National evaluation of the Retirement Villages Care Pilot

Final report

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National evaluation of the Retirement Villages Care Pilot

Final report

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Abbreviations

ABS	Australian Bureau of Statistics
ACAT/ACAS	Aged Care Assessment Team/Service
ACSA	Aged Care Services Australia (part of the St Ives Group)
ADL	Activities of daily living (for example, eating, bathing/showering, dressing, grooming, toilet use, bladder and bowel continence management, walking or wheelchair use, transfers, negotiating stairs)
AIHW	Australian Institute of Health and Welfare
CACP	Community Aged Care Packages
CAL	Core activity limitation
CSI	Caregiver Strain Index
DVA	Australian Government Department of Veterans' Affairs
EACH	Extended Aged Care at Home
GP	General practitioner
HACC	Home and Community Care Program
IADL	Instrumental activities of daily living (for example, shopping, housework, travelling away from home, medication use, using the telephone, managing personal finances)
MBI	Modified Barthel Index
MMSE	Mini-Mental State Examination
NRCP	National Respite for Carers Program
OARS	Older American Resources and Services
RCS	Resident Classification Scale
RVCP	Retirement Villages Care Pilot
VHC	Veterans' Home Care

Summary of findings

This is a report on the evaluation of 10 projects established under the Australian Government Retirement Villages Care Pilot (RVCP). The Pilot is one of a number of initiatives for the care of older Australians to emerge from the *Choosing to Stay at Home* announcement in the 2002–03 Federal Budget. Pilot services across Australia progressively commenced operations between October 2003 and April 2004 under the administration of the Australian Government Department of Health and Ageing (the Department). Together the 10 projects were allocated 280 flexible care places to target the care needs of eligible older people living in retirement villages. The Pilot was expected to continue until June 2006 and participating service providers were required to take part in a national evaluation.

The Australian Institute of Health and Welfare (AIHW) undertook an evaluation of the Retirement Villages Care Pilot under a Schedule to the Memorandum of Understanding between the AIHW and the Department. The project was approved by the AIHW Ethics Committee (Register Number 353) and the Department of Health and Ageing Ethics Committee. Evaluation activities commenced in July 2004 and were completed in mid-2005. Information and data were gathered to assess evidence on whether Pilot services make it possible for more retirement village residents with a need for formal assistance to remain at home. Specifically, the evaluation was designed to address four key issues:

1. **What are the novel features of RVCP packages vis-à-vis Extended Aged Care at Home packages (EACH) and Community Aged Care Packages (CACP)?**
2. **Do recipients of RVCP packages of care have a reduced need to enter residential aged care facilities as a result of receiving the package?**
3. **Do more retirement village residents than before have the option of being cared for at home as a result of the Pilot?**
4. **To what extent do government and package recipients share the cost of supplying care?**

The AIHW was further briefed to identify the strengths and any weaknesses of the Pilot. Principal evaluation findings are discussed below.

Principal evaluation findings

Overview of the Retirement Villages Care Pilot target group

The Pilot has operated in 45 retirement villages in the five mainland states and the Australian Capital Territory. The 10 projects comprise a mix of single village and multiple village operations with a variety of staffing arrangements ranging from dedicated teams of RVCP care workers to full integration of the RVCP into existing mainstream program service delivery systems.

Care recipients in the Pilot must be residents of the retirement villages selected for the Pilot and must have a current ACAT approval for low or high level permanent residential aged care. ACAT clients with approval for only residential respite care are not eligible. Care recipients may occupy either independent living units or serviced apartment-style accommodation.

Evaluation involved 238 care recipients and 104 family carers. Eighty-four per cent of evaluation participants were living in independent living units during the evaluation and the other 16% of participants were living in serviced apartments. Residents in serviced apartments ordinarily pay for a minimal level of domestic assistance, for example, 2 hours per week; where this arrangement existed prior to the RVCP service being established it continued with the RVCP providing additional support. For the vast majority of RVCP recipients, the Pilot was their first experience of regular and ongoing assistance with the activities of daily living from, or in conjunction with, their retirement village.

The RVCP targeted a care recipient group with similar overall age and sex structure to the CACP recipient population. Approximately 50% of evaluation participants were aged 85 years or over during the evaluation. Women made up 74% of the group.

Two sets of measures of need for assistance among RVCP recipients as at date of entry to a pilot project, each with a different derivation, show close agreement. The first set of measures are ratings of core activity limitation recorded by care managers consistent with definitions used in the Australian Bureau of Statistics Survey of Disability, Ageing and Carers. Core activities comprise self-care, mobility and communication activities. According to these, 14% of RVCP care recipients who participated in the evaluation showed severe or profound core activity limitation on entry to a project. The second set, activities of daily living measures, revealed that 12% of clients showed high dependency in self-care and/or mobility when they started with a project (derived from the Modified Barthel Index; the Index does not cover need for assistance in communication activities). These proportions compare with approximately 80% of CACP recipients aged 65 years or over identified in the 2002 CACP Census as having severe or profound core activity limitation (AIHW 2004a).

Severe or profound core activity limitation usually indicates that a person needs assistance from others on a regular, if not daily, basis. The care needs of most RVCP recipients fall into the area of instrumental activities of daily living—domestic chores, shopping, transport, meal preparation, medication use and management of personal finances. As indicated above, a proportion of RVCP recipients also exhibited high personal care needs.

Notable differences between RVCP recipients and CACP recipients are in the areas of living arrangement and access to care from relatives and friends: 81% of evaluation participants lived alone and 44% had a family carer (versus 50% and 57% of CACP recipients respectively in the financial year 2003–04). Most family carers of RVCP recipients were non-resident daughters and sons.

Novel features of RVCP packages

Four novel features of RVCP packages were identified:

- The targeting of residents in retirement villages has enhanced access to care packages for the target group. A substantial proportion of RVCP recipients have received a coordinated package of care at an earlier stage in the care needs continuum than might otherwise have been the case.

- RVCP service providers are able to offer per client weekly hours of service that span the range of weekly hours of care seen in CACP and EACH. Some projects demonstrated this capacity during the evaluation, while weekly service hours per client in other projects have ranged up to levels recorded for an average CACP.
- RVCP packages can offer a more comprehensive service mix than CACP by the inclusion of nursing and allied health care. One in four RVCP recipients received some amount of nursing care during the evaluation. Thus, an RVCP service can offer the types of assistance available through EACH packages to clients according to prevailing need rather than according to a nominal level of care or package construction.
- On-site staff or a dedicated team of RVCP care workers has enabled some projects to deliver a personalised level of service that has high preventive care and social support value for care recipients at relatively low cost. This takes the form of frequent, short visits to care recipients (for example, up to three times daily) to check on condition, assist with medications and, where necessary, provide guidance or physical assistance to promote mobility. The cost of providing this level of assistance is likely to be prohibitive unless care recipients are co-located.

The novel features of RVCP packages compared with CACP and EACH packages are implementation specific. In some projects the RVCP has functioned as an extension of an existing CACP service and these models showed little differentiation from a CACP service apart from the targeting of retirement village residents. Other projects have demonstrated a personalised level of service that may be difficult to replicate without a co-located care recipient group and staff dedicated to RVCP service delivery. One example is the capacity of some RVCP services to make frequent, brief visits each day to clients in need of medication management or regular monitoring. This has the benefit to clients of providing preventive care and reassurance that support is available at short notice. Yet frequent short encounters can be provided relatively cheaply when clients are co-located. Further, it represents a qualitative difference between the RVCP and mainstream service provision such as through CACP that needs to be taken into account when comparing average weekly hours of service per client. Staffing arrangements, in addition to co-location of clients, have a direct bearing on a project's capacity to deliver this level of service.

In the RVCP, a flexible funding model has enabled providers to balance the needs of low and high care clients in a community setting and to adjust service delivery to meet the changing needs of individual care recipients. At entry to a project, the 'typical' RVCP recipient shows minimal loss of function in activities of daily living involving self-care and mobility (ADL) but more considerable loss of function in instrumental activities of daily living, which include domestic work, travelling away from home, shopping for food and clothes, meal preparation, medication use and management of personal finances. However, a small proportion of RVCP recipients showed high dependency in ADL at date of entry to a project and one in five recorded loss of ADL function during the reporting period. Projects differ in terms of the average level of need for assistance and the degree of variation in measured need within the care recipient groups.

RVCP packages comprise one or more types of assistance in addition to case management and care coordination. Domestic assistance, personal assistance, nursing care, food services and social support together accounted for over 80% of expenditure on services in the quarter ending 31 December 2004. Proportionate expenditure by service category varied across the projects, particularly in relation to the delivery of nursing care, allied health care and transport services.

The provision of nursing and allied health care is an important distinguishing feature of RVCP packages from those funded by the CACP program, which does not offer these types of assistance. Six RVCP projects delivered nursing care services in the reporting period. In the other four projects, use of nursing care was either not recorded, or recorded nursing services were obtained by private means (possibly as a continuation of private arrangements predating the RVCP). Six projects delivered allied health care, mainly podiatry and physiotherapy. It is possible other projects would fund nursing and allied health care but that no care recipient needed these care types during the evaluation. The AIHW has previously found that, in any given quarter, around 35% of CACP recipients also receive assistance through the Home and Community Care Program, including nursing care (AIHW: Karmel & Braun 2004). Greene et al. (1998), reporting on a large demonstration project in the United States, suggest that home care services based on provision of ADL assistance without parallel offerings of health-related services are unlikely to maximise the potential of community care for reducing older people's use of residential services. Also, in comparing the costs of RVCP and CACP packages it is important to take into account this main distinguishing feature.

Service levels ranged from an average of one hour per client week in direct assistance excluding ancillary services such as delivered meals and transport up to an average of 27 hours per client per week. Thus, a range of service levels from low-end HACC clients up to and exceeding a typical EACH package were observed. During the reporting period most RVCP recipients received weekly service hours on a par with an average level of CACP service.

Impact of the RVCP on need for residential aged care among retirement village residents

The evaluation found evidence that the RVCP has helped delay entry to residential aged care among retirement village residents. It also found indications of a relatively higher rate of entry to residential care among older people in retirement villages compared with care package recipients in the wider community.

