reported as occurring most often on a daily basis (80%, 45% and 46% of each group of veterans report daily receipt of these services).

Veterans’ current needs

Veterans were asked to indicate the extent to which their current needs were met. All veterans indicated that their needs for the four VHC service types were at least partially met, but there were differences in needs for specific services between the groups and according to functioning.

As might be expected from the number of veterans in receipt of domestic assistance, and the relative importance of ‘cleaning’ amongst the ‘other services’ received by veterans, all veterans reported some degree of unmet need for domestic assistance. Table 38 shows that approximately 59% of all veterans reported that domestic assistance needs were only partially met. The level of unmet need in regard to travelling to places beyond walking distance and shopping for groceries and food was less, with around 63% of all veterans reporting that their needs were fully met for both functions. Despite this, many veterans commented on their need for help with carrying heavier items and in getting to and from shops.

Table 38 Domestic assistance, travelling, shopping – current need

	Receiving VHC (n=742)	Not approved for VHC (n=32)	Not applied for VHC (n=32)	Total
Domestic assistance				
Fully met	40%	50%	59%	41%
Partially met	60%	50%	41%	59%
Total	100%	100%	100%	100%
Travelling				
Fully met	61%	67%	59%	61%
Partially met	39%	33%	41%	39%

	Receiving VHC (n=742)	Not approved for VHC (n=32)	Not applied for VHC (n=32)	Total
Total	100%	100%	100%	100%
Shopping				
Fully met	63%	65%	62%	63%
Partially met	37%	35%	38%	37%
Total	100%	100%	100%	100%

Veterans were also asked about their future needs for a wider range of services. Many veterans indicated that they found it difficult to comment on their future needs, either because of their age, their health status or that of their spouse/carer, or because they were unsure how long their present situation would remain as it was. While some acknowledged that, realistically, they would need more help in the future, they were not prepared to indicate the extent of that help.

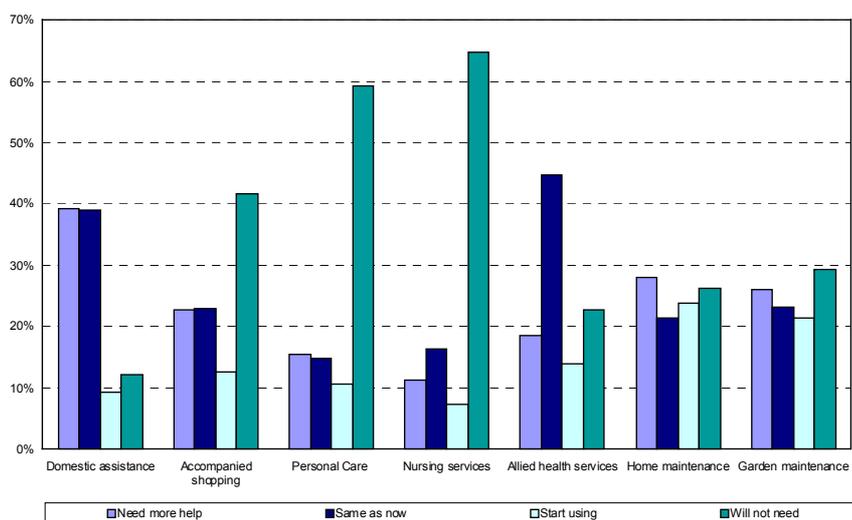
Answers regarding future needs are based on my present abilities and it is impossible to predict what will happen in the future.

My age is 89-90 January 2008. I live in a self contained unit where I prepare my own meals and do my own laundry. Since my last fall on 1st June I have noticed a big deterioration in my health. I am living with the feeling of more blackouts.

At the present I am in reasonable health and able to handle all general living and financial activities, but obviously this will inevitably change in the next few years. I expect my family will be able to do some of this, but sometimes it doesn't work out that way..

Nevertheless, about 78% of veterans made an attempt to estimate their future need for services. Figure 77 illustrates the responses from these veterans, by major service. Overall, veterans indicated substantial levels of future need for domestic assistance, home and garden maintenance and accompanied shopping.

Figure 77 Veteran’s assessment of their needs in the next 1-2 years



In their comments, many veterans noted the need for more assistance with transport at present (for shopping, medical appointments, banking or for social activity). A number of veterans referred to the impact that loss of currently held driving licences would have. Some women referred to the fact that they had never held a licence and their consequent need for transport in the event of the death of their husband. More veterans referred to help with transport as a definite future need.

Transport is a problem and in time will get worse. I will not be able to reach my dentist, hearing or eye people or hairdresser or anything beyond walking distance.'

