Contents

1. Evaluation at a glance .......................................................................................... 3
   1.1 Background and context ............................................................................ 3
   1.2 Key lessons learned .................................................................................. 4
   1.3 Other Evaluation findings: what worked, for whom ............................... 5
   1.4 Key factors for success in implementing short-term enabling interventions 6

2. The Better Practice Project ................................................................................. 7

3. About the demonstration projects ...................................................................... 8
   3.1 Shared features ......................................................................................... 8
   3.2 The four projects ..................................................................................... 9
   3.3 Services accessed during BPDP programs ............................................. 16

4. Evaluation findings ............................................................................................. 20
   4.1 Client profile ............................................................................................. 20
   4.2 Project implementation ............................................................................ 21
   4.3 Client outcomes ....................................................................................... 26
   4.4 Use of resources ..................................................................................... 30

5. Lessons learned .................................................................................................. 33
   5.1 Different models of short-term intervention are effective ....................... 33
   5.2 Engaging key stakeholders with an enabling approach ......................... 33
   5.3 Recognising the value of specialist skills ................................................. 34
   5.4 Adapting models of service delivery to support enabling practice .......... 35
   5.5 Engaging with the client’s whole life ...................................................... 36
   5.6 Recognising where the greatest gains can be achieved ......................... 36
   5.7 Understanding the inherent biases .......................................................... 37

6. After the demonstration projects ...................................................................... 38
   6.1 The enabling philosophy .......................................................................... 38
   6.2 Short-term intervention initiatives ............................................................ 38

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ADHC and the evaluation team would like to thank the organisations and their staff who participated in the Demonstration projects for their commitment to and enthusiasm for the projects. ADHC would also like to thank the participating clients and their carers/families who generously provided their time and shared their experiences.
1. Evaluation at a glance

1.1 Background and context

In 2010, Ageing Disability and Home Care (ADHC), NSW Department of Family and Community Services began The Better Practice Project to explore new ways of providing Home and Community Care (HACC) services in NSW. The Better Practice Project aimed to support the adoption of evidence-based practices to enhance the independence and quality of life of older people requiring support to live at home. Four demonstration projects were funded to implement an enabling approach with people who were HACC eligible and aged over 65 or aged over 45 for Aboriginal and Torres Strait Islander people.

Enabling is an umbrella term which includes evidence–based practices associated with wellness, active ageing, early intervention, person-centred responses, preventative intervention and short term restorative or ‘reablement’ interventions. This approach aims for increased functionality in performing the common tasks of daily living and improved feelings of personal wellbeing.

The Better Practice Demonstration Projects (BPDPs) ran from 1 July 2010 to 31 December 2011. The four projects involved an eight to 12 week multidisciplinary intervention, based on a goal-oriented assessment and the implementation of flexible strategies to assist clients to reach their individual goals.

The BPDPs were evaluated by Glen Sorensen, Clare Crawford, and Peter Cranko. Qualitative and quantitative data was collected on client functional ability and personal wellbeing at entry to the programs, at exit, and (for a sample of clients) at three months after exit.

The four projects were located in:

- Clarence Valley – hosted by Clarence Valley Council.
- Eastern Sydney – hosted by Catholic Community Services.
- Northern Beaches (Sydney) - hosted by Community Care Northern Beaches Inc.
- Singleton - hosted by Ourcare Services.

There were a total of 207 admissions to the four BPDPs. Of these, 188 (91%) resulted in completed short-term intervention programs. On average, a BPDP program lasted 61 days and involved:

- An in-depth assessment process, lasting on average around four hours
- Development of a support plan for achieving client goals
- Implementation of that plan, through case management/care coordination and additional supports including:
  - Care/support worker one-to-one hours (‘direct care’)
– Specialist services purchased e.g. occupational therapy
– Equipment and home modifications
– Other supports specifically identified to respond to client goals.

1.2 Key lessons learned

The evaluation identified seven key lessons.

1 Different models of short-term intervention are effective
There is no single template for the enabling approach. There are many ways to achieve positive impacts for clients.

2 Engaging key stakeholders with an enabling approach
Engaging the cooperation / acceptance of key stakeholders (clients, staff and key referral partners) is not a simple straight forward process. Patience, “one to one” effort and flexibility are required in many instances.

3 Recognising the value of specialist skills
A particular combination of practical and personal skills is needed to effectively support an enabling intervention.

4 Adapting models of service delivery to support enabling practice
An enabling approach requires new ways of organising service delivery which can respond to individual clients’ priorities and changing needs.

5 Engaging with the client’s whole life
The delivery of truly person-centred care requires an understanding of, and engagement with, all aspects of a client’s life and circumstances.

6 Recognising where the greatest gains can be achieved
While enabling approaches can be used effectively across a range of circumstances, the short-term intervention model is most effective when used at the first point of contact between a client and the service system.

7 Understanding the inherent biases
Models of care which have a particular focus are effective at delivering improved client outcomes in the areas they target. These biases can present limitations as well as offer opportunities, and organisations need to be aware of this tension.
1.3 Other Evaluation findings: what worked, for whom

About two-thirds of participants in the BPDP programs were female, and most were aged between 75 and 84.

Participants recorded higher average scores for wellbeing and functional ability on exit than they had on entry. 89% of clients who provided personal feedback reported positive impacts from the BPDPs. The evaluation also found that:

- participants reported higher scores three months after exiting the programs than they had on entering – though gains tended to slow and/or drop back after the short-term intervention ended
- Greater satisfaction with levels of health was the largest single area of improvement – followed by satisfaction with what people were achieving in life, and ability to do shopping without assistance
- Each BPDP tended to achieve the best results in the areas in which its clients identified the most goals – suggesting that the design of the programs was responsive to individual client goals
- Participants who entered the BPDP programs with lower scores for function and wellbeing tended to make greater gains
- Types of supports that were associated with greater gains in client outcomes included occupational therapy and additional hours of one-to-one support
- BPDP programs required, on average, 2.4 times as long as conventional HACC for assessment, 2.5 times as long for care coordination, and 1.5 times more in average hours per month of direct care
- At least one-third (and up to one-half) of clients exited a short-term intervention requiring no further support services.

What the clients have said!

I was very happy to be able to enter into this program and have benefited really well by it as I was beginning to be a little lazy in cooking and cleaning but after talking and taking part in this program I soon realised my mistakes and have certainly changed my options. Thank you.

Client, Eastern Sydney Demonstration Project

This program helped me a lot and I was surprised that a few exercises regularly done could have made me confident and steady when walking. I was falling regularly and have not fallen since or felt wobbly. I am now less dependent on my husband and have renewed some of my household chores and decisions. The program has restored some of the balance in this household.

Client, Northern Beaches Sydney Demonstration Project
I found the program helpful as I was able to move at my own pace with help. I feel I am further ahead in my efforts to return to living independently.

Client, Singleton Demonstration Project

Being involved in this program has given me more confidence and helped me to implement motivational goals for further bettering my life. Thank you so much for allowing me the opportunity to be involved in it.

Client, Clarence Valley Demonstration Project

In terms of use of resources, the evaluation identified significant differences in the approaches to resource use between the four projects reflecting the different models and their areas of focus.

In comparison with conventional HACC services, the evaluation found that although a short-term enabling intervention requires more resources to implement, it has the potential to save costs overall in the medium to long term.

During the pilot period, the BPDPs adapted and refined their models in response to lessons learned from their own experiences or those of the other projects. The evaluation found that the major areas of change for the BPDPs were around:

- Increasing success in identifying and securing appropriate referrals
- More effective promotion strategies
- Training and staff development
- Adapting practices in assessment, goal setting, care coordination and case management
- Broadening the definition of the target groups for whom the approach was considered appropriate
- Developing more flexible approaches to the management of service delivery.

All of the BPDP host agencies are continuing to develop their enabling practices following the completion of the demonstration project pilots.