Seventy-two per cent of evaluation participants were still living at home by completion of follow-up in June 2005; 68% of the group were still with an RVCP service. Of the 13 clients with ACAT approval for high level residential care, eight clients remained in community care. During the evaluation another 11 clients experienced an increase in care needs to the equivalent of high care (as assessed by ACAT or the RVCP project coordinator) but were still at home and receiving RVCP services in June 2005.

Average hours of assistance delivered to RVCP recipients in the reporting period are strongly correlated with measured levels of need for assistance in activities of daily living (ADL). Thus, there is evidence that RVCP packages address one important area of need that is a known risk factor for entry to residential aged care. The primary mechanisms in the RVCP for reducing need for residential care services among care recipients is the provision of ADL support, medication management and frequent monitoring during the day in periods of high support need.

In total 18% of evaluation participants had entered permanent residential aged care by completion of follow-up. RVCP recipients who transferred to residential aged care did so on average 327 days after commencing RVCP services. It was found that 80% of RVCP recipients are still at home 300 days after the initial needs assessment. This probability takes

account of attrition due to death (approximately 5% of evaluation clients were deceased at time of follow-up) and entry to residential aged care or hospital.

Heavy use of medical services and/or urgent hospitalisation was recorded in the months prior to admission to residential aged care for 42% of RVCP recipients who transferred to residential care. Evidence of acute health events or unstable medical conditions in the form of medical and hospital use was recorded for relatively more RVCP recipients who entered high level residential care than for those who enter low level residential care.

Of the 43 evaluation participants who moved into permanent residential aged care, 24 entered a low care facility. Survey responses from some of these participants highlighted lack of access to assistance outside standard business hours, unpredictable staff and/or service times, and lack of flexibility in a care package to meet increased needs as major factors leading to the choice of residential care.

Among the evaluation participants in receipt of an RVCP package between 1 October and 31 December 2004, 5.5% separated during that quarter to enter residential aged care. Comparable data have been produced for CACP in 2002 (Karmel 2005). In the quarter from 1 October to 31 December 2002, an estimated 4.5% of CACP recipients separated from a CACP service in that quarter and entered residential aged care within 90 days. However, this evaluation has established that the RVCP has serviced a group of clients with relatively lower ADL support needs, on average, compared with CACP clients.

This report discusses the complex dynamics that impact on rates of admission to aged care facilities among RVCP recipients, particularly the choice of a residential low care service over continuing package care by some RVCP recipients. The CACP census recorded a significantly higher rate of severe or profound core activity limitation than the RVCP evaluation; however, RVCP recipients as a group differ from CACP recipients in three important respects:

- RVCP recipients are more likely than CACP recipients to live alone (81% versus 50% of CACP recipients in 2003–04)
- RVCP recipients are less likely than CACP recipients to have a family carer (44% versus 57% of CACP recipients in 2003–04)
- relatively few RVCP recipients have a co-resident family carer (11% compared with an estimated 28% of CACP recipients).

Older ACAT clients who live alone are more likely than those who live with others to receive an ACAT recommendation for residential care and it has been suggested elsewhere that clients' psycho-social needs are an important consideration in many ACAT recommendations for low level residential care (LGC 2002). As the bulk of assistance to frail older people more generally is provided by family members, a lower rate of carer availability among RVCP recipients suggests that factors other than need for assistance are in play. Although the needs profile recorded for RVCP recipients reflects a group with overall lower levels of need for assistance than the CACP recipient population, the RVCP target group shows lower availability of a key enabler for community living in the face of increasing disability at older ages—care from family.

A number of questions remain as to how the 'pull factors' that see people leaving the family home to enter a retirement village might influence care preferences in later life and whether living in a retirement village is itself a factor that leads to a higher risk of using residential aged care services because of individual characteristics and the less secure accommodation tenure of leasing and licensing arrangements for retirement village living compared with living in a private residence in the community.

It is concluded that when an RVCP service delivers client-centred care with a genuine commitment to ageing in place the packages do help people to avoid or delay entry to residential care.

Do more retirement village residents than before have the option of being cared for at home as a result of the Pilot?

Results of a Care Experience Survey and case study reports provided by project coordinators convey a message of high acceptance of Pilot services among care recipients and family members and a sense that services mostly meet or exceed expectations. Selected quotations from the survey help to demonstrate that consumers see the Pilot as a new care at home option:

> 'Provide enough support to remain in my/his own unit safely. At times to meet need appropriately in cooperation with other services (private).'
>
> 'The pilot program would give assistance to the client on a day-to-day basis. Reduced stress on partner and other family members. Hoping this assistance will enable us to keep the couple together for a longer period.'
>
> 'That I am able to stay in my own unit, without going into a nursing home.'

The Pilot has delivered tangible benefits in the form of instrumental support but there is also anecdotal evidence that it has raised levels of anticipated support and sense of security among care recipients, families and the wider retirement village communities. Anticipated support—the believing that help is available if and when needed—is reported in the literature to be associated with improved long-term care outcomes for older people. It is clear from responses to the survey that thoughts of entry to residential care were uppermost in the minds of a proportion of care recipients and family carers before joining the Pilot.

More than half of evaluation participants (58%) were not accessing government-funded community care before the RVCP. In four projects this proportion is 80% or higher. The most commonly accessed community care program prior to the RVCP was Home and Community Care (23% including care recipients who previously accessed both Home and Community Care and Veterans' Home Care). Only 9% of evaluation participants transferred to the RVCP from CACP, usually to ensure continuity of care provider. The RVCP has provided a new option to the 91% of care recipients who had not previously accessed package care.

Sharing the cost of care

During the evaluation, flexible care subsidy from the Australian Government ranged from $39.06 to $68.07 per allocated place day, according to the respective project allocation of low and high care places. Flexible care subsidy contributed between 83.6% and 96.7% of project income during the evaluation.

Projects mostly adhered to standard policy for the charging of client co-payments. Recorded client co-payment amounts vary from a project average of $1.43 to $10.39 per client per day. These averages reflect mostly bi-modal patterns of co-payment within projects, whereby a proportion of clients pay nil or negligible co-payment due to financial hardship and other clients pay a standard rate. Two providers with core business operations in the for-profit sectors charge higher rates of co-payment based on assessed capacity and willingness to pay. Self-funded retirees have generally made higher contributions, of up to $24 per client per day in one project.

Other forms of individual contribution to the total amount of care received may include care from family, paid services delivered by the retirement villages under a serviced apartment contract, and standing private arrangements that continue in parallel with RVCP services (mostly podiatry, allied health care and meal services).

In the quarter ending 31 December 2004, total expenditure varied across the projects from $25.50 to $59.31 per client service day. Total expenditure in most projects did not reach the level of income in the quarter; according to reports from the projects, these results reflect a consistent trend. Per client costs would vary according to level of need and service mix, although the variation cannot be quantified because client-level costing of services was not undertaken for the evaluation. Financial results (and estimated weekly hours of care) pertain to the type of care and service environments of the RVCP projects and do not necessarily translate into estimates for different service delivery scenarios.

Other findings

ACAT assessment (refer Chapter 2, section 2.3)

Current ACAT/ACAS approval for either community and/or low or high level residential care is required for RVCP eligibility. ACAT assessment was completed within 1 year prior to commencement of RVCP services for 86% of clients (205 clients). Eight clients are recorded as not having a valid ACAT approval at the time that services commenced (approvals were dated 1998, 2001 and 2002); all of these were clients who transferred to the RVCP from a CACP package. A further 25 clients completed ACAT assessment after commencement of RVCP services, most often due to delays in obtaining ACAT assessments and the practical difficulty of delayed ACAT assessment when a person has already completed initial needs assessment by a project coordinator. A small number of project coordinators indicated that referring ACATs appeared to be attaching low priority to assessments for the RVCP.

Indications of reduced use of hospital emergency departments (refer Chapter 2, section 2.3)

Between one-fifth and one-quarter of RVCP care recipients can be expected to have unplanned or urgent hospital admissions when tracked for a period of between 4 and 6 months. While the evaluation revealed no strong evidence of a reduced rate of hospital admission, the evaluation data capture period coincided with greatly reduced reported use of hospital emergency departments (assuming that all events were recorded) compared to self-reports of use in the 6 months prior to joining the RVCP. There were far fewer visits to emergency departments, both in absolute number and relative to the numbers of unplanned hospital admissions in the period that clients were receiving RVCP services. Approximately 81% of the clients who had urgent/unplanned hospital admissions before joining the RVCP recorded emergency department visits, compared with only 2% (one client out of 47) of clients who recorded urgent/unplanned admissions during the evaluation data capture period.

Emergency department triage is a common pathway to urgent/unplanned hospital admission, the other being general practitioner (GP) consultation. Given the reported reductions in use of emergency departments by hospitalised clients, we reviewed the entire (self-report) health service use records of those who recorded urgent/unplanned hospital admissions during the evaluation. Most had recorded general practitioner consultations that took place within days of hospital admission. The data therefore suggest that, at the time of receiving RVCP services, clients were more likely to enter hospital via general practitioner

referral than through emergency department triage compared to the period immediately prior to joining a project. The avoidance of waiting in an emergency department has major benefits for patients, and admission via general practitioner referral reduces use of hospital emergency departments.

These indicators of reduced use of emergency departments as a means to access acute care provide only circumstantial evidence of the impact of RVCP services on clients' use of hospital services since there is no valid comparison or control group with which to compare the outcomes of RVCP clients. However, the results are supported by accounts of project coordinators and case studies of clients in this report that demonstrate the active role of RVCP case managers and care workers in monitoring clients' health status, medication management, assisting clients to recover after hospitalisation, and in seeking medical advice or assistance when required.

Targeting (refer Chapter 3 and project reports in Part B)

'Targeting' refers to the processes and procedures used to systematically decide who may receive services and under what conditions and in what amounts services are delivered. Targeting in the RVCP has been achieved by the screening of retirement village populations to identify individuals who could benefit from the provision of services (or screening of referrals from these populations). A proportion of people identified as having potential to benefit from the RVCP already had a valid ACAT approval and were therefore already within the target group of a project. Another group of clients were identified through surveys of participating villages and referrals made through awareness among village residents that a Pilot project had commenced operations. This latter group of clients needed to be assessed by an ACAT to establish whether they also belonged to the Pilot target group.