Since my husband's heart attack he prefers not to drive into town

Home modifications and aids and equipment to assist veterans to live at home

About 55% of veterans reported that they had made modifications to their homes and almost 70% of these provided details of modifications made.

Table 39 Home modifications

	Receiving VHC	Not approved for VHC	Not applied for VHC	Total
Entrance modifications, handrails	70	5	2	77
Ramps	21	1	0	22
Yard, external modifications	3	0	0	3
Bathroom modifications	249	9	18	276
Home security, personal alarms	4	0	0	4
Walking aids, wheelchairs	2	0	0	2
Bed modifications	3	0	0	3
Chair modifications	1	0	0	1
Windows, doors modifications	1	0	0	1
Stair lifts	3	0	0	3
Laundry, extensions, other	1	1	0	2
Total	358	16	20	394

Table 39 shows that modifications to bathrooms are by far the most common type of modification made to veterans' homes. Modifications to home entrances, and installation of handrails and ramps comprise the other major changes made to veterans' homes.

Table 40 Aids and equipment

	Receiving VHC	Not approved for VHC	Not applied for VHC	Total
Chairs - adjustable, special	33	1	2	36
Ambulatory aids - walkers, walking frames, sticks and canes	117	8	2	127
Bedding aids and equipment	30	0	1	31
Personal alarms, security aids (eg sensor lights), Vital call	3	0	1	4
Misc aids including to pick things up, portable oxygen	6	1	1	8
Shower, bath and toilet aids and equipment	28	1	0	29
Motorised vehicles e.g. Gophers, Batscooters	2	0	0	1
Wheelchairs and other wheeled equipment	32	0	2	34
Total	251	11	9	271

About 33% of veterans said that they had purchased aids or equipment to assist them to live at home and almost 80% of these provided details of purchases. Table 40 shows that walking aids comprise by far the biggest group of purchases and that other key purchases include adjustable

chairs, bedding equipment, wheelchairs and other wheeled equipment, and shower/bath/toilet equipment.

Satisfaction with VHC

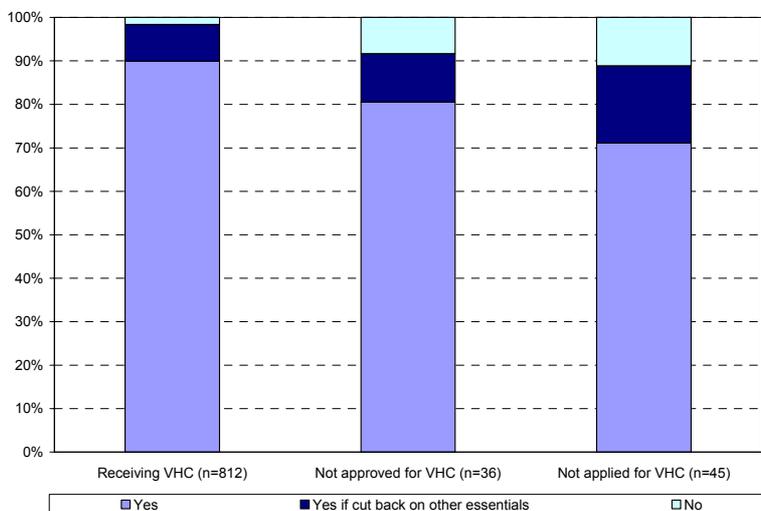
Veterans receiving VHC services were asked about their satisfaction with the program. About 93% of these veterans responded to these questions, of these, the vast majority (87% or 725) were satisfied or very satisfied with the program overall. Slightly more veterans (760) were satisfied or very satisfied with the quality of VHC services, than with the amount of VHC services (728). A small number of veterans (18) were dissatisfied with the quality of VHC services and 10 veterans were ‘very’ dissatisfied. A slightly higher number of veterans (30) were dissatisfied with the amount of services and 12 were ‘very’ dissatisfied. Given the response rate, these figures should be considered alongside the additional comments and criticisms of VHC noted in earlier sections of this report.

Most respondents had not contacted the 1300 Veterans’ Home Care Assessment Agency phone line, (67% of respondents or 572 veterans). Of the 259 veterans who had contacted the agency, 71% were satisfied with the response, 24% were neither satisfied nor dissatisfied, 4% (13 veterans) were dissatisfied and 1% (2 veterans) were ‘very’ dissatisfied.

Ability to pay for services

Veterans were asked for their views on the costs of services that they were receiving now, and those that they might need in the future. Almost 85% of veterans responded to this question, most of whom (791) were veterans receiving VHC.

Figure 78 Ability to pay current fees



The overwhelming response was a willingness to pay more, both for a greater range of services, and to receive more of a particular type of service.

Figure 78 shows that a sizeable majority of veterans and substantially more of those receiving VHC than other veterans indicated that they could afford their current fees without cutting back on other essentials.