1.4 Key factors for success in implementing short-term enabling interventions

Overall, the experience of the BPDPs indicates that the key ingredients to successful implementation of an enabling approach based on a short term intervention are:
Start with a small program, which can grow as staff and referral partners learn how it works and can be most effective

Promotional strategies with clear, simple messages about enabling and its value that are carefully targeted to reach potential clients and responsive referral partners

A workforce trained in the philosophy of enabling, skilled in applying enabling techniques to their community care practice and provided with opportunities to reflect on practice

Strong, targeted partnerships with potential referral sources, families, other support providers and brokered agencies

A comprehensive assessment process that builds rapport, encourages the client to identify what would make a difference to their life and leads to the identification of achievable and measurable goals set by the client

An intervention plan that is individually tailored to the client and their situation that may focus on functional gain, improvements in feelings of personal wellbeing or both

Capacity and permission for community care agencies to implement a range of innovative strategies that may be outside their traditional range of service and support

An intervention budget with the capacity and flexibility to support lower to higher cost interventions

Some form of ongoing monitoring of motivation and progress and for episodic case management/care coordination, if needed

A flexible and reflective model of management, with continuous learning built into processes.

2. The Better Practice Project

In 2010, Ageing Disability and Home Care (ADHC), NSW Department of Family and Community Services, began The Better Practice Project to explore new ways of providing Home and Community Care (HACC) services in NSW. The Better Practice Project aimed to support the adoption of evidence-based practices to enhance the independence and quality of life of older people requiring support to live at home. Four demonstration projects were funded to implement an enabling approach with people who were HACC eligible and aged over 65 or aged over 45 for Aboriginal and Torres Strait Islander people.

Enabling is an umbrella term which includes evidence–based practices associated with wellness, active ageing, early intervention, person-centred responses, preventative intervention and short term restorative or ‘reablement’ interventions. Enabling interventions build on client strengths, abilities and interests by designing and implementing a goal-orientated personal plan of action that will truly make a difference to a person’s ability to live independently. This approach aims for increased functionality in
performing the common tasks of daily living and improved feelings of personal wellbeing.

The Better Practice Demonstration Projects (BPDPs) ran from 1 July 2010 to 31 December 2012.

The BPDPs were evaluated by Glen Sorensen, Clare Crawford, and Peter Cranko. The evaluation used an action research approach to explore:

- How and to what extent an enabling approach with a short term intervention can lead to increases in personal wellbeing and functional capacity for older people
- Whether and to what extent an enabling approach with a short term intervention can reduce or delay the need for formal community care service provision
- The key success factors, challenges and lessons in implementing an enabling approach with a short term intervention in community care settings
- Whether and to what extent an enabling approach based on short term interventions appear to be a cost effective approach to meeting the needs of the target groups.

3. About the demonstration projects

3.1 Shared features

There were four demonstration projects. All projects involved an eight to 12 week multidisciplinary intervention, based on a goal-oriented assessment and the implementation of flexible strategies to assist clients to reach their individual goals. Qualitative and quantitative data was collected on client functional ability and personal wellbeing at entry to the programs, at exit, and (for a sample of clients) at three months after exit.

There were a total of 207 admissions to the four BPDPs. Of these, 188 (91%) resulted in completed short-term intervention programs. On average, a BPD program lasted 61 days and involved:

- An in-depth assessment process, lasting on average around four hours
- Development of a support plan for achieving client goals
- Implementation of that plan, through case management/care coordination and additional supports including:
  - Care/support worker one-to-one hours (‘direct care’)
  - Specialist services purchased e.g. occupational therapy
  - Equipment and home modifications
  - Other supports specifically identified to respond to client goals.
There was a wide range in the types and levels of supports provided. For some clients, the process of detailed assessment and goal setting, together with key referrals or equipment, was enough. Other clients required substantial practical assistance and/or encouragement to pursue their identified goals over the period of the program.

Table 1: Overview of BPDP programs

<table>
<thead>
<tr>
<th></th>
<th>Clarence Valley</th>
<th>Eastern Sydney</th>
<th>Northern Beaches</th>
<th>Singleton</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of people who started</td>
<td>51</td>
<td>66</td>
<td>61</td>
<td>29</td>
</tr>
<tr>
<td>No. of people who completed</td>
<td>48</td>
<td>55</td>
<td>59</td>
<td>26</td>
</tr>
<tr>
<td>Average program length (All projects average: 61 days)</td>
<td>60 days</td>
<td>67 days</td>
<td>57 days</td>
<td>57 days</td>
</tr>
</tbody>
</table>

3.2 The four projects

Table 2 describes the key features of the management and administration structures of each project. Profiles of the individual models of care developed for each BPDP follow Table 2.
<table>
<thead>
<tr>
<th>Project and area covered</th>
<th>Up and About Clarence Valley LGA</th>
<th>Enabling Pilot Eastern Sydney: Waverley, Woollahra, Randwick, Botany LGAs</th>
<th>Enable Me Northern Beaches Sydney: Manly, Warringah, Pittwater LGAs</th>
<th>Better Practice Demonstration Project Singleton LGA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Host agency</td>
<td>Clarence Valley Council Community Support Services managing 21 funded services across the NSW Far North Coast with 3 service outlets: Grafton, Maclean &amp; Ballina</td>
<td>Catholic Community Services (CCS) Large church/charitable sector community services provider operating across NSW and the ACT</td>
<td>Community Care Northern Beaches (CCNB) NGO providing a range (18) of community care programs for older people and people with a disability across Northern Sydney</td>
<td>Ourcare Services Community based multi-service outlet offering 14 HACC services across Singleton (and other parts of the Upper Hunter)</td>
</tr>
<tr>
<td>BPDP within agency structure</td>
<td>BPDP set up as separate project within Community Support Services Division</td>
<td>BPDP defined as ‘top tier’ of 3 levels of enablement practice implemented for all CCS services</td>
<td>BPDP set up as separate project within CCNB</td>
<td>BPDP set up as separate service type alongside mainstream community services</td>
</tr>
<tr>
<td>BPDP governance arrangements</td>
<td>Consultative committee including Council, ADHC regional office, Home Care, Aboriginal Home Care, Community Health, Home Maintenance and Modifications, Cranes and Community Transport</td>
<td>Project Manager Enabling Services (established 2007) managed BPDP as part of wider approach, reporting to CCS internal accountability structures</td>
<td>Project reported to Director of Strategy, as part of management team, then to CEO and Board of Directors</td>
<td>Advisory group including Ourcare, ADHC regional office, Community Care Access Point, Hunter New England AHS, Division of GPs, Aged Care Assessment Team, IMPACT group, HACC Development Officer</td>
</tr>
<tr>
<td>BPDP staffing arrangements</td>
<td>Directly employed staff including 3 existing coordinators and direct care staff who received enablement training</td>
<td>All CCS staff trained in enabling Pool of 7 coordinators under project manager, with support from internal direct care staff including allied health assistants</td>
<td>Existing case manager deployed as dedicated Enable Me assessor Single multi-skilled key worker brokered for this project</td>
<td>Dedicated coordinator for this project, supported by multi-skilled existing staff</td>
</tr>
<tr>
<td>Target clients (key features)</td>
<td>People with low to moderate needs who were medically stable Specific intention to include Aboriginal and Torres Strait Islander people</td>
<td>All referrals for HACC domestic assistance or personal care were potential clients; also included existing clients of these services</td>
<td>People who had not yet accessed the HACC service system or were receiving low level HACC support</td>
<td>People whose primary need was for social support, as well as those with functional needs</td>
</tr>
<tr>
<td>Referral / intake process</td>
<td>Screened by general Council intake and referred to BPDP if interested</td>
<td>Screened and referred from CCS central intake</td>
<td>Clients sought through local networks e.g. GPs, seniors’ groups, other service providers</td>
<td>Referrals through Hunter Region Community Access Point</td>
</tr>
<tr>
<td>Service delivery</td>
<td>8 weeks, with possible extension to 12 weeks Council’s direct care workers and brokered services One coordinator as key contact</td>
<td>6-8 week intervention at level 1 Lead coordinator for each client, supported by multi-skilled internal staff and brokered allied health (private and AHS)</td>
<td>Case management done by dedicated assessor All other services brokered externally</td>
<td>6-8 week intervention Dedicated coordinator as key contact and direct care provider, supported by mainstream Ourcare services and brokered services</td>
</tr>
<tr>
<td>Client contribution</td>
<td>None requested</td>
<td>Weekly charge and cost of equipment if able to pay otherwise no fee</td>
<td>None. Some clients contributed towards the cost of equipment</td>
<td>Weekly charge and contribution to equipment/modifications</td>
</tr>
</tbody>
</table>
3.2.1 Up and About: Clarence Valley

The Clarence Valley BPDP engaged the services of a consultant to help them scope and design their model of care. The model was implemented by the Clarence Valley Council service delivery team, with the guidance of the project’s Consultative Committee.