The experience of assessing clients referred by RVCP projects led some ACAT members to suggest that targeting people on the basis of accommodation setting does not always ensure that aged care services are targeted towards the people with the greatest need for those services, that is, these ACAT staff were comparing levels of need among people referred for RVCP packages to those of their wider client groups. ACATs at some locations were thought to be attaching low priority to referrals received from RVCP providers and some project coordinators encouraged family members to make referrals to ACAT in the belief that this was likely to achieve a speedier response. Targeting in the RVCP appears to have caused difficulties when targeting by service providers to fill available places represents a departure from the more usual outcomes of targeting by ACATs. RVCP service providers have occasionally commenced services with ACAT approval pending because of the practical dilemma of having assessed a resident as being in need of assistance, having a package available, but facing lengthy delays in ACAT assessment (hence the ACAT assessment results reported above).

The contentious issue for these ACAT staff does not appear to centre on *eligibility* for community-based aged care services but on the differential level of *access* to care packages and in addition, the provision of packages with capacity to deliver high level care to relatively low care clients (the concept of the RVCP was likened to queue jumping). Other ACAT members were pleased to be involved in the Pilot because of the opportunity to be able to offer an immediate package of care to eligible ACAT clients.

While a form of novel service delivery can be expected to elicit a range of views on its acceptability in the context of mainstream services, the concerns expressed by some ACATs need to be considered in the development of service delivery models that involve compliance with eligibility criteria related to ACAT approval.

Targeting people at the lower end of the care continuum for the provision of formal services is thought to have long-term benefits for individuals and aged care systems. A study of targeting in the HACC Program, for example, concluded that initial service use has a protective effect against ACAT recommendation for admission to nursing home care, whereas additional service use was found to have no significant effect on the likelihood of a recommendation for nursing home care (DHAC 1999). Similarly, a Canadian study reported that for people who entered care in the community at the most basic level, none of the top 10 patterns of care (by frequency) included a move to a facility, but at higher starting levels of care 'a general trend toward an increasing proportion of clients having patterns which involved moves to a facility' was observed (Uyeno & Hollander 2001).

A main strength of the Pilot thus lies in its ability to give retirement village residents access to care packages at a relatively early stage in the care needs continuum. Admittedly, the narrow targeting has resulted in unused capacity as reflected in financial results reported for the evaluation and it is pertinent to ask why projects have consistently generated cash surpluses instead of offering care packages to higher numbers of people given the said widespread need for packages in the target group. New services take time to establish. Over time, performance information, including financial results, becomes part of an information feedback loop that informs providers about financial risk. At the time of the evaluation one service provider (Mandurah Retirement Village) was intending to take on additional unfunded clients by drawing on cash reserves. It is possible that other Pilot providers would move in that direction as they became more certain of being able to support existing clients for the medium to long term. The behaviour of providers over a longer timeframe will provide a clearer picture of the relationship between targeting in the RVCP and resource utilisation.

Unique features of retirement village living (refer Chapter 4)

In the course of the evaluation it became evident that complex dynamics exist in the retirement village sector and these are likely to influence service provider and resident responses to service provision that supports ageing in place.

A number of different financial arrangements exist whereby people gain right of occupancy to units in retirement villages, for example, leases, licences, body corporate and strata titles, company titles and unit trusts. Many do not confer property ownership to the resident. In certain circumstances continued occupancy can become subject to negotiation between a resident and village management. The support of ageing in place for an individual resident may not always be consistent with business imperatives under the range of occupancy arrangements (especially when there is high demand for units), or for all operators in the sector. A three-year assisted living pilot in the United States has also highlighted these issues in relation to resident relocation (Munroe & Guihan 2005).

Further, it is speculated that the experiences and preferences that lead people into retirement villages may predispose them to enter residential services at a higher rate than is observed among older people at the same level of need for assistance living in private residences. The possible influence of self-selection factors on service seeking behaviour in the target group is discussed in Chapter 4. There may be considerable scope for care packages to reduce actual entry to residential aged care among residents of retirement villages but this would depend on packages addressing the specific 'push' and 'pull' factors that influence members of the target group to enter residential care. At the present time, the dynamics of the sector that influence residents' use or non-use of community services (and related outcomes) are perhaps not well understood.

According to one RVCP service provider, people living in serviced apartments within retirement villages often find they cannot access services funded by the Home and Community Care Program (very few RVCP clients living in serviced apartments had been receiving assistance through any government support program prior to the RVCP; refer section 2.3). Program Guidelines for Home and Community Care state:

> For example, the HACC Program does not generally provide services to residents of aged care homes or to recipients of disability program accommodation support service, when the aged care home/service provider is receiving government funding for that purpose. Nor does it generally serve residents of a retirement village or special accommodation/group home when a resident's contract includes these services…Residents of retirement villages or independent living units are eligible for HACC services except when a resident's contract includes these services. (*National Program Guidelines for Home and Community Care Program 2002,* p. 9)

Official policy is that if a resident receives a specific service, such as housework and laundry, through their contract with a retirement village operator, then HACC will not fund laundry services. However, the person may be eligible for other types of HACC services, for example, home nursing (HACC Outcomes Section, Australian Government Department of Health and Ageing).

It is said that, in practice, HACC service agencies in at least one area deem residents in serviced apartments to be ineligible for any HACC-funded services. This would seem to stem from a misinterpretation of the HACC Program Guidelines as they relate to retirement village residents who privately purchase a service contract. If so, it seems problematic that community service agencies make judgments about what is and is not included in a resident's service contract given that agencies are unlikely to have a reliable knowledge of the provisions of those contracts. The evaluation found that some RVCP recipients had been receiving HACC services prior to the RVCP but these people were all living in independent living units.

Living in an independent living unit in a retirement village rarely carries an entitlement to the provision of aged care services and the Pilot has been a first experience of care services associated with retirement village living for the majority of RVCP recipients. Ordinarily, people who live in independent living units need to access aged care services via the same channels as older people in private residences. A number of RVCP service providers referred to difficulties they had experienced historically in assisting residents to obtain care package services. It is not known whether this stems primarily from local supply and demand factors or also possibly from attitudes among mainstream service providers towards delivering services into retirement villages.

In conclusion, the Retirement Villages Care Pilot has met with a high level of acceptance from clients and their families, and service providers. Services have targeted multiple areas of assistance, including those covered by a conventional CACP service, but extending to home nursing and allied health care if required. The highly individualised and on-site nature of service provision in those projects where providers offered a dedicated RVCP service allows for multiple daily visits to a client. The co-location of a service provider and client group is an efficient means of closely monitoring high-needs clients and clients returning home after hospitalisation, and for providing clients with access to assistance at short notice. In responding to the Care Experience Survey (overall response rate of 75%), 80% of respondents indicated that the RVCP was meeting all of their previously unmet need for assistance and 72% of carers and relatives who completed the carer section confirmed that the RVCP was a suitable care option for the foreseeable future.

Format of the evaluation report

This report is divided into two parts. Part A starts with a brief introduction to the RVCP and assisted living more generally and describes the aims and methods of the national evaluation project (Chapter 1). Chapter 2 overviews the RVCP projects and presents socio-demographic and functioning profiles of RVCP recipients who participated in the evaluation and their carers. Chapters 3, 4 and 5 address the evaluation issues in turn. Chapter 6 concludes Part A by summarising the main evaluation findings and the identified strengths and weaknesses of the RVCP model of service provision. Part B contains a separate report on each RVCP project that outlines the service environment, client group, and the anticipated and unanticipated effects of Pilot services at a local level. Client case study reports, where supplied, are included in Part B.

Part A

Main report

1 Introduction

The Retirement Villages Care Pilot was announced in the 2002–03 Federal Budget as one of a number of *Choosing to Stay at Home* initiatives for older people. The Pilot has made available a pool of flexible care places outside of annual Aged Care Approvals Rounds to target the aged care needs of older people living in retirement villages. Pilot services across Australia progressively commenced operations between October 2003 and April 2004 under the administration of the Australian Government Department of Health and Ageing. Ten projects were established with a combined allocation of 280 flexible care places and were expected to continue operating until June 2006. Participating service providers were required to take part in a national evaluation.

This report presents the findings of a national evaluation of the Retirement Villages Care Pilot undertaken by the Ageing and Aged Care Unit of the Australian Institute of Health and Welfare (AIHW). The evaluation project was completed under a Schedule to the Memorandum of Understanding between the AIHW and the Department, with approval from the AIHW Ethics Committee (Register Number 353). Data collection commenced in July 2004 and was completed in mid-2005.

The Retirement Villages Care Pilot (RVCP) is targeted at residents of retirement villages who need formal assistance to remain at home for as long as possible. Pilot projects were established in all mainland states and the Australian Capital Territory. Each offers a mix of low and high care equivalent packages that varies from project to project but averages 20% of places funded for high care overall (Table A1.1).

Operational guidelines for the RVCP specify the requirements that need to be met for a person to be eligible to receive RVCP services (DoHA 2005a). Briefly, a care recipient must have a current Aged Care Assessment Team (ACAT) approval for community care and/or low or high level residential aged care. Approved providers must enter into a formal agreement (care recipient agreement) that details mutual rights and responsibilities, before a client commences services. Services operate in accordance with the provisions of the *Aged Care Act 1997*.

The RVCP national evaluation appears to be the first systematic investigation of the aged care needs of retirement communities throughout Australia. Large-scale studies with a similar focus are also sparse in the international literature. A 1996 report from the Organisation for Economic Co-operation and Development recommends the testing of community care models under a range of different real-world conditions:

> There is plenty of evidence that community care options can enable frail older people to stay in their own homes. However, whether it is cheaper and whether it reduces the use of alternatives is much more doubtful. In experimental situations where there is a coordinated effort and competent case management, some substitution effect can be found, but even in such cases the evidence is not overwhelming…A single demonstration in a single state cannot show us whether these conditions can be replicated and maintained in an ongoing program (Kemper et al. 1987 in OECD 1996:74).

Maddox (2001) in the United States has lamented the hiatus in research on the interaction between housing and living arrangements and 'successful ageing' in later life over the past few decades. He advocates a new research agenda in the field of assisted living housing for older Americans.