I would pay extra if the fee wasn't too much more.

More veterans who had not applied for VHC indicated that they would need to cut back on other essentials to continue to afford their current fees.

About 70% of veterans indicated whether they would be willing to pay more for more services, or a larger range of services. Figure 79 and Figure 80 show that considerably more veterans receiving VHC were prepared to pay more than other veterans for more or a larger range of services.

Home care is very good but the things I can't manage to do are quite costly. Such as painting and anything that requires a ladder.

Figure 79 Willingness to pay more for more services

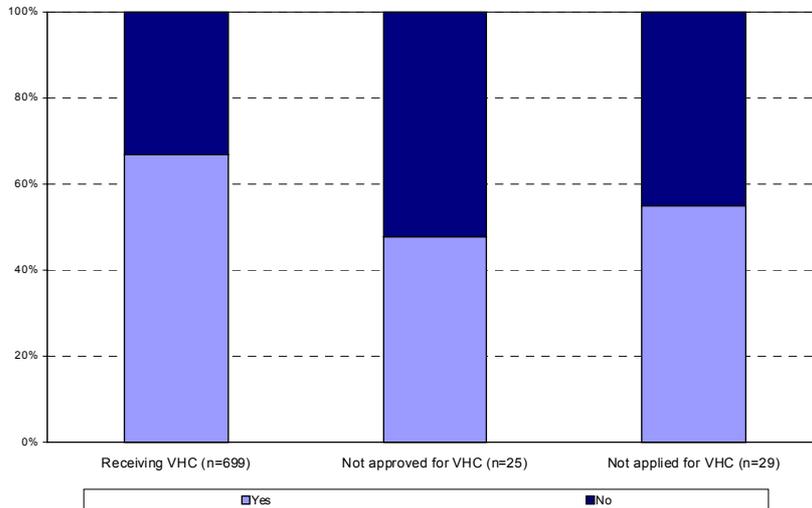
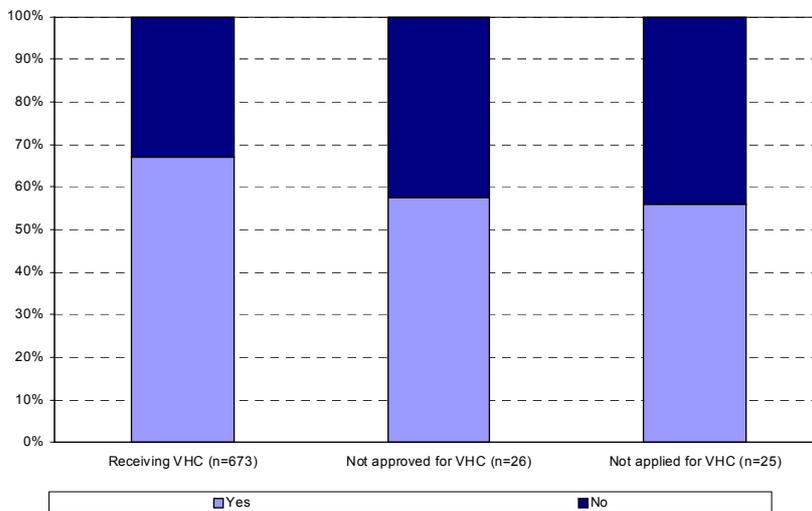


Figure 80 Willingness to pay more for larger range of services



Finally, a number of veterans commented on the inequity of their spouse becoming ineligible for VHC services in the event of their death. Others complained about the ‘overseas service’ requirement for gold card eligibility.

Appendix 5

Results of the VHC service provider survey

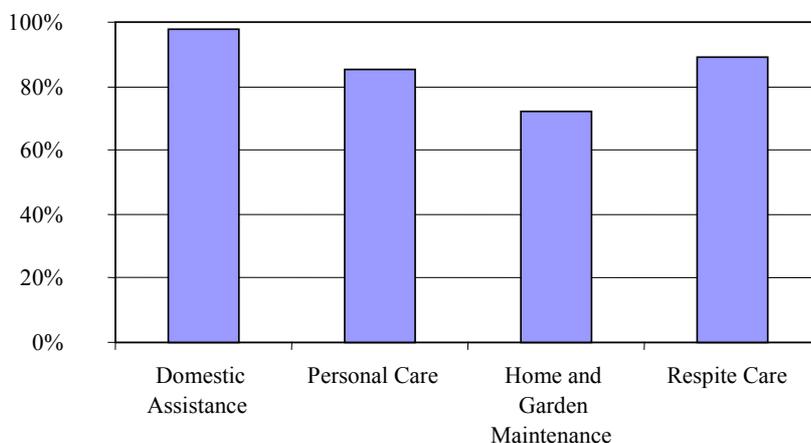
The survey of service providers aimed to investigate what VHC services were provided and whether VHC recipients were different in any of their characteristics compared to other clients of the providers. It also asked whether clients were receiving care services *additional* to those received under VHC (i.e. to top up the range of existing services) or as an *alternative* to VHC (i.e. instead of VHC services). The survey also asked service providers how the program could change to better meet veterans' needs.