Potential clients had to expressly choose to participate in a short-term enabling intervention, as opposed to receiving mainstream services. They were screened by assessment staff to further ensure that only people who expressed interest in trying the approach were accepted. As for all the projects, there were initial difficulties in securing appropriate referrals.

Clarence Valley’s model placed very strong emphasis on capturing client goals in their own words. The Clarence Valley team modified the original assessment tools to increase the narrative flow of interaction between assessor and client, and developed prompts and processes to actively encourage the client to identify their challenges and articulate their own solutions. Quite often, clients suggested an innovative solution, usually a piece of equipment, outside the usual community care service range of responses.

The model of care allocated each client a notional budget which represented the amount of resources available from the project’s overall funding allocation. This ‘budget’ was spent on interventions which included provision of health information; exercise, mobility and strength building programs; and home modifications and assistive equipment. All direct support was supplied by Council’s workers who had received training in the enabling approach and on supporting clients with exercise regimes.

The ‘individual budget’ approach allowed considerable flexibility in developing strategies to meet the goals that clients identified. This BPDP was much more likely than the others to use funding to purchase aids and equipment and was the only demonstration project to set up and resource an exercise group for several BPDP clients who lived in the same retirement village.

Special characteristics of this BPDP

- Individual client ‘budget’ approach – with purchasing of a very wide range of different types of services and supports
- No limit on what could be purchased, with emphasis on purchasing things that clients identified as potentially making a real difference to improving their lives, e.g. a weatherproof awning, running shoes, a lawnmower, plumbing works
- Particularly strong involvement from the local ADHC regional office.
3.2.2 Enabling Pilot: Eastern Sydney

In Eastern Sydney, the BPDP was just one component of an organisation-wide shift towards an enabling philosophy in care delivery which commenced in 2007. As part of this, Catholic Community Services (CCS) was already working to empower clients to take increased responsibility for their own support needs and to self-manage access and care, rather than being case managed.

A more flexible and episodic approach to the delivery of services was part of this new direction, and the BPDP was considered as ‘level 1’ in a three tier system through which it was expected that clients would move as their needs changed:

- Level 1: Enabling Restorative Packages—short-term, goal-based restorative intervention e.g. teaching a client new techniques to clean their own home (the BPDP program)
- Level 2: Enabling Maintenance Services – ongoing services delivered with an enabling philosophy, e.g. domestic assistance with the client completing some tasks
- Level 3: Basic service – services delivered by the care worker (conventional HACC).

At Eastern Sydney, the BPDP involved the application of an enabling approach to the provision of three conventional HACC service types: personal care, domestic assistance and social support. Brokerage funding was to be used to purchase allied health, and to hire assistive equipment if it was required. No non-consumable assistive devices would be purchased by the project, and a limit of $50 per client was set for assisting clients to purchase consumable supports e.g. long-handled sponges.

Clients were admitted through CCS’ central intake. All clients had been referred for HACC domestic assistance or personal care services and were on a waiting list to receive them or (later in the project) were already receiving these services. The BPDP was not described or promoted as a separate option within CCS services. Clients’ willingness to engage in enablement was gauged by assessors who gained consent and determined the appropriate ‘tier’ of service to meet their needs. Standard HACC charges were levied for all levels of care.

The Eastern Sydney BPDP envisaged an average of 45 hours of care for each six-week program, with the largest portion of this dedicated to allied health – both externally purchased through a partnership with St Vincent’s Hospital and delivered as direct care by trained CCS Allied Health Assistants. Existing HACC funding for domestic assistance and personal care would be used to provide these services for BPDP clients, and social support would be provided by volunteers, coordinated by a part-time in-house position funded through the BPDP.
This BPDP was part of larger process of organisational change for CCS. Reflecting this, the project had a strong emphasis on staff development and training to support delivery of core CCS services using the new enabling philosophy. As well as training and internal capacity building, the model included significant peer support arrangements, such as mentoring and fortnightly case meetings.

Special characteristics of this BPDP

- A large organisation, with the largest internal workforce of the BPDPs, and a strong focus on capacity building for the delivery of enabling approaches across the whole organisation
- Clients did not expressly choose between BPDP and mainstream HACC services as with other BPDPs
- Inclusion of clients who had established conventional HACC services (later in the project)
- All recruitment through CCS intake, with no specific marketing or promotion of the enabling project as an option distinct from conventional services.

3.2.3 Enable Me: Northern Beaches Sydney

Community Care Northern Beaches engaged a consultant to assist in the development of the project model and resources. The agreed model built on CCNB’s extensive experience with case management, short term transition support and brokerage. It had an early intervention focus and targeted people who were HACC eligible but either not yet accessing the HACC service system or were accessing low level support (e.g. meals, transport, minimal social support, etc).

The Northern Beaches Sydney BPDP model involved a single CCNB case management staff member who acted as assessor and primary coordinator of services for all BPDP clients. When support workers were needed, the assessor used brokerage funding to purchase external support, as CCNB did not employ its own allied health or direct care staff. Brokerage funds were used to engage an allied health team for the duration of the project, contract an exercise physician to work with individual clients in their homes, and purchase aids and equipment.

The Northern Beaches Sydney BPDP model of care had a strong focus on building physical strength and resilience, using both health (allied health) and fitness (exercise physician) professionals. The project also used the key worker role to deliver support in a range of ways including implementing exercise programs in clients’ homes, conducting transport training, linking and accompanying clients to community groups and supporting clients to learn new ways to approach tasks of everyday life.
In response to less than expected referrals early in the project, CCNB decided to expand the project’s target group. It proved challenging to easily reach older people who were not known to the community care service system.

CCNB saw the BPDP as a practice project, so did not charge clients for participation though did seek client contributions for purchased equipment.

**Special characteristics of this BPDP**

- An organisation with extensive experience in case management services
- Model of care with strong focus on building physical strength
- Use of a full brokerage model to purchase all direct support and other services.
3.2.4 Better Practice Demonstration Project: Singleton

The Singleton BPDP ran in parallel with mainstream HACC services. Potential clients had to express willingness to engage with the enablement approach, and had to be assessed as having potential to benefit from the program.

In Singleton these criteria for inclusion were further filtered through the Community Care Access Point (CCAP), through which all community care referrals in the Hunter region are directed. Initially, the BPDP experienced some difficulties in the number of referrals it gained, as the CCAP chose whether to refer clients to the BPDP or to Ourcare’s conventional HACC services. This issue was addressed once Ourcare assumed responsibility for these decisions.

In designing their model of care, Singleton sought to ensure the sustainability of the project beyond the period of BPDP funding. For this reason, the model focused on a case management approach, assisting clients to access supports already available to them, such as the Enhanced Primary Care Program for allied health and the local seniors’ gym. Clients were also asked to pay standard HACC service fees, and to contribute to the purchase of equipment or other supports.

The model was centred on a specialist BPDP assessment and care coordination role, supported by Ourcare’s mainstream HACC services where required. An existing staff member was trained as the designated coordinator for the project. The role had very broad guidelines for its activities, and the model had no restrictions on what brokerage funding could be used to purchase, though large items of expenditure required approval from the management team.

This BPDP had a focus on social inclusion as well as functional skills, and used volunteers to support social goals which extended beyond the duration of the demonstration project intervention, such as gym programs and transport training. The model had a strong focus on connecting people back to their community in ways they had previously enjoyed participating, such as bingo and social groups.

Uniquely among the four projects, the Ourcare model included a formal mid-term review of clients’ progress and assessment of their continued ability to benefit from participation in the project. Clients who were not making gains or showing potential to make gains, or who did not wish to continue with the project, were transferred to Ourcare’s mainstream HACC services.

Special characteristics of this BPDP

- Presence of the Hunter Community Care Access point
- Focus on social goals, including specifically targeting social isolation
- Mid-term review for all clients
Strong focus on long-term sustainability of the model, with accompanying commitment to keeping costs down.