Table A1.1: Retirement Villages Care Pilot projects in the national evaluation

Approved provider	Official start date	Number of participating villages	Village locations	RVCP provider an established community aged care provider?	Place allocation		
					Low	High	Total
HN McLean Memorial Retirement Village	15 December 2003	5	Inverell, northern NSW	Yes	15	5	20
Australian Unity Retirement Living Services (NSW) Pty Ltd	29 March 2004	8	Sydney, Bowral and Central Coast, NSW	No	45	8	53
Morshead Home for Veterans and Aged Persons	16 December 2003	4	Canberra, ACT	No	22	3	25
Forest Place Group	1 October 2003	1	Durack (Brisbane), Qld	No	20	7	27
Southern Cross Care	11 November 2003	4	Melbourne and Geelong, Vic	Yes	22	3	25
Kingston City Council	13 October 2003	4	Melbourne, Vic	Yes	20	2	22
ECH Incorporated	5 January 2004	8	Adelaide, SA	Yes	30	5	35
Resthaven Incorporated	16 October 2003	1	Murray Bridge, SA	Yes	8	7	15
Mandurah Retirement Village	15 October 2003	1	Mandurah, WA	No	12	6	18
Aged Care Services Australia	20 October 2003	9	Perth, WA	Yes	30	10	40
Total		**45**			**224**	**56**	**280**

Regnier et al. (1995), cited in Maddox (2001), define assisted living housing as comprising four main concepts to a greater or lesser extent:

- a private place of one's own
- service matched to individual need, including around the clock capacity to respond to unscheduled care needs
- sharing responsibility among service provider, family and resident
- providing residents with choice and control over their lives.

Surveys in the United States depict the typical older person who is attracted to assisted living housing as an 83-year-old woman needing assistance in three activities of daily living. It is further estimated that one in two residents in assisted living housing have dementia (Maddox 2001). Maddox suggests that the disparity between affordability and a widespread consumer preference for assisted living housing should be addressed given the model is 'an effective strategy for minimizing functional dependency in later life'.

Stimson (2002) distinguishes between 'push factors' and 'pull factors' as different types of motivation for relocating to a retirement village. Retirees often decide to move into a retirement village because of their current circumstances—push factors. Among these, health problems and social isolation through, for example, death of a spouse are common. A gender imbalance in retirement communities might reflect a greater social isolation push factor among single older women. Pull factors relate to the built environment and range of services and facilities in the village. Many retirement village residents choose a village that provides a higher level of care than they require at the time of entry, reflecting a strong desire to age in place. A 24-hour emergency call system and on-site hostel or nursing home services were rated as desirable or very desirable by 60% or more of retirees in a survey of residents conducted by the University of Queensland (Stimson 2002:73).

Retirement villages combine the positive elements of age-homogeneous residence and neighbourhood living. Biggs et al. (2000) cite studies that suggest that 'rather than being seen as a negative consequence of institutionalisation, leading to increased dependency and lowered health status, the concentration of older people in retirement communities is claimed to maintain and in some cases enhance social, mental and physical wellbeing in later life'. Their study of culture in a United Kingdom retirement community found that ready access to social support has a positive effect on the wellbeing of most residents, assisting them to live the rhetoric of 'positive ageing'. However, there were also hints of exclusivity and difficulties for less mobile residents: 'there was considerable talk about negative wellbeing existing as a state of mind, and the remedy as an act of will' (Biggs et al. 2000).

1.1 Retirement living versus assisted living housing

In Australia, retirement villages operate variously as clusters of independent living units without organised services to facilities that offer a full range of social and health care services in a self-contained living environment. The extent of self-containment varies, from fully self-contained living to congregate dining and entertainment areas. The Retirement Village Association, representing some 300 villages around Australia, defines a retirement village as 'a housing development designed specifically to cater to the needs and lifestyle of the over 55s' (RVA 2003). This broad definition covers many models and styles of accommodation

that are described by terms such as 'self-care units', 'independent living units', 'villa' and 'serviced apartments'.

Phillips et al. (2000) have proposed that retirement villages can be defined by the following characteristics:

- a retirement element—residents are no longer in full-time employment and this affects their use of time and space
- a community element—an age-specific population, living in the same geographically bounded area
- a degree of collectivity—with which residents identify, and which may include shared activities, interests and facilities
- a sense of autonomy with security.

State and territory legislatures have defined 'retirement village' primarily in terms of the residence contract that deals with physical premise characteristics and legal arrangements that confer the right of occupancy (Boxes 1 to 6 list definitions from relevant Acts and Codes of Practice). Thus, the retirement village concept covers a variety of physical and social environments and levels of service provision. This variety is seen in the villages where RVCP services have been introduced, which range from little more than low-cost cluster housing for older people to high-end accommodation with resort-style facilities and programs.

The Australian Consumers' Association has reported a degree of consumer dissatisfaction surrounding the failure to provide promised or implied services and facilities. Part of the confusion appears to be connected with the so-called 'three-level' care in retirement villages. Village operators commonly use the following terms to describe various care level options (ACA 2003):

- *Independent living* whereby residents are responsible for their own care. Accommodation is in self-care units. Services other than accommodation might be available at an additional cost ('flexi-care').
- *Assisted living* whereby personal care and/or domestic services are readily available on a regular basis for an additional fee, usually via a service contract between village management and resident.
- *Hostels and nursing homes:* some villages have hostel and nursing home facilities on the same site but the allocation of low and high care beds attracting Australian Government residential care subsidy is determined on a needs basis.

Sixteen per cent of RVCP evaluation clients were living in serviced apartments during the evaluation. The remaining 84% of clients were living in independent living units. There were no instances of retirement village management delivering care services to residents in independent living units other than through goodwill. Perhaps contrary to a common assumption, most residents of independent living units need to access aged care services via the same channels as older people in private residences.

Box 1.1: Definition of 'retirement village' according to the *Retirement Villages Act 1999* No. 81 (New South Wales): s. 5

(1) For the purposes of this Act, a retirement village is a complex containing residential premises that are:

(a) predominantly or exclusively occupied, or intended to be predominantly or exclusively occupied, by retired persons who have entered into village contracts with an operator of the complex, or

(b) prescribed by the regulations for the purposes of this definition.

(2) It does not matter that some residential premises in the complex may be occupied by employees of the operator or under residential tenancy agreements containing a term to the effect that this Act does not apply to the premises the subject of the agreement (instead of being occupied under residence contracts), or that those premises do not form part of the retirement village.

(3) However, a retirement village does not include any of the following:

(a) any building or any part of a building used or intended to be used for the provision of residential care, within the meaning of the Aged Care Act 1997 of the Commonwealth, by an approved provider under that Act,

Note. Paragraph (a) excludes from the definition of retirement village buildings that are commonly known as Commonwealth-subsidised hostels and nursing homes.

(b) a nursing home within the meaning of the Public Health Act 1991,

(c) any building or part of a building intended to be used for the provision of respite care (within the meaning of the Aged Care Act 1997 of the Commonwealth),

(d) a residential park (within the meaning of the Residential Parks Act 1998),

(e) a place at which accommodation is provided by the Aboriginal Housing Office or the New South Wales Land and Housing Corporation (unless it is provided pursuant to a joint venture, or otherwise in conjunction, with another person or body),

(f) a boarding-house or lodging house,

(g) any accommodation provided in a complex for employees of the complex who are not residents of the retirement village,

(h) any residential premises the subject of a residential tenancy agreement in the form prescribed under the Residential Tenancies Act 1987 to which the operator of a retirement village is a party and that contains a term to the effect that this Act does not apply to the residential premises the subject of the agreement,

(i) any other place or part of a place excluded from this definition by the regulations.

Box 1.2: Definition of 'retirement village' according to the *Retirement Villages Industry Code of Practice* (*Australian Capital Territory) Fair Trading Act 1992*

'retirement village' means an existing or proposed complex, or part of a complex, comprising residential premises (other than residential aged care facilities covered by the Commonwealth Aged Care Act 1997) predominantly or exclusively occupied, or intended to be predominantly or exclusively occupied, by retired persons;

'residence contract' means a contract, agreement, scheme or arrangement by which a person obtains or maintains the right to occupy residential premises in a retirement village, and includes:

(a) a lease;

(b) a licence to occupy;

(c) a right conferred by shares;

(d) a management agreement; or

(e) an agreement for sale, or a conveyance, of property that is subject to the Unit Titles Act;

Box 1.3: Definition of 'retirement village' according to the *Retirement Villages Act 1986* (Victoria): s. 3

'retirement village' means a community –

(a) the majority of which is retired persons who are provided with accommodation and services other than services that are provided in a residential care facility; and

(b) at least one of whom, before or upon becoming a member of the community, pays or is required to pay an in-going contribution;

'services' means any of the following –

(a) management and administrative services;

(b) gardening, repair and maintenance services;

(c) hospital, nursing or medical services including accommodation;

(d) shops and other services for the provision of goods to residents;

(e) hostel accommodation;

(f) laundry services;

(g) the provision of meals;

(h) services or facilities for the recreation or entertainment of residents;

(i) other services for the care or benefit of residents;

Box 1.4: Definition of 'retirement village' according to the *Retirement Villages Act 1999* (Queensland): s. 4–8

(1) A "retirement village" is premises where older members of the community or retired persons reside, or are to reside, in independent living units or serviced units, under a retirement village scheme.

A "retirement village scheme" is a scheme under which a person –

(a) enters into a residence contract; and

(b) in consideration for paying an ingoing contribution under the residence contract, acquires personally or for someone else, a right to reside in a retirement village, however the right accrues; and

(c) on payment of the relevant charge, acquires personally or for someone else, a right to receive 1 or more services in relation to the retirement village.