A total of 167 providers responded to the survey with 145 completing the whole survey. Providers were asked 26 questions which are reported on fully in this section of the report. Follow up telephone calls to non responders were not conducted as outlined in the methodology as the 145 completed surveys submitted represented approximately 80% of all contracted service providers. The survey dataset was therefore considered representative of service provider organisations.

Service stream

Service providers were asked in which VHC service stream they provided services to VHC clients. Almost all providers (98%) indicated that they provided domestic assistance to their VHC clients, followed by respite (89%) and personal care (85%). The number of providers providing home and garden maintenance services to VHC clients was less at just over 72%. Results are summarised in Figure 81 below.

Figure 81 Respondents providing services in each VHC stream



Services provided to VHC recipients

Providers were asked to estimate how many of their clients they provide VHC services to. There was a 97% response rate to this question, which is summarised in Table 41 below.

Table 41 Number of clients receiving VHC services from Respondents

Number of clients	Number of agencies	Percent of agencies
0 to 10	11	6.8
10 to 30	20	12.3
30 to 50	11	6.8
50 to 100	23	14.2
More than 100	97	59.9

Approximately 60% of agencies indicated that they currently provide VHC services to more than 100 clients. Providers indicating that they provide VHC services to less than 100 clients may either be a smaller agency or provide services under more than the VHC program.

Approximately 90% of providers also provided information on how many clients they currently provide services to in each service stream. Table 42 below shows the percentage of providers in each VHC service stream who provide services to an estimated number of VHC recipients.

Table 42 Percentage of clients currently receiving services in each VHC service stream

Service stream	Nil	1 to 10	10 to 30	30 to 50	50 to 100	More than 100
Domestic Assistance	2.0	8.1	11.5	10.1	16.9	51.4
Personal Care	21.7	45.7	15.2	7.3	4.4	5.8
Respite Care	7.5	50.0	19.4	10.5	6.0	6.7
Home & Garden Maintenance	21.1	35.3	15.0	9.0	11.3	8.3

The majority of providers (51%) who provided domestic assistance provided this service to more than 100 clients while the majority of providers provided personal care (67%), respite (57%) and home and garden maintenance (56%) to less than 10 or no clients. While there was a high number of providers who indicated that their agency provided respite, personal care and home and garden maintenance, this does not seem to be well utilised under the VHC program. One reason why personal care may not be utilised is because this goes primarily to DVA nursing providers.

VHC recipients' living situation

Approximately 78% of providers indicated that more than a third of their VHC recipients lived alone while 81% indicated that more than a third of other program clients (e.g. HACC clients) lived alone. Table 43 below shows the providers' estimate of how many of their clients lived alone or with someone.

Table 43 Proportion of VHC and other clients estimated to live alone or with someone

Living arrangements	None to about a third	Between 1/3 rd and 2/3 rd	More than 2/3 rd
Alone - VHC	21.8	52.6	25.6
Alone - Other	18.6	56.9	24.5
With someone - VHC	53.2	38.7	8.1
With someone - Other	46.9	38.8	14.3

Approximately 75% of providers also provided an estimate on the proportion of those clients who lived with someone by occupant category and program (Table 44).

Table 44 Proportion of veterans estimated to live with another person by occupant category and program

Occupant	None to about 1/3 rd	Between 1/3 rd and 2/3 rd	More than 2/3 rd
VHC Program			
Spouse or Partner	40.2	44.3	15.6
Parent	100.0	0.0	0.0
Daughter and/or Son	97.3	2.8	0.0
Other relative	99.0	1.0	0.0
Friend	100.0	0.0	0.0
Other Program/s			

Spouse or Partner	39.8	44.1	16.1
Parent	95.1	2.4	2.4
Daughter and/or Son	92.0	6.9	1.2
Other relative	96.3	2.4	1.2
Friend	97.4	0.0	2.6

A spouse or partner was the most likely person that a VHC client lived with. Approximately 60% of providers estimated that a third or more of their VHC clients who lived with someone lived with a spouse or partner. All providers estimated that between none and less than a third of VHC clients lived with a parent or friend and over 97% said that none to less than a third lived with a daughter, son or other relative.