3.3 Services accessed during BPDP programs

The mix of services accessed by clients of each of the four BPDPs varied according to the needs of individual clients and the design of each project’s model of care. The resources which were used to provide services to BPDP clients fell into three main categories:

- Time spent in assessment and care coordination or case management
- Time spent providing direct care
- Money spent purchasing specialist services, equipment, or other supports.

Table 3: Overview of resources used to provide services

<table>
<thead>
<tr>
<th>Total expenditure (completed clients, n=188)</th>
<th>Hours of assessment / care coordination / case management</th>
<th>Hours of direct care</th>
<th>Money spent purchasing services and equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPDP total reported resource use</td>
<td>2,088</td>
<td>2,398</td>
<td>$182,842</td>
</tr>
<tr>
<td>BPDP average resource use per client</td>
<td>11</td>
<td>13</td>
<td>$973</td>
</tr>
</tbody>
</table>

These totals include resources expended from BPDP funding, as well as resources used to deliver BPDP programs but funded from other sources, e.g.

- HACC services funded through existing HACC program funding
- Enhanced Primary Care program allied health services accessed during the period of the BPDP
- Equipment and home modifications purchased, or contributed to, by clients and/or by referral to HACC home modifications during the period of the BPDP.

3.3.1 Assessment and care coordination or case management

Assessment and care coordination or case management for BPDP clients involved different activities to conventional HACC services.
Assessment of BPDP clients required a substantial investment of face to face time. It included eliciting the client’s individual ‘story’, administration of the PWI and IADL tools to capture clients’ self reported levels of functional ability and personal wellbeing, and participation in the TUG test to record an objective indicator of functional levels. BPDP assessment also involved identification of individual client goals, and development of a support plan for achieving these.

Ongoing care coordination for the BPDPs was also more intensive than for conventional HACC services, with a wide range of possible interventions to arrange and numerous referrals.

Graph 1: Assessment and care coordination or case management time per completed client

3.3.2 Direct care

Direct care included time spent providing assistance and support to the client on a one-to-one basis by a care or support worker. It included both:

- HACC–type services such as domestic assistance delivered with an enabling philosophy, e.g. teaching clients new techniques for completing household tasks
- More flexible forms of support such as accompanying clients to learn public transport routes or supporting them to complete exercise or allied health programs in their homes or elsewhere.

Direct care could be provided by a single dedicated key worker, or by a combination of different staff employed by the agency either exclusively for BPDP clients or across these and conventional HACC services.
There was a wide range in the amounts of direct care accessed by participants during the BPDP programs - 20% of participants accessed no direct care at all, while 21% accessed 20 hours or more. This variation reflects the variety of types of BPDP client interventions.

For some clients the process of detailed assessment and goal setting, together with key referrals or equipment, was enough to set them on their way to achieving their goals without further support. Other clients required substantial direct care in the form of practical assistance and/or encouragement to pursue their identified goals over the period of the program.

3.3.3 Specialist services, equipment and other supports

BPDP clients also accessed a range of specialist services, equipment and other supports. These other services/supports were, in some cases, provided outside the direct BPDP program.

Equipment was the most frequent single category of expenditure: 105 clients received equipment purchased by the BPDP in whole or in part, with a further 18 clients purchasing equipment themselves. Individual items cost from a few dollars up to over $3,000, and ranged from personal care and domestic assistance aids, such as toe washers, shower stools and lightweight vacuum cleaners to more unusual items such as an adjustable rolling garden seat, training shoes, and a lawn mower.

Physiotherapy was the next most frequent purchase. When combined with occupational therapy, 69% of clients received some form of allied health service (physiotherapy, occupational therapy, or both).
30% of BPDP clients received exercise or personal training services. This category included both one-to-one personal training and equipment and professional skills purchased to run an exercise intervention for a group of Clarence Valley clients living in a retirement village.

22% of all clients received home modifications. This was a major category of expenditure funded outside of the BPDPs: through HACC, but also through DVA, public housing or privately.

Beyond these principal categories of expenditure, several clients received support from dieticians, counsellors, podiatrists, ‘spring cleaning’ services, chiropractors, excursions/outings groups, and other supports include cooking lessons, driving lessons and rubbish removal.
4. Evaluation findings

The evaluation assessed the BPDPs in four areas:

- Client profile
- Project implementation
- Client outcomes
- Use of resources.

4.1 Client profile

4.1.1 Client demographics

About two-thirds of participants in the BPDP programs were female, and most were aged between 75 and 84. Participants aged under 65 were included either because they were Aboriginal or Torres Strait Islander and aged over 45, or were experiencing early onset of conditions related to ageing.

The BPDPs were not allocated specific resources to target people from CALD or Aboriginal and Torres Strait Islander backgrounds, and as a result numbers from these groups were small – seven CALD participants and five Aboriginal and/or Torres Strait Islander participants.

A majority of participants (64%) lived alone. Virtually all of the remaining participants lived with family, most with partners. The majority of participants (76%) reported that they did not have a carer.

4.1.2 Functional and wellbeing profile on entry

At assessment, self-reported data on personal wellbeing (captured through the Personal wellbeing Index or PWI) and functional ability (captured through the Instrumental Activities of Daily Living or IADL tool) was collected from all BPDP clients. These scores were indexed on a scale of 0-100, where 100 represented full satisfaction with life or full functional ability in all areas. Of the 188 clients who completed the BPDPs, 77% scored 80 or more for their functional ability on entry to the programs. The average score was 85.
4.2 Project implementation

All of the BPDPs adapted and refined their models of care during the period of the evaluation. Some changes were related to improvements in practice in assessment, care planning and service delivery. These changes were a response to increased knowledge and confidence among staff or to lessons learned within their project or from the other projects. Other changes resulted from organisational reviews or restructures at agency level, staff turnover, new systems (e.g. IT), and changes in BPDPs’ governance, management or reporting arrangements. External factors, such as lack of appropriate referrals and changes in the local community services network, also had impacts.

4.2.1 Referrals

All of the BPDPs experienced much more difficulty with recruiting participants for their programs than they had expected. It took at least six months for new referrals to reach expected levels, and most projects had trouble meeting the targets originally set. The reasons for this included:

- ‘Filtering’ through an intermediary central referral point – In Singleton the Community Care Access Point, and in Eastern Sydney the internal CCS referral service, took time to understand what the BPDPs offered and to be able to identify appropriate clients.

- Lack of understanding in the wider referral network – All four projects had to invest more time and resources than expected in educating referral partners such as GPs and hospital discharge planners about the enabling approach and their specific models – with varied success.

- Resistance to the idea of enabling among clients and their families - staff encountered reluctance on the part of some clients, or their families, to accept a BPDP program in place of a conventional HACC service. This was particularly difficult where clients had existing domestic assistance services, or had been on waiting lists for extended periods and did not wish to risk losing their present level of support.

- ‘Competition’ with other forms of community care – community packaged care presented an alternative form of support for a similar client pool. Communicating the potential benefits of an Enabling short term intervention to potential clients and referral partners proved a challenge.

- Initial limited ability of staff to articulate and promote the benefits of participation – general challenge faced by staff in describing the enabling approach and the benefits of the short-term intervention model prior to having seen it in action. Staff became much more confident to pursue referrals as time passed and they had examples and experience on which to draw.
For some projects, these obstacles to referrals reduced over time, as both internal staff and external referral partners improved their understanding of what the enabling approach offered to clients. Other factors which improved rates of appropriate referrals included:

- **Targeted face-to-face promotional activities with referral partners.**
- **Changed arrangements with central intake and referral points** – Allowing some project teams to make their own decisions about whether a client was appropriate for inclusion in the BPDP or for conventional HACC services.
- **Recognition of the need to ‘sell’ the enabling approach to potential clients and their families** – Development of techniques and examples to convince potential participants of the value of the enabling approach.
- **Broadening the target groups** – As BPDPs became more confident in delivering enabling services they were able to target clients with a greater range of support needs than they had initially anticipated.

Overall, the number of clients participating in the BPDPs increased each quarter over the duration of the pilot programs.

### 4.2.2 Promotion

BPDPs found that different promotion strategies had variable levels of effect. Some which they had expected to be effective were less successful than anticipated, including:

- General publicity articles in local media and general flyers, prior to the commencement of BPDP programs
- General promotion through project advisory committees – at Clarence Valley and Singleton.