Box 1.5: Definition of 'retirement village' according to the *Retirement Villages Act 1987* (South Australia): s. 3

'retirement village' means a complex of residential units or a number of separate complexes of residential units (including appurtenant land) occupied or intended for occupation under a retirement village scheme;

'retirement village scheme' or 'scheme' means a scheme established for retired persons and their spouses, or predominantly for retired persons and their spouses, under which –

(a) residential units are occupied in pursuance of lease or licence; or

(b) a right to occupation of residential units is conferred by ownership of shares; or

(c) residential units are purchased from the administering authority subject to a right or option of repurchase; or

(d) residential units are purchased by prospective residents on conditions restricting their subsequent disposal,

but does not include any such scheme under which no resident or prospective resident of a residential unit pays a premium in consideration for, or in contemplation of, admission as a resident under the scheme;

Box 1.6: Definition of 'retirement village' according to the *Retirement Villages Act 1992* (Western Australia): s. 3

'retirement village' *means a complex of residential premises, whether or not including hostel units, and appurtenant land, occupied or intended for occupation under a retirement village scheme or used or intended to be used for or in connection with a retirement village scheme;*

'retirement village scheme' *or* ***'scheme'*** *means a scheme established for retired persons or predominantly for retired persons, under which —*

(a) residential premises are occupied in pursuance of a residential tenancy agreement or any other lease or licence;

(b) a right to occupation of residential premises is conferred by ownership of shares;

(c) residential premises are purchased from the administering body subject to a right or option of repurchase;

(d) residential premises are purchased subject to conditions restricting the subsequent disposal of the premises; or

(e) residential premises are occupied under any other scheme or arrangement prescribed for the purposes of this definition, but does not include any such scheme under which no resident or prospective resident of residential premises pays a premium in consideration for, or in contemplation of, admission as a resident under the scheme;

The RVCP can be characterised as extending the model of independent living in a retirement village to the assisted living concept through a partnership between government, service provider and client. In addition, the RVCP aims to strengthen shared care arrangements in existing assisted living situations. Most RVCP recipients live in independent living units but one project specifically and exclusively targets residents in serviced apartments.

In the following section we describe the purpose and methods of the evaluation of RVCP services.

1.2 Evaluation aims and methods

The national evaluation was designed to answer four key issues (Box 1.7). Scoping work was completed in December 2003 and an application for conduct of the evaluation was approved by the AIHW Ethics Committee on 3 March 2004 (Register Number EC 353).

Implementation of the framework has generated detailed data on the socio-demographic characteristics and care experience of a cohort of RVCP recipients. The care experiences of participating clients—hereafter referred to as 'evaluation clients' to distinguish them from the larger group of RVCP recipients—were recorded over a period of 18 weeks (26 July to 29 November 2004). Follow-up of accommodation status was completed in most cases by June 2005. Individual follow-up periods vary up to 18 months from commencement of RVCP service.

Box 1.7: Issues to be addressed by the national evaluation of the Retirement Villages Care Pilot

1. *What are the novel features of RVCP packages vis-à-vis Extended Aged Care at Home packages (EACH) and Community Aged Care Packages (CACP)?*
2. *Do recipients of RVCP packages of care have a reduced need to enter residential aged care facilities as a result of receiving the package?*
3. *Do more retirement village residents than before have the option of being cared for at home as a result of the Pilot?*
4. *To what extent do government and package recipients share the cost of supplying care?*

Source: Australian Government Department of Health and Ageing.

Evaluation guidelines were issued to projects in June 2004 and data collection commenced on 26 July 2004. The collection of client service activity data and functional assessment data was completed by 29 November 2004. Any care recipient who was active on 26 July 2004 or who commenced RVCP services between that date and mid-October 2004 was invited to participate in the evaluation. Participation was subject to full disclosure of the evaluation protocol and receipt of a signed consent form by a project coordinator. Clients were informed that they could withdraw from the evaluation at any point and that it was possible to decline to take part in specific parts of the evaluation should they wish. Withdrawal or non-participation did not affect receipt of services. Recruitment of clients for the evaluation and the procedure for obtaining informed consent was managed by project coordinators using documents and forms provided by the AIHW. The AIHW evaluation team did not have direct contact with clients and projects were instructed not to disclose client identity in records sent to the AIHW.

Projects supplied financial and occupancy reports for the December 2004 quarter. These reports cover all of a project's RVCP care recipients.

An overview of evaluation methods follows.

Quantitative methods

Projects populated an evaluation database by recording socio-demographic data for clients and a summary of each client's service activity between 26 July and 29 November 2004. The collection covers previous use of government-funded aged care services, medical and hospital service use immediately prior to entering the RVCP and information about ACAT assessment and referral to an RVCP project. Project coordinators had access to codes for over 60 types of assessment and direct care services for the recording of client services.

Several different baseline measures of client functional status were recorded. One set of measures describes the severity of activity limitation that a client experiences in core daily activities. Core activities include self-care (eating, bathing or showering, dressing, grooming, toilet use and continence management), mobility (mobilising on a level surface and transferring to or from seated or prone positions), and communication (understanding others and making oneself understood). Activity limitation is rated on a five-point scale from no limitation to profound limitation. A severe or profound level of activity limitation is understood to mean that an individual needs the assistance or supervision of another person to perform an activity that is normally undertaken on at least a daily basis. These definitions

are those used in the Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers.

A second set of measures comprises scores that reflect a client's level of dependency, or need for assistance, in basic and instrumental activities of daily living (ADL and IADL measures). ADL and IADL scores are composites of scores on a number of items. ADL items cover self-care and mobility as described above whereas IADL items cover aspects of domestic functioning including housework, shopping, ability to get to places away from home, self-medication, management of personal finances and telephone use. The AIHW chose a 10-item variant of the Modified Barthel Index (MBI) and the seven-item Older American Resources and Services (OARS) IADL scale for ADL and IADL measurement respectively. MBI scores can range from zero to 20 points with 20 points indicating independence in self-care and mobility. It has been suggested that 12 points is a threshold indicator of severe dependency in self-care and mobility (Shah et al. 1989). OARS IADL scores can range from zero to 14 points. Higher scores relate to higher functioning on both scales.

Copies of the Mini-Mental State Examination for assessment of cognitive function were supplied to projects as an optional functional measure. None elected to use the instrument.

Projects were asked to record each set of measures twice, once at entry to the project and a second measure taken as close as practicable to 16 weeks after the first. Baseline measures were reconstructed from records for established clients and were recorded on entry to a project for clients who commenced services during the evaluation period. Self-reports of participation were recorded for new clients as they entered a project and again at the final assessment point.

If a client had a carer who agreed to participate in the evaluation, projects used the 13-item Caregiver Strain Index (Robinson 1983) to assess carer strain at two points in time.

Discharge destination and living arrangement was recorded if a client left a project during the evaluation. Project coordinators were able to add descriptive information to client exit records, for example, to explain unusual circumstances. In June 2005, follow-up was completed for all clients who were recorded as ongoing in RVCP projects as at 30 November 2004.

A summary of the data collected by each project is included with the project description in Part B of this report. Copies of instruments can be found in Appendix 1.

Qualitative methods

During June and July 2004, the AIHW evaluation team met with staff in the 10 projects. This provided an opportunity for semi-structured interview and informal discussions about project operation, client groups and local conditions. Brief written responses to a list of discussion topics and notes of the discussions that took place were used to prepare a written narrative on each project. Projects were invited to submit client case studies to supplement the quantitative data.

At the request of the AIHW evaluation team, project coordinators issued a Care Experience Survey questionnaire to each client for completion and return direct to the AIHW via reply paid post. The questionnaire contains a section for the client to complete plus a number of questions specifically for a family carer, if available. Survey results are cited throughout the report where relevant to topics of discussion and a summary of results is provided in Appendix 2. A copy of the survey instrument is available on request from the AIHW.

Strengths and limitations of the national evaluation

The national evaluation was conducted as an observational study of a cohort of care recipients. Data collection commenced within 6 to 8 months of most projects being established and accepting their first clients. Evaluation is thus of a formative program and providers new to care package delivery may have been developing and refining systems and practices during the reporting period.

The evaluation protocol lacks some key features of impact evaluation that assist with the attribution of outcomes to project activity such as random or systematic allocation to intervention and control groups and methods of achieving a separation between intervention, in this case service delivery, and outcome measurement. Attribution of objective outcomes to care intervention is therefore speculative.

An observational design may not be such a serious limitation in the present context. First, the care of older people is highly individual and often their circumstances are in a constant state of change. It is unlikely that random allocation or matching, even if possible and ethically acceptable, would achieve comparable baseline control and intervention groups given the low number of clients in each project compared to sample sizes that are typical in large controlled studies. Second, the aim of allocation procedures is to eliminate or at least quantify the range of extraneous variables that might impact on the outcomes to be measured. In a real world setting it is not possible to hold constant, measure, or even identify all of the factors that could pre-exist or emerge to influence outcomes for an individual care recipient. Perhaps more importantly, evidence of the effects of anticipated support in other studies provides a sound basis for using qualitative data to associate the outcomes of interest with project interventions.

In keeping with the action research focus, the evaluation was designed to collect a comprehensive set of data and information with minimal interruption to services and intrusion on clients. The result is an evaluation with much greater scope to explain the ‘how’ and ‘why’ than would be possible with a costly, narrowly defined and artificial experimental design.

Perhaps a more serious constraint is the lack of independence between service provision and the measurement and recording of evaluation data. The AIHW has conducted the evaluation at arm’s length in the interests of the privacy and comfort of care recipients. Responsibility for data collection, using AIHW developed tools, rested with the project coordinators. Functional assessments of clients were performed or arranged by the coordinators. Where possible, these were designed to supply data for the evaluation with minimal disruption to the schedule of home visits by incorporating them into routine client reviews. Baseline ADL measures were reconstructed from the client file and ACAT documentation in cases where a client was already established in a project by the time the evaluation started. The AIHW emphasised to coordinators that the purpose was not to measure project effectiveness on the basis of change in ADL measures but to use these measures to report on level and type of need in the target group and to explore possible associations between outcomes and ADL support needs. Core activity limitation ratings (no limitation or slight, moderate, severe or profound) were compared with ADL measures and the two sets of measures were found to be in close agreement.

Most clients were not followed for a sufficient length of time to produce reliable measures of long-term accommodation outcome. The elapsed time between baseline and final assessment varies depending on when a client commenced services in relation to the start of the evaluation. In most cases the accommodation outcome data will be censored by the window

of opportunity for evaluation. Client accommodation status was recorded at or around 29 November 2004 and again in June 2005, giving a medium term account of progress for most participants. Eligibility criteria requiring ACAT approval for at least low care are thought to reduce the impact of the limited period of follow-up, that is, according to the required ACAT approval, all clients are assessed as being 'at risk' on entry to the RVCP.

Limited follow-up is more of a problem in relation to evaluating project effectiveness for clients at the lower end of the care continuum. High care clients are by definition at high risk of entering residential aged care when they enter the RVCP. Arguably, even a minimum 16-week period of community care could be judged a 'success' for clients in this group. There is evidence that ACAT recommendations for residential low care are often based on the psycho-social needs of people who live alone (LGC 2002) and it is therefore reasonable to evaluate effectiveness from clients' subjective assessments of services. Client feedback provides an independent assessment of project effectiveness and, if carefully designed, can be used to establish whether there is evidence of anticipated support. This is an important objective of the Care Experience Survey.