The pattern was similar for clients of other programs, however, between 1% and 3% of providers said that two thirds or more of their 'other program' clients lived with a parent, son, daughter, other relative or friend. Just fewer than 7% of respondents indicated that between one and two thirds of their 'other program' clients lived with a son or daughter.

Health and ability of VHC recipients

Providers were asked to judge the health of their VHC recipients and their ability to undertake tasks that providers perform for them compared to their general community care client group. The results are shown in Table 45. Approximately 94% of providers said that the health of their VHC recipients was either the same as or better than their general community care client group and 93% said they had the same or better ability to undertake the tasks they perform for them.

Table 45 Health and ability of VHC clients compared to general community care clients

Level	Health of VHC Clients (n) (%)		Ability of VHC clients (n) (%)	
	Better	28	19.6	22
About the same	106	74.1	109	77.3
Worse	9	6.3	10	7.1
Total	143	100.0	141	100.0

Access to additional community and health services

Approximately 85% of providers indicated whether any of their VHC program clients receive additional community and health services not provided by VHC. Approximately 79% of agencies indicated that their VHC clients received additional community and health services not provided by VHC while 17% didn't know.

The proportion of providers whose VHC clients receive other services is presented in Table 46 below. The majority of responses to this question indicated that less than a third of their VHC clients received other services with only 23.5% indicating that a third or more of their VHC clients received other services.

Table 46 Proportion of VHC clients receiving other services

Client proportion	Number of agencies	Percentage of agencies
None to about a third	70	64.8
Between one third and two thirds	22	20.4
More than two thirds	16	14.8

Approximately 56% of providers indicated that they were able to identify which additional services their VHC clients received. Table 47 below summarises the proportion of providers with VHC

recipients who receive additional services by service stream and whether services are an alternative, or additional, to VHC. Respite has not been included as it is funded differently to domestic assistance, personal care and home and garden maintenance.

Of those providers who reported that their VHC clients received alternative services to VHC, only 16% of providers indicated that VHC clients received alternative domestic assistance services compared to 47% and 44% for personal care and home and garden maintenance services respectively. The proportion of providers indicating that their VHC clients received additional domestic assistance was higher at 39%, although additional personal care was lower than for alternative personal care at 32% and almost 54% of providers indicated that their VHC clients received additional home and garden maintenance services. This would seem to indicate that VHC clients often get additional domestic assistance and home and garden maintenance but are more likely to get personal care services from an alternative to VHC, such as through DVA nursing.

Table 47 Proportion of VHC clients who receive additional or alternative services by service stream

Service Stream	Yes %	No %	Don't know %	Total (n)
Alternative to VHC				
Domestic Assistance	16.1	72.8	11.1	81
Personal Care	47.0	43.4	9.6	83
Home & Garden	43.5	38.8	17.7	85
Additional to VHC				
Domestic Assistance	38.8	47.1	14.1	85
Personal Care	31.7	55.7	12.7	79
Home & Garden	53.9	29.5	16.7	78

Providers were asked whether they knew of any other services that their VHC clients currently used to live at home. Approximately 47% of providers indicated that they were able to identify other services that VHC recipients use to live at home.

Table 48 below gives a summary of services that agencies indicated were services that VHC clients used to support living at home. The other services used most often as identified by providers were food services (13.5%), such as meals on wheels, and social support and transport services (11% each).

Table 48 Other services identified by providers and how often they were identified

Other services	Respondent number	Respondent percentage
Food services	35	13.5
Social support	29	11.2
Transport	29	11.2
Nursing	27	10.4
Respite/day care	26	10.1
Packaged care	19	7.3
Assisted outings	19	7.3
Personal care	10	3.9
Home maintenance	9	3.5
Garden maintenance	8	3.1
Allied health	7	2.7
Specialist health	5	1.9

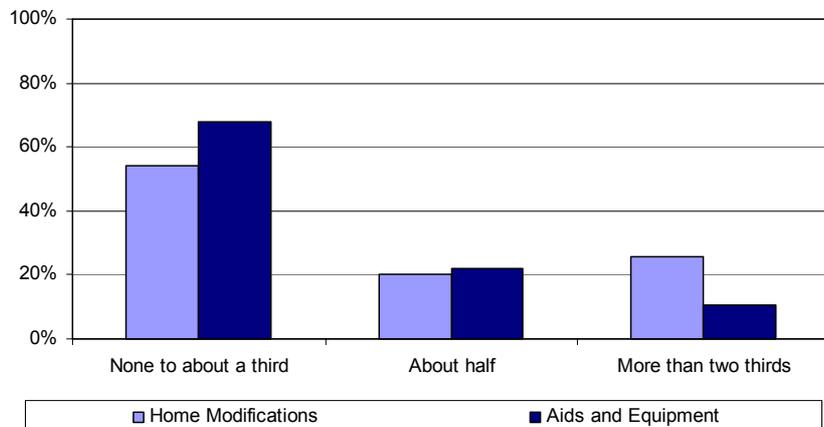
Other services	Respondent number	Respondent percentage
Equipment and modifications	5	1.9
Domestic assistance	5	1.9
General health	2	0.8
Other/non-specific	24	9.3
<i>Total</i>	<i>259</i>	<i>100.0</i>