Some approaches which were more effective at some BPDPs than others included:

- Letters to local GPs – effective at Singleton, where established relationships already existed with GPs
- Presentations at health and community care service provider forums – again, effectiveness depended on the quality of pre-existing relationships.

More effective promotional strategies were developed as the BPDPs progressed. These tended to be more personal and to include an opportunity for people to ask questions of staff and, in some cases, former clients of the BPDPs. These included:

- Briefing existing referral partners to explain and promote the BPDP
- Existing service provider networks – both internally, with other service streams within the host agency, and externally, through established connections
Direct promotion to older people at existing meetings such as Probus clubs, retirement villages, and church groups

Specific targeting of older people on waiting lists for Community Aged Care Packages (CACPs) or other services

Word of mouth among former, current, and potential clients.

Local media placements later in the program, including examples of specific interventions and stories of their positive impacts for specific former clients, were more successful than earlier generic media releases.

4.2.3 Training and staff development

Training and staff development opportunities were provided to staff throughout the projects. Training offered to assessment, co-ordination and direct care staff included sessions on enablement, ‘asking better questions’, innovative ways to work with clients and completing needs identification tools. Less structured staff development opportunities to reflect on enabling practice occurred in staff meetings and personal learning journals.

All of the BPDPs reported that adoption of enabling practices by their staff was slower and/or more challenging than they had anticipated. Staff with backgrounds in disability or occupational therapy generally found the changes in practice easier to understand and implement, while those with a more conventional HACC or community care background found the transition harder. Some of these staff felt that they were exposing BPDP clients to greater risk of harm, or were ‘not doing their jobs properly’ by encouraging clients to get more involved.

Other findings from the BPDPs’ experiences included:

- **The importance of matching staff skills and interests to roles** – The Eastern Sydney project identified, over time, certain skill sets among its coordinator team which were more suited to assessment and goal development or to ongoing support. The Northern Sydney project experimented with different people in both its key worker and exercise physiologist roles in order to find people who were suitable and skilled in working under an enabling approach with older people.

- **The need for multi-skilled workers** – All of the BPDPs found that using staff that were able to work with clients across a range of intervention types allowed the development of stronger personal relationships and ultimately delivered better outcomes. For example, staff that were able to supervise exercises, travel train, provide emotional support, and introduce new equipment could build strong relationships with clients and support them holistically in pursuing their goals.

- **The need for strong interpersonal skills** – In order to develop meaningful goals and implement strategies for achieving them, the BPDPs found that their staff needed to have both personal confidence
to engage with clients about their lives and choices, and sensitivity to clients’ individual personalities, experiences, and priorities.

- **The value of staff seeing results** – All of the projects reported that, although training greatly assisted in providing background for staff, actually witnessing the positive impacts on clients of an enabling intervention was the greatest incentive for staff to change their own practices. Eastern Sydney used regular case conferencing to share stories from BPDP interventions, both to assist in care planning and to support workers learning from one another’s experiences. Other projects also provided a range of reflection opportunities.

- **Improvements in job satisfaction** – BPDP staff involved in enabling interventions frequently reported that the new approach was more satisfying than their previous work. At Clarence Valley, the new skills and confidence of BPDP workers was recognised to the extent that ‘poaching’ of staff by coordinators of other internal programs became an issue.

### 4.2.4 Assessment and goal setting practices

The length of time for client assessment was initially a strong concern for several BPDPs. Some project assessors questioned the value of imposing such a significant burden on clients, as well as the time required to administer the assessment tools and record functional and wellbeing information. These concerns were allayed once the projects started. Assessors were soon reporting that the assessment tools, processes and times were not only accepted by clients but were also resulting in a greater depth and quality of client information than previously experienced with conventional assessment practices.

For the most part assessment times decreased over the course of the BPDP as staff became more experienced in the new practice.

The assessment processes at the four projects evolved over the course of the evaluation period as assessment staff better understood the ways in which they could use the process and tools to co-design individual client programs. Particular changes included:

- **Use of assessment as rapport-building** – Over time, assessors began to talk about assessment increasingly in terms of engagement with the client and hearing the client’s story, rather than simply collecting information. Singleton and Eastern Sydney BPDPs recognised this dual function of assessment by routinely splitting it into two sessions – one to meet the client, build rapport and identify some key goals, and then a second visit to further explore the client’s goals and develop a plan for achieving them.

- **Use of assessment as a core part of the intervention program** – In contrast to a conventional HACC assessment, which precedes the delivery of care services, BPDP staff began to see the assessment process as the beginning of the delivery of support to the client. In
several cases, assessment and referrals alone served to support clients to meet their goals, without any further interventions.

- **Using assessment tools as the basis for goal-oriented care planning** – All BPDPs reported that they increasingly used the process of collecting information on wellbeing and function through the assessment tools as triggers for identifying client goals and achievement strategies. This meant that the separation between assessment and goal setting became much less clear.

- **Adapting the assessment process** – All the BPDPs found ways to make the administration of assessment tools more natural for clients. Clarence Valley BPDP had a particular focus on this aspect of assessment, they changed the sequencing of the assessment process and added what they found to be ‘The Miracle Question’:

  *If you had a great day lined up, what would it look like? What’s stopping you from doing these things?*

Singleton adapted the Clarence Valley BPDP approach to focus on questions about activities which a client had previously enjoyed, and the reasons why they could no longer do these.

- **More listening, less talking** – Allowing clients time to tell their own stories was recognised as crucial to effective assessment and goal setting by all BPDPs. In particular, assessors identified that describing possible service or support options too early in the assessment process precluded clients from naturally developing their own possible strategies to achieve their goals. The partnership role between assessor and client worked better when assessors let clients do more of the talking.

- **Focusing on the client’s whole support network** – The impact of the views of the client’s family and friends was found to be greater for an enabling approach than with conventional HACC services. Staff reported that family influence had significant effect on levels of client enthusiasm and commitment to achieving goals, and that the involvement of the wider support network was also helpful for providing practical assistance to clients in pursuing their goals. Similarly, family and carers could offer barriers to goal achievement, and some projects delivered counselling or other services to carers as part of clients’ BPDP programs.

4.2.5 Developing new approaches to management

BPDP programs involved a greater range of interventions, and a greater variety in service levels, than conventional HACC management systems could provide. Therefore, more flexible responses were required such as:

- Quick response times which supported clients to remain engaged with the enabling process
- Purchase of private services to accelerate access when necessary
Use of staff to deliver ‘moral support’, for example with visits to the gym, rather than specific services

Subsidising (or paying for) equipment and other supports, to help clients with limited resources make the decision to act.

The three BPDP projects hosted by agencies with substantial experience of delivering conventional HACC domestic assistance and personal care services identified challenges associated with the greater flexibility of the BPDP models of care. These challenges included:

- Managing and monitoring both BPDP project and individual client budgets (where relevant) with non-traditional expenditure
- Allocating additional time and resources to a comprehensive assessment process and collaborative problem solving, including mentoring and case conferencing
- Less prescriptive care worker duties, role descriptions, and accountabilities, and the associated need to develop outcomes-based accountability systems for staff
- Demands for more flexible rostering systems, to allow changes in staffing levels to respond to reducing client needs over a short period
- The interplay of providing a traditional service response as well as an enabling support option, especially when staff and systems were applied across both.

4.3 Client outcomes

Client outcome data was collected on 188 people at entry and exit from the BPDP programs, with 101 of these followed up three months after exit. Also 112 clients provided feedback on their experiences and outcomes via a return survey.

4.3.1 Gains in function and wellbeing

Over half of the 112 clients who provided feedback via the survey reported that they felt physically stronger (56%), were able to do more for themselves (55%), or were more active (54%). One third reported that, after exit, they needed less help from other people. In relation to personal wellbeing, 54% of the survey respondents reported that they felt happier, 52% that they were more satisfied about their lives, and 48% felt more in control of their lives. 41% reported that they were more independent.