The evaluation has collected very detailed information about services delivered to clients to facilitate care model differentiation and economic evaluation of projects. It is not possible to attribute outcomes to specific service types or levels of service because the evaluation has not dictated how and by whom various services are received. This is an evaluation of care packages, not care types.

1.3 Format of the evaluation report

The evaluation report is presented in two parts. Part A presents an overall picture of the RVCP and the 10 projects plus findings in relation to the evaluation questions:

- Chapter 2 describes RVCP projects and evaluation participants to provide context for the evaluation findings.
- Chapter 3 identifies the novel features of RVCP care packages.
- Chapter 4 explores whether RVCP services have reduced need for residential care in the target group.
- Chapter 5 looks at how the cost of care is shared.
- Chapter 6 summarises the evaluation results.

Results from the Care Experience Survey are reflected in Chapters 3–5. A fuller summary of survey results is included in Appendix 2.

Part B of the report contains detailed project descriptions.

2 Project and participant profiles

This chapter gives an overview of the RVCP projects and summarises key socio-demographic and functional characteristics of RVCP recipients to provide a context for addressing the evaluation questions in Chapters 3, 4 and 5.

2.1 Project overviews

RVCP projects divide broadly into two groups based on whether services are delivered into one or multiple villages. Within each group, different staffing models exist for the delivery of RVCP packages. In some cases where the approved provider operates established HACC or CACP services the RVCP has been integrated into the service delivery infrastructure for other programs. The HN McLean Memorial Retirement Village, Aged Care Services Australia, Southern Cross Care (Victoria), Kingston City Council, and ECH projects operate on this basis. The Resthaven project operating in Murray Bridge Lutheran Homes Retirement Village is an example of an established CACP provider operating a distinct service for the RVCP using a dedicated team of care workers. Other projects involve new entrants to care package service delivery having established new infrastructure to service clients in one or more villages, for example, Australian Unity Retirement Living Services, or expanding existing service capability for care package clients, for example, Forest Place Retirement Village and Mandurah Retirement Village. Morshead Home RVCP is a consortium of members operating different staffing models. These various arrangements in place at the time of the evaluation are summarised in Table A2.1.

Two projects are operated by service providers that are otherwise operationally independent of the participating villages—Resthaven Incorporated and Kingston City Council. In all other projects, the provider of RVCP services has a financial interest in one or more participating villages, through village ownership and/or via management contracts with village owners.

Part B contains a report on each project and its participating clients and carers. Below is a brief overview that draws on those reports.

Single village projects

Forest Place and Mandurah retirement villages each delivers RVCP services to residents in just one village, which in each case is owned and operated by the RVCP approved provider. Both are established providers of retirement accommodation and residential aged care accommodation services. The RVCP is their first venture into community care package delivery. Resthaven Incorporated delivers RVCP services into the Murray Bridge Lutheran Homes Retirement Village, which is owned by the Lutheran Church of Australia.

Forest Place Retirement Village

Forest Place Retirement Village is located in Durack, a suburb of Brisbane, and comprises independent living units and serviced apartments at various levels of affordability. A range of services is available to residents at extra cost. A medical centre, pharmacy and nursing home are co-located. Forest Place Retirement Village is part of the Forest Place Group, a large for-profit organisation that operates in the retirement living and real estate sectors.

The RVCP project targets residents in serviced apartments. Domestic assistance (approximately 2 hours per week), laundry and some meals are included in the standard serviced apartment contract. Management at Forest Place deliberately targeted this group because of identified high unmet need for assistance, in most cases due to residents' physical frailty. Among the RVCP projects, Forest Place is at the high end of the 'assisted living housing' concept.

The Forest Place project coordinator indicated that it is not uncommon for residents in serviced apartments to face barriers to accessing community care because service agencies consider the group to be well catered for by service arrangements within the village and to be financially advantaged compared to older people in the wider community. It was suggested that this view needs to be challenged because many residents of serviced apartments have remained independent of government-funded assistance until very old age, at which stage additional care to meet increased need for assistance may be beyond the limit of a resident's remaining disposable income.

Another distinguishing feature of the Forest Place project is the relatively few years that most clients have spent in their serviced apartment. Duration of residence in a Forest Place serviced apartment among the evaluation clients varied from one to 6 years, with a mean of just 2 years. While clients' reasons for moving into a serviced apartment were not investigated, it is plausible that many moves would be pre-empted by failing health or altered family circumstances such as widowhood. The coordinator at Forest Place said that older people living in serviced apartments tend to be 'planners', in that they plan ahead for their changing needs. Only four Forest Place clients had a family carer and no client had a co-resident carer, which is a different pattern of informal care to that of other projects.

The Forest Place project operates from within the medical centre. Care management and coordination is performed by a registered nurse on staff and services are delivered by existing care workers. Transport to and from medical appointments may therefore be less of an issue for RVCP recipients at Forest Place than in other projects. Forest Place Retirement Village was funded to operate 7 high care places; the evaluation group included seven clients who had ACAT approval for high level residential care when they commenced RVCP service.

Table A2.1: RVCP projects, scope and staffing models

		Approved provider (AP)		
Project scope	**Project staffing model**	**Name**	**Does AP manage participating villages?[a]**	**Does AP own participating villages?[a]**
One retirement village	Existing staff at Forest Place Retirement Village	Forest Place Retirement Village	Yes	Yes
	Existing staff at Mandurah Retirement Village	Mandurah Retirement Village	Yes	Yes
	Dedicated RVCP service team	Resthaven Incorporated	No	No
Multiple retirement villages	Dedicated RVCP service team	Australian Unity Retirement Living Services	Yes	Australian Unity RLS owns 4 of the participating villages. The other 4 villages are managed but not owned by Australian Unity.
	RVCP staff service clients of other community care programs	HN McLean Memorial Retirement Village	Yes (1 of the 5 villages)	Yes (1 of the 5 villages)
		Southern Cross Care Victoria	Yes (3 of the 4 villages)	Yes (3 of the 4 villages)
		Kingston City Council	No	No
		ECH Incorporated	Yes	Yes
		Aged Care Services Australia	Yes (5 of the 9 villages)	ACSA parent company, The St Ives Group, owns 2 of the 9 participating villages
	Some consortium members operate with a dedicated RVCP service team (Morshead Home & Villaggio) while others have staff servicing RVCP clients and clients of other community care programs (Goodwin & Canberra Masonic Homes)	Morshead Home for Veterans and Aged Persons	Yes (each partner in the Morshead RVCP consortium manages its own village)	Yes (each partner in the Morshead RVCP consortium owns the village into which it delivers RVCP services)

(a) At time of the evaluation.

Mandurah Retirement Village

Mandurah Retirement Village is located in the small coastal township of Mandurah, about 80 kilometres south of Perth. The village opened in 1972 and offers affordable self-care accommodation. Mandurah Retirement Village Incorporated is a not-for-profit community organisation managed by a board of volunteers.

Serviced apartments and a nursing home are located adjacent to the village. RVCP care recipients participating in the evaluation are a mix of residents in independent living units (12) and serviced apartments (eight). This characteristic makes Mandurah Retirement Village RVCP second only to Forest Place RVCP in terms of the proportion of clients living in supported accommodation.

Mandurah has recorded the second highest proportion (95%) of evaluation clients without a family carer.

Duration at Mandurah Retirement Village ranges from one to 20 years among the evaluation clients; over one in five clients have lived at Mandurah Retirement Village for over 10 years.

The project draws on existing infrastructure that services residents in serviced apartments and, more recently, a new nursing home.

Resthaven Incorporated

The Resthaven RVCP project offers services to residents of the Lutheran Homes Retirement Village in Murray Bridge, near Adelaide. Resthaven Incorporated, an arm of the Uniting Church in Australia, is an approved provider for Community Aged Care Packages and residential aged care and operates Day Therapy Centre and respite care services. The organisation has participated in a number of other government community care pilots. Resthaven's history in community care package delivery distinguishes it from the other providers in the single village, single program category.

The project was established to address unmet need for community care among village residents that is said to have arisen because of a severe shortage of care packages in the region. Resthaven evaluation clients had lived in the village for an average of 9 years (from 3 to 18 years). All Resthaven RVCP care recipients were living in independent living units; the village does not ordinarily offer care services. None of the evaluation clients had an actively involved family carer.

Care management for RVCP recipients is integrated into the Resthaven Community Care Division but the project employs dedicated RVCP care workers.

Multiple villages projects

Australian Unity Retirement Living Services

Australian Unity Retirement Living Services offers RVCP services to residents of multiple villages located over a large geographic region that takes in the Central Coast and Southern Highlands of New South Wales. Australian Unity either owns or manages each village. Australian Unity Retirement Living Services, formerly known as Retirement Lifestyle Services, is a large for-profit operator in the retirement living and real estate sector.

This project has the largest allocation (53 places) of all the RVCP projects and marks a debut into government program delivery for Australian Unity. The venture has required the establishment of entirely new infrastructure, network and capacity building with other

health and community service agencies. Evaluation coincided with the first 6 months of operation during which the project experienced some staffing difficulties and unanticipated delays in filling places. These difficulties were caused or exacerbated by the project's large geographic service area and diverse range of retirement communities. Participating villages have been established for between 5 and 30 years and include sites ranging from prestige to more low cost retirement accommodation.

Australian Unity RVCP care services are delivered by salaried employees. The aim is to maintain a caseload of one care manager per eight care recipients, with a primary and secondary care worker for each care recipient to maintain continuity of care.

HN McLean Memorial Retirement Village

HN McLean Memorial Retirement Village RVCP services retirement communities in Inverell, northern New South Wales. Participating villages vary from the conventional model of retirement living represented by HN McLean Memorial Retirement Village to complexes of independent living units with no on-site management that cater primarily to financially disadvantaged older people.

HN McLean Memorial Retirement Village is an approved provider of low and high residential aged care and Community Aged Care Packages (general and Indigenous CACP). Other services include a Day Therapy Centre and dementia care.

Three-quarters of evaluation clients in this project had a family carer, mostly daughters or daughters-in-law who were not residing with the RVCP recipient. There is said to be a shortage of mainstream aged care packages in the region and access to visiting geriatricians and psycho-geriatricians is limited. The target group faces considerable difficulties in accessing specialist health services because the nearest major centre, Brisbane, is four hours away by road transport.