- General health includes health education and fitness programs.
- Specialist health includes case management, care coordination and post acute care.
- Food services were mainly delivered meals.
- Assisted outings included accompanied shopping, bill paying and banking.
- Social support included a general reference to social support as well as social activities, groups and clubs.
- Transport included community transport and transport to medical and other appointments.
- Other/non-specific services included references to volunteer, private, HACC or extra services but were not defined.

Modifications and equipment

Respondents were asked to indicate the proportions of their clients who have had modifications done to their home or have aids or equipment to make it easier to live at home. Figure 82 below compares respondent estimates of those VHC recipients with home modifications and aids or equipment.

Figure 82 Provider estimate of the proportion of VHC clients with home modifications and aids or equipment



Providers seemed more aware of whether or not their VHC recipients used aids or equipment compared to home modifications. Approximately 31% of providers stated that they didn't know what proportion of their VHC clients used aids and equipment and 36% said they didn't know what proportion of their VHC clients had modifications to their homes to make it easier to live there.

Approximately 51% of providers said that only up to a third of their VHC clients had modifications to their homes while 68% indicated that only up to a third of their VHC clients used aids and equipment. Only 26% of providers indicated more than two thirds of their VHC clients had home modifications and 10% of providers indicated that more than two thirds of their VHC clients used aids and equipment. There appeared to be fewer providers with high proportions of VHC recipients using aids and equipment than providers with high proportions of VHC recipients with home modifications. The majority of providers had fewer VHC clients using aids and equipment compared to those who had home modifications to help them live at home.

The need for change to meet veteran need

Providers were asked to think about the next 5 years and to state whether they thought the VHC program, as it is currently structured, would adequately meet the changing needs of the veteran community. Approximately 60% of providers responded to this question. Table 49 below presents a summary of responses. Approximately 92% of agencies indicated that the program will need some level of change in the next 5 years. Only 8% of agencies felt the program needed no change.

Table 49 Proportion of providers who feel the current program will meet veterans' needs

Changes to VHC needed	Number	Percent
No change needed	11	8.3
It will need minor changes	57	43.2
It will need major changes	64	48.5

Assessment

Providers were asked about the level and type of changes needed to the assessment process. Approximately 89% of providers who answered this question felt changes were needed in the assessment process with the majority indicating that major changes were needed. Table 50 below gives a summary of responses about change to the assessment process.

Table 50 Proportion of respondents who feel change is needed in the assessment process of the VHC Program

Response	Number	Percent
No change needed	13	11.5
Minor changes needed	39	34.5
Major changes needed	61	54.0

Providers were asked to outline changes to the assessment process they felt were needed. The change suggested most often was for the implementation of more in-home or face-to-face assessments or that the current phone based assessment was inadequate. In addition to this, providers often suggested that increased information sharing of the assessment details with the service provider and expansion of the current assessment tool would also improve the outcomes of assessment. Table 51 below expands on the changes suggested by providers.

Table 51 Summary of suggested improvements to the assessment process

Suggested improvement	Number of providers
In home assessment	62
Information sharing of assessment details with service providers	12
Expand current assessment tool	11
Phone assessment is inadequate	10
Flexibility and clarification in service provision	8
Better communication/ feedback between assessors and service providers	5
Better review/referral process	4
Case management	4
Local assessors – interstate assessment problematic	4
Use local provider as assessors	4
Mainstream assessment – integrate with community and ACAT	4
Care coordination	2
Client centred care/continuity of care	2
Improve administration	2
Develop care packages	2

Suggested improvement	Number of providers
Use ACCNA & CENA for assessment	1
Increase resources for assessment	1
Low level service not appropriate as needs increase	1
Review Costs	1
Use other care professionals	1

Range of services

Providers were asked to indicate the level of change that was needed to the range of services provided by the VHC program. Just over 68% of providers provided a response to this question. Of these approximately 47% felt only minor changes were needed in the range of services VHC provides and a further 39% felt major changes were needed. Table 52 below outlines the level of change that respondents thought was needed to the range of VHC services.