During their BPDP programs, the average scores for wellbeing and functional ability increased for the BPDP client group as a whole, and for the client groups of each individual BPDP.
Table 4: Gains in average personal wellbeing and functional ability scores, entry to exit

<table>
<thead>
<tr>
<th>Personal wellbeing (PWI)</th>
<th>Functional ability (IADL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry Exit Gain</td>
<td>Entry Exit Gain</td>
</tr>
<tr>
<td>All clients (n=184/187)</td>
<td>70.3 76.6 6.3 84.5 87.2 2.7</td>
</tr>
</tbody>
</table>

Of the 167 BPDP clients for whom Timed Up and Go (TUG) scores were available at entry and exit, 78% made gains during the period of their programs.

89% of clients who provided personal feedback after completing their programs reported ongoing positive impacts from participation in the BPDPs. Almost 80% of respondents reported that they intended to continue exercising and strengthening their bodies, with 61% indicating that they would continue to use the aids and equipment supplied to them through their programs.

For the 101 clients who were followed up three months after exit, the evaluation found that on average these clients reported higher scores for both personal wellbeing and functional ability three months after exiting the programs than they had on entering – though the rate of gain tended to slow and/or drop back after the short-term intervention had ended. Functional ability was more likely to continue to improve after exit than was personal wellbeing.

For both functional ability and personal wellbeing, clients who entered the programs with lower scores tended to make greater gains. This relationship holds for both the exit and the three month follow-up.

4.3.2 Areas of greatest improvement

For the BPDP client group as a whole, greater personal satisfaction with levels of health was the largest single area of improvement during their participation in the projects. Other areas where BPDP clients reported significant average gains during their programs were:

- Satisfaction with what they were achieving in life.
- Ability to do their own shopping.

In terms of wellbeing, BPDP clients generally also felt more satisfied with their standards of living, with feeling safe, feeling part of the community, and with their future security.

In terms of functional ability, the top areas of improvement were housekeeping, laundry, and travel outside the home, followed by food preparation, managing finances, climbing stairs, bathing and dressing.
Alongside functional ability, the IADL tool also recorded clients’ levels of difficulty in performing tasks. Generally, clients were more likely to achieve a decrease in difficulty than an improvement in functional ability.

Analysing the different levels of gain in the various areas of function and wellbeing tested by the assessment tools, the evaluation found that the BPDPs generally achieved the best client outcomes in the areas in which their clients identified the most goals. This suggests that the design of the individual BPDP programs was generally responsive to individual client goals, and was also effective in implementing interventions which supported achievement of those goals.

4.3.3 Relationship between type of intervention and gains in outcomes

A wide range of different amounts and types of intervention were accessed by BPDP clients. Table 5 explores the types of intervention that were associated with the greatest gains.

Table 5: Average gains in function and wellbeing for client groups who accessed different supports, entry to exit of BPDP programs

<table>
<thead>
<tr>
<th>Category of support</th>
<th>No. of scores IADL/PWI</th>
<th>Average functional gain</th>
<th>Average wellbeing gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>All supports - whole client group</td>
<td>188/184</td>
<td>2.7</td>
<td>6.3</td>
</tr>
<tr>
<td>Equipment</td>
<td>123/120</td>
<td>2.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>104/101</td>
<td>2.5</td>
<td>4.8</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>71/69</td>
<td>8.75</td>
<td>17.5</td>
</tr>
<tr>
<td>Exercise</td>
<td>56/55</td>
<td>1.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Home modifications</td>
<td>43/42</td>
<td>2.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Other e.g. dietician, driving lessons</td>
<td>39/38</td>
<td>2.5</td>
<td>9.1</td>
</tr>
</tbody>
</table>

This shows that average gains in function and wellbeing for clients who accessed occupational therapy were considerably higher than for those who accessed any other category of support, and that people who accessed a range of ‘other’ supports reported the next greatest average gains in wellbeing.
Table 6 explores this relationship with the “three month follow up” clients.

Table 6: Average gains in function and wellbeing for client groups who accessed different supports, entry to three months after exit from BPDP programs

<table>
<thead>
<tr>
<th>Type of support</th>
<th>No. of scores</th>
<th>Average functional gain</th>
<th>Average wellbeing gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>All supports - whole client group</td>
<td>100/99</td>
<td>9.5</td>
<td>6.0</td>
</tr>
<tr>
<td>Equipment</td>
<td>66/66</td>
<td>7.6</td>
<td>5.5</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>52/52</td>
<td>10.1</td>
<td>4.9</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>44/44</td>
<td>10.1</td>
<td>7.0</td>
</tr>
<tr>
<td>Exercise</td>
<td>20/21</td>
<td>4.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Home modifications</td>
<td>26/26</td>
<td>6.7</td>
<td>5.8</td>
</tr>
<tr>
<td>Other e.g. dietician, driving lessons</td>
<td>17/18</td>
<td>9.4</td>
<td>7.9</td>
</tr>
</tbody>
</table>

This indicates that clients accessing occupational therapy and ‘other’ supports also had higher gains in both functioning and wellbeing at three months after exit. Also, clients accessing physiotherapy showed comparatively higher functional gains.

4.3.4 Characteristics of clients with biggest sustained gains

Around 29% of the clients who were followed up at three months after exit had made and sustained significant gains in both function and wellbeing. The experience of the BPDPs suggests that the short-term interventions were most effective for:

- People who were well motivated and positive about participation
- People who had low functional ability – and who were assisted in improving this by allied health (and equipment and home modifications where appropriate)
- People who accessed occupational therapy.

The analysis also suggests that these people benefited from the ability to access higher levels of direct care during the short-term intervention period.
4.3.5 Levels of services accessed compared with conventional HACC

The BPDP experience suggests that:

- Assessment time for a short-term enabling intervention is approximately 2.4 times that of conventional HACC services.
- Care coordination requires approximately 2.5 times as long, during the short-term intervention period.
- Direct care hours per month are on average 1.5 times greater during the short-term intervention than in ongoing conventional HACC services.

Table 7: Comparison of monthly service delivery for BPDPs and conventional HACC

<table>
<thead>
<tr>
<th></th>
<th>Assessment (hrs)</th>
<th>Care coordination (hrs per month)</th>
<th>Direct care (hrs per month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPDP averages</td>
<td>4.0</td>
<td>3.3</td>
<td>6.1</td>
</tr>
<tr>
<td>Conventional HACC</td>
<td>1.7</td>
<td>1.3</td>
<td>4.0</td>
</tr>
</tbody>
</table>

4.3.6 Impact on ongoing HACC service use

At the point of exiting from the BPDP clients, about one-third of clients reported that they planned to look after themselves without help. Only 5% reported that they needed ‘a lot of services’ to stay in their homes.

The BPDP experience suggests that at least one-third (and up to one-half) of clients exit a short-term intervention with no further support services. The limited data available suggests that this pattern remained at three months after exiting the programs, but it was not possible to examine impacts on service use over any longer period.

4.4 Use of resources

4.4.1 Key differences in resource use between the models

The four BPDPs had different approaches to the allocation and management of the resources they had available for the delivery of client programs. The impacts of these different approaches are reflected in their patterns of resource use. In particular:

- The Clarence Valley and Northern Beaches BPDPs used an ‘individual client budget’ approach to the allocation of resources. This meant that these two models tended to design intervention programs to suit the resources available for the direct care of each client, on the basis of their allocated portion of the overall BPDP funding.
- The Singleton BPDP sought to establish a model which could be sustained after its completion. This meant that this model tended to
seek to minimise its dependency on the specific BPDP funding, and to make use of supports available elsewhere, such as the Enhanced Primary Care program and client funding options.

- The Eastern Sydney BPDP considered the pilot program to be just one part of a shift in the approach of the whole organisation. Conventional HACC funding was used, as well as BPDP funding, to deliver services to BPDP clients.