RVCP services are delivered by existing care staff working across the range of HN McLean community care programs. Allied health care and other professional services are brokered as required.

Southern Cross Care (Victoria)

Southern Cross Care (Victoria) operates an RVCP project to deliver services into three villages owned by Southern Cross Care and a fourth village owned by Mercy Health, located in the northern and eastern suburbs of Melbourne and in the Barwon region, near Geelong. Southern Cross Care operates on a not-for-profit basis.

The organisation is an approved provider for residential aged care, Community Aged Care Packages, Extended Aged Care at Home and Home and Community Care. In addition, Southern Cross Care delivers Day Therapy Centre and National Respite for Carers Program services.

All evaluation clients were living in independent living units but RVCP packages are available to eligible residents in serviced apartments. Should a resident in a serviced apartment be accepted into the project, RVCP services would be provided in addition to services already in place through the client's serviced apartment contract. All high care places are allocated to one site.

A relatively high proportion of Southern Cross Care evaluation clients transferred to the RVCP from other programs (61%). Three RVCP care managers work across multiple programs including CACP and EACH. Salaried cross-program care workers deliver basic RVCP services; allied health services are brokered as required.

Kingston City Council

Kingston City Council RVCP covers four retirement villages in the local government area serviced by Kingston City Council in metropolitan Melbourne. Villages are owned and managed by other organisations. The council is a local government provider of Home and Community Care, Community Aged Care Packages and Veterans' Home Care (Department of Veterans' Affairs) services.

All clients were living in independent living units and care services are not available to residents from any of the participating villages. Many RVCP recipients were council clients who transferred to the RVCP from other programs (this project has recorded the highest proportion of evaluation clients with a history of formal assistance from government-funded programs—90% of clients).

RVCP care workers are salaried employees of the council, apart from a small number working under contract. All work across the council's multiple service programs.

ECH Incorporated

ECH Incorporated is the approved provider for an RVCP project in Adelaide that offers services in eight retirement villages owned and operated by ECH. All ECH RVCP recipients live in independent living units and no other care services are available through the retirement villages. ECH operates a basic level of case management called the Support Coordination Service. Support coordinators are available to assist ECH village residents to locate and coordinate community services.

ECH operates low and high level residential aged care services, including respite care and Community Aged Care Packages. In addition, ECH is a service agent for a Day Therapy Centre and Home and Community Care and has participated in Aged Care Innovative Pool pilots.

Evaluation clients in the ECH project had been living in their retirement villages for between one and 31 years. The mean length of residence of 14 years was one of the longer averages recorded by the RVCP projects. Almost half of the clients had a family carer and most carers were a son or daughter of the RVCP client.

Care workers are employed by ECH and work across multiple programs. In mid-2004, project staff included two half-time coordinators and 31 home support workers.

Aged Care Services Australia

The Aged Care Services Australia (ACSA) project delivers services into nine retirement villages, two of which are owned by The St Ives Group, ACSA's parent organisation. All villages are located in Perth, in close proximity to each other.

ACSA is a large for-profit organisation that delivers a range of aged care services including residential care, Community Aged Care Packages, Commonwealth Carelink Centres, assessment and home care coordination for Department of Veterans' Affairs clients in addition to private home care services for people in retirement villages and the wider community.

The Community Care Division employs seven care coordinators and a team of service coordinators who work across all of the community care programs including the RVCP. Care coordinators are responsible for assessment, care planning, monitoring and client review. Service coordinators administer the programs. Care coordinators work in multidisciplinary

teams that include registered nurses and social workers. ACSA employs around 145 care staff on a part-time or casual basis, and staff members work across all ACSA programs. RVCP recipients are allocated a care coordinator and services are delivered by between one and four care workers, depending on client needs and staff availability. The RVCP integrates into existing ACSA service delivery structure and processes.

Almost 60% of ACSA evaluation clients were receiving formal assistance through a government support program prior to joining the project and the majority of those clients transferred to an RVCP package from CACP. This project has recorded the highest proportion of CACP transfers (41% of evaluation clients).

Almost half of ACSA evaluation clients had a family carer at the time.

Morshead Home

Morshead Home for War Veterans and Aged Persons (Morshead Home) operates an RVCP project that offers services to residents at the Morshead Home retirement village and villages owned by Canberra Masonic Homes, Goodwin Homes and Villaggio Sant' Antonio. All six sites are located in Canberra. The project consortium represents a mix of approved providers of care packages and HACC services and new entrants to the community care sector. Morshead Home is an established provider of residential aged care (low and high care facilities are located adjacent to the retirement village) but the RVCP project is the organisation's first venture into government-funded care package delivery. A shortage of post-acute care services in the Canberra region was a principal reason for the introduction some years ago of private care packages for residents at the Morshead village. An application for RVCP funding was a logical extension of this earlier initiative.

Of the three partner organisations, Goodwin Aged Care Services (Goodwin Homes) is an approved provider for Community Aged Care packages and Canberra Masonic Homes is an approved provider for Home and Community Care and Veterans' Home Care. Villaggio Sant' Antonio does not deliver care packages apart from the RVCP. All members of the consortium operate retirement village accommodation and residential aged care facilities.

The project coordinator sited at Morshead Home has a care management and coordination role for RVCP recipients at Morshead Home and Villaggio. Canberra Masonic Homes and Goodwin Homes have their own RVCP coordinators who liaise regularly with the Morshead lead coordinator. Essentially, after a person is accepted into the project from Canberra Masonic Homes or Goodwin Home villages, they are managed independently of the Morshead coordinator. Morshead Home and Villaggio employ dedicated care staff for the RVCP; existing care staff working with care recipients in other programs deliver RVCP services at the Canberra Masonic Homes and Goodwin Home sites.

Staff turnover in the RVCP project team and within partner organisations has caused significant difficulties for the evaluation. The project made a concerted effort to recover lost ground and supply all requested information, however some gaps remain in the services and financial data.

2.2 RVCP service expenditure profile

Projects reported expenditure in the December 2004 quarter against different types of assistance delivered to care recipients, including any who did not participate in the evaluation.

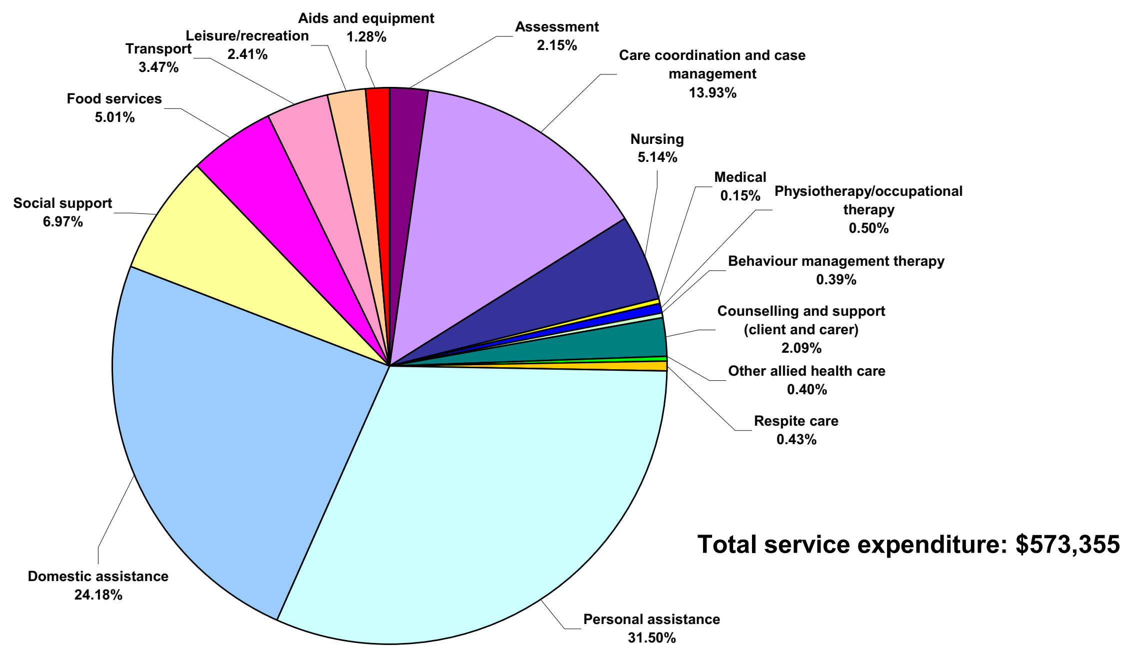
Service activity was reported against the following service categories (projects could add to the standard list of categories if necessary):

- assessment
- care coordination and case management
- nursing care
- medical services
- physiotherapy/occupational therapy
- behaviour management therapy
- counselling and support (client and carer)
- other allied health care
- personal assistance
- social support
- domestic assistance
- food services
- home maintenance
- home modifications
- home linen services
- transport
- provision of aids and equipment
- leisure and recreational programs
- centre-based day care
- respite care.

Total reported expenditure on services in the quarter ending 31 December 2004 across the projects, excluding Morshead Home, was $573,355, or approximately 71% of total expenditure reported by the nine projects. Figure A2.1 illustrates a breakdown of expenditure on services to care recipients. It should be noted that each project is delivering a subset of the listed service types.

Over 85% of total services expenditure in the RVCP for the quarter ending 31 December 2004 comprised expenditure on five service categories: personal assistance (32%), domestic assistance (24%), care coordination and case management (14%), social support (7%), nursing services (5%) and food services (5%).

The pie chart of expenditure on care recipient services has been replicated for each project using the financial results reported by the project to highlight different patterns of expenditure (see project expenditure profiles in Part B). Neither the service expenditure profiles nor client level service profiles show consistency across projects within the pilot models (RVCP as a stand-alone program versus RVCP integrated into existing community care program delivery systems).



Note: Excludes Morshead Home project.

Source: Appendix Table A11.

Figure A2.1: RVCP projects, combined expenditure on services to care recipients in the quarter ending 31 December 2004

2.3 Care recipient profiles

An estimated 79% of RVCP recipients who were active from July to December 2004 participated in the national evaluation (Table A2.2). The evaluation recorded data on 238 care recipients and 104 family (or friend) carers.