Table 52 Proportion of providers who feel change is needed in range of services VHC provides

Response	Number	Percentage
No change needed	16	14.2
Minor changes needed	53	46.9
Major changes needed	44	38.9

Providers were also asked to provide feedback on the changes needed to the range of services. These are summarised in Table 53 below. Changes most often suggested were the addition of accompanied or assisted outings such as shopping and bill paying, flexibility in care and the addition of care packages, social support, increased service times and additional services such as gardening, lawn mowing and meal preparation. Better transition to higher level care, recognition of mental health and complex needs and more flexibility in respite were also mentioned.

Table 53 Summary of suggested improvements to the range of services

Suggested improvement	Number
Accompanied/assisted outings (eg. shopping, bill paying)	39
Care models (flexibility, packaged care)	25
Social support	25
Increase service times	23
Additional services (eg. gardening, lawn mowing, meal preparation)	19
Higher level care (transition to, mental health, complex needs)	15
Respite (flexibility in who receives it and type of respite)	12
Payments/funding (travel reimbursement, increase fees and flexibility)	9
Transport for veterans	9
Case management	8
Client centred care	6
Assessment (review)	4
Program change (merge VHC/HACC with one point of contact)	4
Service review (over/under servicing)	4
Care coordination	3
Equipment	1

Quantity of services

Providers were asked to state whether they thought changes were needed to the quantity of services that the VHC program provides. Approximately 87% of providers who answered this question felt that some level of change was needed in the quantity of services provided by VHC with 50% indicating that only minor changes were needed. Table 54 below summarises responses to this question.

Table 54 Proportion of providers who feel change is needed in quantity of services

Response	Number	Percentage
No change needed	15	12.8
Minor changes needed	59	50.4
Major changes needed	43	36.8

Providers also made suggestions on changes needed to the quantity of services provided by the VHC program. The most common change suggested was an increase in the allotted hours for all service types, although many respondents also indicated there was a need for allotted service hours to be more dependent on a client's age and level of need. A number of additional services were also emphasised by respondents as were a range of other issues. Table 55 below outlines changes suggested by agencies.

Table 55 Summary of suggested improvements in quantity of services

Type of change suggested	Number
More hours for all service types	62
Age/need relevant time allocation	18
Additional services (eg, assisted shopping, social support, care coordination, regular gardening, meals)	24
Assessment inadequate	7
Implement one system of care for all	4
Flexibility in current hours	3
No change necessary	3
Use/develop care packages	3
Under-utilisation of personal care workers	2
Other issues raised	5

Care coordination

Providers were asked if changes were needed in care coordination within the VHC program and what those changes should be. Sixty percent of providers responded to this question. A total of 81% of these providers thought there should be change in care coordination within the VHC program although approximately 19% thought there was 'no change needed'. There seemed to be less certainty with this question with fewer providers answering this question and more providers who felt no change was needed. Table 56 below outlines the proportion of agencies who thought some level of change was needed to care coordination in the VHC Program.

Table 56 Proportion of providers indicating the need for change in care coordination

Response	Number	Percentage
No change needed	19	19.0
Minor changes needed	38	38.0
Major changes needed	43	43.0

Suggested changes mainly focussed on care coordination issues, assessment issues and the role of case management. Care coordination issues mainly focussed on defining who has the care coordination role and the need to fund that role. Care coordination was time consuming and often fell to the service provider who was not funded for this time. Service providers also felt that the client need for care coordination was not currently being met.

An issue brought up again that is related to care coordination was the issue of information sharing of assessment details with the service provider. Table 57 gives an outline of providers' suggestions and other issues raised in response to this question.

Table 57 Summary of suggested changes to care coordination

Suggested change	Number
Care coordination issues	46
Define and fund care coordination role	18
Need for care coordination not being met	11
Care coordination by service provider time consuming and unfunded	9
Other care coordination issues	8
Assessment Issues	25
Comprehensive in home assessment	9
Reassessment more frequent	3
Service provider to do assessments	3
Phone assessment inadequate and difficult for client	3
Improve assessment/care pathway	3
Other assessment issues	4
Review role of case management	12
Information sharing with service provider for care coordination	8
Define and streamline organisational aspects of VHC	8
Better communication and channels for feedback	6
Improve interaction/rapport with client/veteran population	4
More time for home visits	2

Other changes

Providers were asked to indicate if they thought other changes were needed to the VHC program. Approximately 68% of respondents answered this question with 54% stating that they thought the program needed other changes and 26% were not sure. Other changes to the VHC program that providers said were needed are outlined in Table 58 below.

Improvements in the administrative and IT aspects of the program was the issue suggested most often with flexibility in service provision and time also mentioned frequently. The sharing of assessment information also came up again as did the need for in-home or face-to-face assessment and client reviews.