It is clear that the design and effectiveness of individual goal-oriented intervention programs is influenced by the service models of the different BPDPs. This influence can occur at several points:

- The selection of a client target group that corresponds to the priority areas of intervention for a particular model, e.g. recruiting older people from domestic assistance waiting lists for programs which focus on interventions to support improvements in housekeeping function

- Influence by assessors during the process of identification of client goals, e.g. responding to a client’s expressed desire to visit a friend with a transport-focused strategy that the provider is easily able to arrange, without necessarily exploring other aspects of the goal which may be more complex than this

- Preference by coordinators and direct care staff to deliver interventions which support goals in some areas over others in the client’s care plan, depending on their levels of confidence, experience, and flexibility, e.g. focusing on goals for which effective strategies have already been implemented for other clients, or on goals for which success could easily be measured

- Ability to access different types of supports, based on the available range and accessibility of services within a geographical area or organisational model, e.g. challenges in access to occupational therapy, especially in regional areas

- Capacity of the service delivery structures of each BPDP to respond to a wide range of different client goals – both in techniques for eliciting goals and in strategies for supporting their achievement, e.g. letting a client identify what interventions would make the greatest difference in their life, rather than offering a list of possible choices.

Truly individualised care requires the recognition of these potential sources of influence and strong commitment to work to reduce their impact on clients. Each of the different BPDP models used different approaches to support flexibility in its use of resources, and mitigate against this risk. For instance:

- Clarence Valley used a large proportion of its total resources to purchase a wide range of different material goods to support individual client goals, ranging from formal assistive aids to everyday household objects – all classified as ‘equipment’ for the purposes of the evaluation

- Eastern Sydney predominantly used resources to purchase direct care hours, including allied health assistant hours, which could be used flexibly to provide a wide range of types of supports
Northern Beaches’ full brokerage model (and urban location) allowed this BPDP to use its resources to purchase a very wide range of different services and supports from external providers.

Singleton BPDP developed an extremely flexible role description for its care coordinator, which gave her the opportunity to use direct care hours in a wide range of ways.

4.4.2 Levels of resource use compared with conventional HACC

All BPDPs used a greater intensity of resources to support their clients during the period of short term intervention than conventional HACC services. Their overall experience was that a two-month short-term intervention required an investment of approximately 1.9 times the total hours of care required for the delivery of conventional HACC services for the same period, together with purchasing of about $1,000 in specialist supports per client.

After the intervention, BPDP experience suggests that ongoing service use by those who participated will fall somewhere between the following two scenarios:

- Scenario 1: One-third of clients exit the short-term intervention with no services, one-third with reduced services (assume 50% lower than HACC average), and one-third with conventional HACC services.
- Scenario 2: Half of clients exit the short-term intervention with no services, and the remaining half split between conventional HACC and lower-level services.

The comparative ‘savings’ in hours for the BPDP-style short-term intervention compared to conventional HACC begin to be evident at between six and nine months after entry to services. These ‘savings’ in hours can be translated into potential funds for the purchase of additional specialist supports and services. The evaluation calculated that at nine months scenario 1 has approximately $300 available per client, and scenario 2 has approximately $500.

The BPDP experience is that expenditure on specialist supports/services was less than $500 per client for 50% of clients, and less than $300 for 40% of clients. This suggests that, by month nine, a BPDP-style short-term intervention model would break even relative to conventional HACC use for 40 to 50% of clients. While many BPDP clients would take longer than nine months to break even, the Evaluation does suggest that the Enabling short-term intervention model offers potential savings in the medium to long term.
5. Lessons learned

5.1 Different models of short-term intervention are effective

While the four BPDPs did share key characteristics, there were significant differences between their approaches, target groups, contexts, and the resources that they could access to support their clients’ programs. Nonetheless, across all the projects staff and clients reported positive experiences, and on average all the BPDP clients reported higher scores in both function and wellbeing three months after exiting the programs than they had on entry.

The different models had strengths and weaknesses, but across the BPDPs effectiveness was linked to:

- Investing in assessment and care coordination at higher levels than conventional HACC
- Accessing allied health (particularly occupational therapy) supports
- Tailoring responses very closely to individual client priorities, with the supports that were accessed by only a few BPDP clients often being associated with the greatest gains in wellbeing and function
- Drawing on local resources and identifying opportunities to build on the strengths of each service delivery model (e.g. flexible direct care hours, equipment that stays with the client after the program, etc).

5.2 Engaging key stakeholders with an enabling approach

The BPDP experience demonstrates the scale of the shift that is required among providers, referral partners, and clients, in order to move towards an enabling philosophy for HACC in NSW. All of the projects emphasised the importance of enabling as a ‘practice’, and the need to understand the practice, not just the theory, before seeking to engage others.

The projects found that the paradigm of ‘doing for’ was deeply embedded in staff attitudes, and often reinforced by the organisational structures and systems which supported existing service delivery. More flexibility was required to deliver the enabling approach. Examples of successful approaches included:

- Identifying individual staff members (or contracted workers) who had greater capacity and willingness to adopt an enabling approach and using them in key roles
- Flexible management and reporting, tied to outcomes rather than processes or outputs
Ongoing training, supported by opportunities for case conferencing and reflection on success stories – preferably including the client’s own voice.

Engaging referral partners with the enabling approach was another challenge which proved larger than expected. The role of BPDP staff as educators to the wider sector was significant. The projects found that a simple flyer or presentation describing the approach was effective with only a limited range of referral partners, and more successful approaches included:

- Speaking individually with community physiotherapists, transitional care providers, community care service providers and seniors groups to allow them to engage directly with staff who had experience of enabling practice
- Targeting government, community and private allied health providers whose therapeutic practice was already based on an enabling philosophy and approach – such as Occupational Therapists.
- Maintaining ongoing contact with key referral partners such as Aged Care Assessment Teams (ACATs) and hospital discharge planners, to describe and explore enabling practice as it evolved, rather than traditional service provision responses.

Clients who had previous experience of receiving maintenance-type services were particularly difficult to engage with the enabling approach. For clients, successful strategies included:

- Strong emphasis on the narrative approach – sharing their story and those of others who had benefited from enabling interventions
- Building rapport and personal connection, so that support was emotional as well as practical
- Targeting people who had experienced strokes, falls, or other sudden changes in function and were motivated to regain their former status
- Building on human relationships – encouraging recruitment through peers such as retirement village residents.

5.3 Recognising the value of specialist skills

All of the BPDP host agencies recognised the value of multi-skilled workers in delivering enabling interventions. Their experience was that while a general enabling philosophy could be effectively applied by a wide range of workers, a particular combination of practical and personal skills was required to support a short-term enabling intervention most effectively – especially during assessment and the design of the intervention program.

The projects found that enthusiastic and capable staff were likely to implement enabling approaches beyond the confines of the BPDPs, while other staff were less interested in adapting to the approach. Overall, the BPDP experience was that targeted short-term restorative interventions were
more effectively delivered by people with interest and skills in enabling, supported by reflective practices to build their knowledge and confidence. Strategies to support this included:

- Considering assessment and goal-setting as the core of enabling practice and focusing resources on improving practice in this area
- Building specialised and recognised teams of workers with skills in working with clients using an enabling approach
- Providing training in enabling philosophy and techniques (e.g. asking better questions, using a range of assessment tools, innovative techniques with clients, implementing in-home exercise programs)
- Supporting and training staff to question their own assumptions about client goals and strategies, and to know when to step back and let clients take risks
- Active reflection on practices and outcomes to identify and respond to assessor and agency bias towards certain types of enabling interventions (e.g. home exercise, purchase of equipment).

5.4 Adapting models of service delivery to support enabling practice

The BPDP experience demonstrated that an enabling approach requires new ways of organising service delivery which can respond to individual clients’ priorities and their changing needs over the period of intervention. A major element of the redesign is in increased partnerships between agencies, to support access to a wider range of different interventions for clients.

The BPDP experience shows that goal-based assessment and care planning underpins enablement practice, but not all interventions need to be delivered by the same agency that completes this core component. Adaptations to service delivery models that worked for the BPDPs included:

- Developing care plans that included background information on clients’ personal goals and approaches to achieving them, so that all workers are aware of the larger picture when delivering support
- Developing outcomes-focused accountability systems for direct care workers, as well as specialist providers, instead of specifying activities or hours
- When purchasing specialist services or equipment for clients, target and build relationships with a small range of providers with an existing interest in and understanding of enabling approaches
- Increased use of case conferencing, including the client, to keep all stakeholders on the same page
- Ensuring that there is flexibility in the plan for the agency to reach beyond traditional service/support types and identify creative solutions that resonate with the client
■ Recognising that some enabling interventions are low cost while others have higher comparative costs which could be shared with the client.