Table 58 Summary of other changes suggested and issues raised

Suggested changes/issues raised	Number
Administrative/IT	12
Service flexibility/time	10
Information sharing	9
In home assessment/review	8

Suggested changes/issues raised	Number
Additional services	6
Funding	6
Integrate VHC into mainstream	6
New care model	6
Payment for un-notified cancellations	6
Transport funding	6
Viability of program	6
Client rapport	5
Align VHC - other program fee structure	4
Younger veterans	4
Client access	3
Packaged care	3
Assessment by service provider	2
Transition	2
Other	11

Changes to improve service delivery

Providers were asked to think about the rest of their current VHC contract period (i.e., the next 2 years only) and to indicate what the VHC Program can do in order to improve how it delivers services to the veteran community. Sixty nine percent of providers responded to this question, discussing a broad range of issues about current services and suggestions for the future. A summary of these issues and suggestions are given in Table 59 below.

The issue referred to most was the sharing of client assessment information with the service provider. It was stated that the lack of detail given in service plans placed an increased burden of assessment and care coordination on the service provider and that, if clients consented to their information being passed on, access to assessment details would greatly improve their ability to provide appropriate services to a client and reduce time spent on care coordination.

There was also a focus on service provision issues, including allowing more flexibility in how service hours are used, increasing the hours of service available to clients and adding more service types to the VHC program such as social support, accompanied shopping and meal preparation. A number of providers also argued for the need to fund the full cost of service provision, including travel time, care coordination time and staff development.

A number of providers also talked about issues relating to the interaction of clients with the VHC program. They stated that more information on services and what's available needs to be provided to the client. There was some suggestion that this could be done as part of an in home assessment. It was also stated that clients can have difficulty with the assessment process. This included difficulty in accessing the assessment agency and difficulty with the phone assessment procedure. Clients most vulnerable to a poor assessment outcome are those with cognitive difficulties and/or complex needs. A number of respondents argued that allowing a family member or regular service provider to advocate on the client's behalf would address many of these difficulties. It was also pointed out that informing the client before any changes are made is also important to reduce the stress and confusion this can cause.

Table 59 Summary of changes suggested in the next two years

Suggested changes/issues raised	Number
Information sharing (with client consent)	19
Flexible services	18
Increased hours of service (all service types)	18
Additional services (social support, accompanied shopping, meal preparation etc.)	14
More information for the veteran/client	14
Better assessment and review process	14
Fund real cost of service provision	11
Social support for the veteran	10
In home/face to face assessment	9
Administrative/IT (delays and claims)	7
Expand assessment tool	7
Client difficulties with assessment agency	6
Allow client advocacy (by family/friend/service provider)	5
Meet changing needs of veterans	5
Collaborate on care coordination	4
Phone assessment inadequate	4
Improve service plans	4
Accompanied shopping	3
Better transition process	3
Inform client of changes	3
One/fewer providers per veteran	3
Service provider should do assessment	3
Under-utilisation of personal care services and PC staff	3
Address carer needs	2
Other	35

Other comments

Final comments were invited to allow providers to raise any issues that may have been missed within the survey. A total of 70 respondents entered a final comment at the end of the survey. There were 103 issues raised and comments made with a broad range of subjects. These are summarised in Table 60 below.

A number of providers indicated that they had no further comments to make or mentioned various difficulties with the survey. However the majority of comments were additional comments about the VHC program.

There were a number of positive comments, including those that said that VHC was a valuable service, that there were good relationships between service providers and assessors and VHC staff and that there was client satisfaction and loyalty to DVA. Other positive comments were mainly in relation to the positives of working with veterans and the VHC program and the different types of support given to service providers.

The majority of comments outlined various issues and improvements that providers feel VHC needs to address. Some providers felt that the needs of VHC recipients were not being met and

that the changing needs of the veteran population and incentives to stay with VHC, such as loyalty to DVA and cost issues, were exacerbating this.

Specific improvements to the VHC program included a number of recurring themes including addressing the full cost of service provision, addressing administrative and IT difficulties and information sharing with the service provider. At a program level some providers argued for the merging of the VHC program with Community Care programs such as HACCC and packaged care.

Table 60 Other comments made by service providers

Suggested changes/issues raised	Number
VHC a valuable service	6
Client needs not being met	5
Merge with community care	5
Address full cost of service provision	4
Administrative/IT difficulties	4
Good relationships/support	4
Information sharing with service provider	4
Client satisfaction/loyalty to DVA	3
New care model needed	3
Centralisation problematic	2
Improve service plans	2
Incentives to stay on VHC	2
Meet changing needs and standards	2
One provider per client	2
Need for packaged care	2
Staff recruitment/retainment	2
VHC population needs changing	2
Other improvements needed	21
Other positive feedback	7
No changes required	14
Problems with/inability to complete survey	7