5.5 Engaging with the client’s whole life

The BPDPs found that the delivery of truly person-centred care requires understanding of, and engagement with, all aspects of a client’s life and circumstances. The barriers to a client achieving their goals may not be physical but psychological, or may lie outside of the person themselves. To be successful, enabling practice must consider the client holistically, including their relationships with other people, their personal history and personality, and their physical environment.

Key lessons in supporting clients under an enabling approach that emerged from the BPDPs included the following strategies:

■ Adopting a holistic approach to assessment and goal-setting which draws on the client’s ‘story’, not just their current situation and needs
■ Defining support worker roles in terms of facilitating a client’s own journey towards their goals
■ Asking questions to help clients identify the things that will truly make a difference to their lives
■ Engaging family, friends, and other people around the client with the process
■ Being prepared for the enabling agency to be the primary motivator until the client internalises this and becomes their own motivator
■ Maintaining contact with clients after exit, monitoring their motivation levels, applauding progress and letting them know they can come back for support.

5.6 Recognising where the greatest gains can be achieved

The experience of the BPDP host agencies was that while enabling approaches could be used effectively across a range of programs, the short-term intervention model was most effective when used at the first point of contact between a client and the service system.

Other observations from the BPDP experience of targeting resources to areas of greatest impact include:

■ Recognising that many important goals may be prosaic and unexciting, and may not be in areas traditionally seen as priorities for HACC services
■ Resisting the temptation to use resources simply because they are available; achieving some clients’ most significant goals may require no support other than reminders or encouragement
The importance of ‘quick wins’ to help staff and clients develop confidence and motivation

Understanding that sustaining improved functional ability without ongoing support and encouragement is challenging – but that models which include a form of limited ongoing monitoring, using volunteers or low-level services, can sustain functional gains

Noting that while allied health and equipment/ modification solutions may be associated with good client outcomes in many cases, other types of short-term tailored interventions, can be equally if not more effective in supporting clients to meet their goals

Being flexible about the time available for intervention and recognising that some clients, such as those with low levels of motivation or with challenges in communication or developing rapport, may require longer

Linking clients into existing community networks, groups and resources

Recognise that positive client outcomes can be achieved even where there is limited long-term improvement in functional ability.

5.7 Understanding the inherent biases

The BPDP experience showed that models of care which have a particular focus are effective at delivering improved client outcomes in the areas they target. Each of the four models influenced the practices of the BPDPs in selecting and recruiting a target client group, identifying and prioritising goals, designing and implementing intervention programs, and recording and reporting client outcomes. The different models also impacted on the approach to resource use, and the profile of resource use.

These biases can offer both opportunities and limitations. The opportunities lie in the extent to which they allow service providers to focus on what they are good at and to enter into complementary partnerships with other service providers to provide service they are not equipped to deliver. The limitation is in the extent to which they can undermine a provider’s client focus if they seek to focus client plans on their own service strengths at the expense of a client’s individual needs. Lessons include:

- Understand the bias inherent in any particular model of care and context for service delivery, and work with it to target clients who will benefit from this approach
- Consider assessment a separate intervention from the delivery of support strategies; free assessment staff to develop goals and solutions which may be beyond the capacity of any one service provider to support
- Do not try to deliver the full range of possible client interventions; develop partnerships and referral pathways to support client goals across the widest possible spectrum of options
- Support and train staff to question their own assumptions about client goals and strategies, and to ‘think outside the box’.
6. After the demonstration projects

The agencies involved with the four BPDPs, and their staff, have all been enthusiastic about continuing to build upon what they have learnt. The distinction between the impacts of increased exposure to the general enabling philosophy and the impacts of the lessons learnt from the direct experience of delivering short-term intervention programs is important.

6.1 The enabling philosophy

All of the projects reported that the general enabling philosophy has filtered through their agencies beyond the people involved in the BPDP pilots, and that shifts in staff and management attitudes and in specific practices – especially around assessment – have been widely observed.

Cultural changes are being supported by management at all of the BPDP pilot sites, with staff reporting the biggest changes as:

■ Taking more time to listen to clients and ask questions, especially during assessment
■ Letting clients do more of the ‘work’ – both in terms of identifying strategies and implementing them; treating clients as partners in their own care
■ Recognising the psychological support role of care/support workers, as well as the practical one.

Improved levels of staff engagement and motivation, associated with these changes, were also widely reported to the evaluation team.

6.2 Short-term intervention initiatives

Specific initiatives have emerged at each of the pilot sites as follows.

Clarence Valley Council

Clarence Valley Council continues to offer its 'Up and About' short-term intervention program, and continues to work to identify ways to improve the assessment process in order to help clients identify and act upon their real motivators for change. Staff are increasingly reporting flow-on effects from an effective short-term intervention which extend far beyond functional improvements into areas of social and emotional health.

The Council has also adopted the assessment tool developed for the BPDP for all its community support programs.
Catholic Community Services

Catholic Community Services has moved away from its ‘three tiers’ of enabling practice and developed a specialist short-term enabling intervention, called the ‘Restorative Care Program’. This program has its own dedicated coordinators with specialist skills in implementing short-term intervention programs, and is administered and advertised as a different service from mainstream in-home support services – though these services are also delivered with an enabling philosophy. After the period of the short-term intervention, if clients require further services they are discharged into mainstream services.

CCS continues to provide staff training in enabling practice, and to build multidisciplinary teams by offering opportunities for care/support staff to be trained as Allied Health Assistants. CCS is finding that staff are more creative in designing and implementing client interventions as they become more experienced and confident in using the approach – and also expecting that the evolution of the HACC program towards increased individual choice and control by clients will continue to support more flexible models of care provision.

Community Care Northern Beaches

Community Care Northern Beaches conducted a second pilot of the enabling approach from mid-2011, targeting people with a disability under the age of 65. This pilot built on the experiences of the original BPDP.

CCNB has conducted an agency-wide process to explore the potential value of an enabling approach with all of its key client groups: older people, people with dementia, younger people with a disability and carers. The organisation is also pursuing ways to implement enabling practice within its own internal structures: team meetings, board meetings, etc.

Ourcare Services

Ourcare Services are also continuing their BPDP short-term intervention model. They are using a new name for the program, and a streamlined version of the BPDP assessment tools, but otherwise the model is largely unchanged.

Across the organisation, Ourcare Services has formally changed the titles of its ‘care plans’ and ‘care workers’ to ‘support plans’ and ‘support workers’. The organisation has also identified key strategies in the effective internal communication of enabling practices, including a strong focus on the client’s subjective experience, and the importance of ensuring that all stakeholders, including board members, are aware of what enabling means.
The Ourcare Services team are also acting as a resource for other service providers in the Hunter region that have expressed interest in implementing an enabling approach.

The experiences of participating staff

*It is so much better to get the client involved and motivated, to try and help themselves. It is much more rewarding for them and they feel a big sense of satisfaction.*

Direct Support Worker, Eastern Sydney Demonstration Project

*I now fully appreciate the impact that we can have on people’s lives by simply listening. I don’t need to have all the answers; they already have the answers but have probably never said them out loud to hear them. The client actually does all the work and I just assist.*

Coordinator, Clarence Valley Demonstration Project

*I changed the name of our “care workers” to “support workers” because what we wanted our clients to know that we are there to support them. I also don’t walk into an assessment and say, this is what we can do for you. I let the client tell me their story of what they used to do and how they find it difficult now and also what they are still able to do for themselves. I look at ways we could assist them with things they are unable to do now, and work out if it’s just equipment needed, or a different piece of equipment, that would help them. I just needed to look outside the box.*

Coordinator, Singleton Demonstration Project
Would you like to know more about the Evaluation?

This report is an abbreviated version of an evaluation report originally prepared by Clare Crawford, Glen Sorensen and Peter Cranko, who were engaged by ADHC to undertake the evaluation of the Better Practice Demonstration projects.

PDF and/or hard copies of the full report can be obtained by emailing the Better Practice mailbox at betterpractice@facs.nsw.gov.au.

Please indicate the format (PDF of hard copy) in which you would like the report. If requesting a hard copy please provide a postal address.

Would you like to know more about Enabling?

Go to www.adhc.nsw.gov.au/bpp to view or download information/resources on The Better Practice Project and the enabling approach that underlies it.