Age and sex

Projects have targeted very old residents in retirement villages. Fifty per cent of evaluation participants were aged 85 years or over (Table A2.3). Women comprised approximately three-quarters of the evaluation group.

Table A2.2: RVCP, number of care recipients and evaluation participants by discharge status and project, July to December 2004

		RVCP care recipients July–December 2004		Evaluation participants 26 July–30 November 2004		
Project	Place allocation	Number[(a)]	Total discharges	Number	Discharges to 30/11/2004	Participation rate (%)
HN McLean Memorial Retirement Village, NSW	20	24	4	20	2	83.3
Australian Unity RLS, NSW	53	30	7	21	5	70.0
Morshead Home, ACT	25	33	9	19	5	57.6
Forest Place, Qld	27	33	6	28	6	84.8
Southern Cross Care, Vic	25	30	5	18	2	60.0
Kingston City Council, Vic	22	26	6	23	2	88.5
ECH Incorporated	35	42	7	38	3	90.5
Resthaven Incorporated, SA	15	16	2	14	1	87.5
Mandurah Retirement Village, WA	18	22	4	20	3	90.9
Aged Care Services Australia, WA	40	47	7	37	4	78.7
Total	**280**	**303**	**57**	**238**	**33**	**78.5**

(a) Sum of September quarter active care recipients and December quarter commencements.

Sources: September and December quarter occupancy reports, courtesy Australian Government Department of Health and Ageing (total care recipients); RVCP evaluation database.

Table A2.3: RVCP evaluation, number and per cent of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
Less than 65	1	2	3
65–74	4	12	16
75–84	26	72	98
85+	31	90	121
Total	**62**	**176**	**238**
		(per cent)	
Less than 65	0.4	0.8	1.3
65–74	1.7	5.0	6.7
75–84	10.9	30.3	41.2
85+	13.0	37.8	50.8
Total	**26.1**	**73.9**	**100.0**

Average age is consistent across the projects; greater age variation was observed in some projects during the evaluation (Figure A2.2). Each box in Figure A2.2 represents the middle 50% of client ages in a project—the lower edge aligns with the 25th percentile age, the upper edge aligns with the 75th percentile age and the heavy line that typically bisects a box is the median, or 50th percentile age. Low and high age outliers, or extreme values, are marked with a circle.

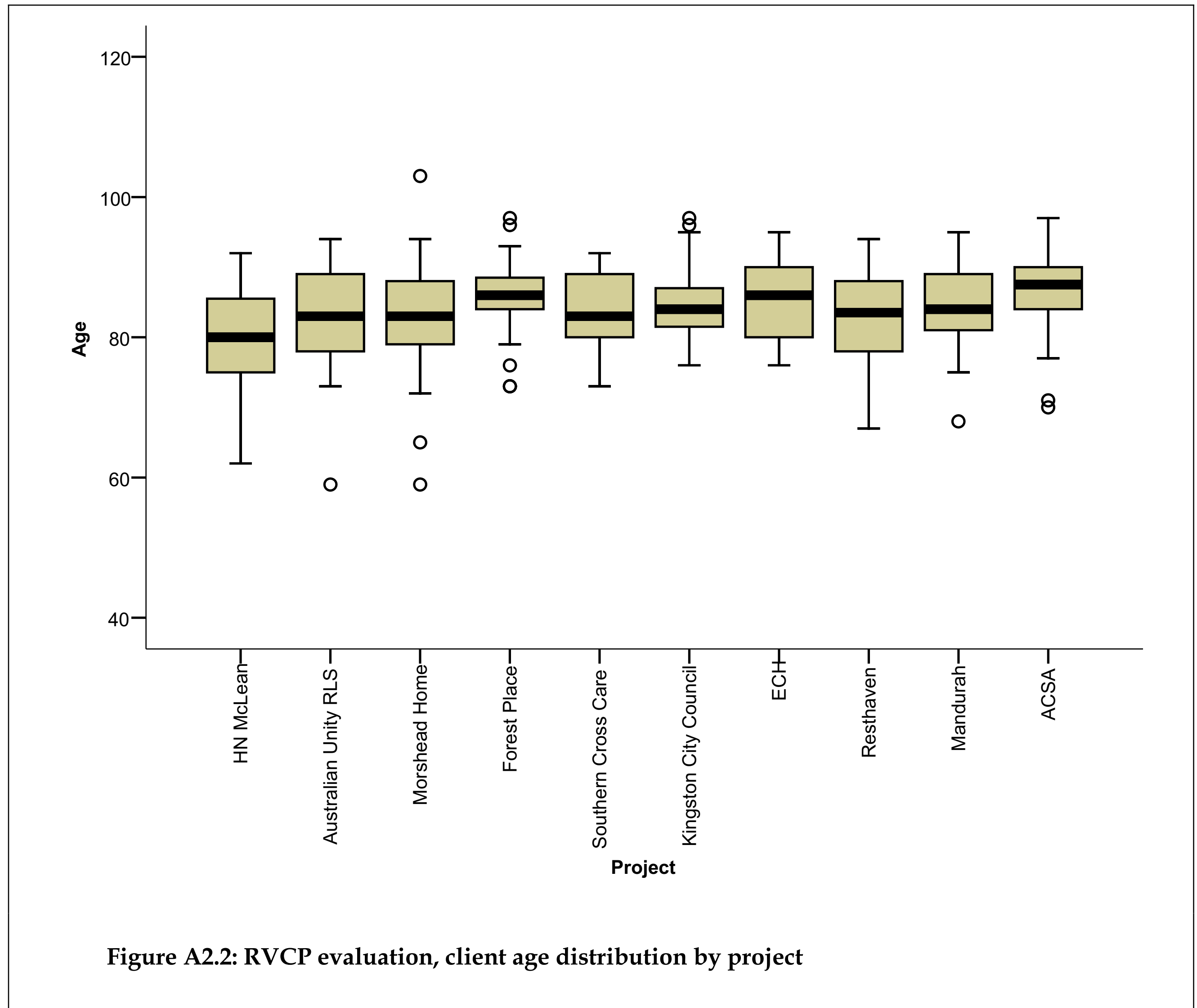


Figure A2.2: RVCP evaluation, client age distribution by project

Living arrangements and carer availability

Eighty-four per cent of clients were living in independent living units during the evaluation. Prior to the RVCP, clients in independent living units did not receive care services from their retirement village. The most structured form of assistance was in the form of information and referral services, for instance, the ECH Support Coordination Service. The other 16% of clients were living in serviced apartments. Residents in serviced apartments ordinarily pay for a minimal level of domestic assistance through a retirement village service contract, for example, two hours per week.

Eighty-one per cent of clients were living alone. Overall, 44% of clients had a carer (Table A2.4). Age and co-residency profiles of carers reflect the fact that the RVCP is catering to a high proportion of very old residents. There is a high rate of non-resident carers: 75% of carers were not living with the RVCP recipient and 64% of carers were a son, daughter, or

son- or daughter-in-law (Table A2.5), which is in turn reflected in a mostly middle-aged carer group. Two projects, Resthaven in South Australia and Mandurah Retirement Village in Western Australia, recorded lower rates of carer availability compared to other projects.

Table A2.4: RVCP evaluation, number of clients by living arrangement and carer availability

Usual living arrangement	No carer	Has a carer	Total
		(number)	
Lives alone	117	76	193
Lives with family	16	24	40
Lives with others	1	4	5
Total	**134**	**104**	**238**
		(per cent)	
Lives alone	49.2	31.9	81.1
Lives with family	6.7	10.1	16.8
Lives with others	0.4	1.7	2.1
Total	**56.3**	**43.7**	**100.0**

Table A2.5: RVCP evaluation, number of carers by relationship of carer to client

	Carer co-residency status			
Relationship of carer to client	Not co-resident	Co-resident	Not stated	Total
Spouse/partner	3	23	—	**26**
Son or daughter	61	2	—	**63**
Son- or daughter-in-law	3	—	—	**3**
Other relative	8	1	—	**9**
Friend/neighbour	1	—	—	**1**
Not stated	1	—	1	**2**
Total	**77**	**26**	**1**	**104**

— Nil.

In addition to carer availability, frequency of social interaction, defined as visits or contact with family or friends outside the household, was recorded. The results demonstrate that living in a retirement community does not guarantee against social isolation. Approximately 14% of clients did not have regular visits from family or friends and just under 5% had infrequent or no social interaction—visits or contact—with people outside of the household. Among the 193 clients who were living alone, 31 (16%) were reported to have no regular visits from family or friends.

Government program support

Over half the evaluation clients (58%) were not receiving assistance through government-funded community care programs before joining the RVCP, although in Figure A2.3 this proportion is seen to vary by project—from 9% for Kingston City Council to 86% for Mandurah Retirement Village. Thirty-five of the 39 clients (90%) living in serviced apartments did not receive assistance through government support programs before the RVCP. Approximately 20% of clients across the projects were receiving HACC services and an additional 3% were receiving HACC and Veterans' Home Care services simultaneously. Nine per cent of clients transferred from CACP to the RVCP, often to achieve the efficiency of one set of care workers for all RVCP recipients in a village. The majority of CACP transfers are in the Aged Care Services Australia project (ACSA is an established CACP provider).

The proportion of clients with previous use of government-funded community care services was considerably higher in each of the two Victorian projects—Kingston City Council and Southern Cross Care Victoria. Both organisations are providers for the Home and Community Care Program, which is jointly funded by the Australian and State/territory governments, and the RVCP projects operated by Kingston City and Southern Cross recorded relatively high rates of transfer from HACC services to the RVCP. Australian Unity Retirement Lifestyle Services and Forest Place Retirement Village projects each recorded 80% or more clients with a history of no previous government program support. Mandurah Retirement Village also recorded a high proportion of clients with no previous government program support (75%).

Data from Forest Place Retirement Village suggest that older self-funded retirees may be more likely to delay accessing government-funded community aged care, drawing on private resources to meet their needs. Since the Forest Place RVCP project exclusively targets residents in serviced apartments, it is possible that the service use histories of clients at Forest Place reflect access barriers to HACC-funded services; indeed, staff at Forest Place indicated that HACC service agencies do not accept referrals for serviced apartment residents because they are deemed by the agencies to be receiving HACC-type services through their serviced apartment contracts. HACC is the largest government-funded program for community-based care to frail older people and younger people with disabilities and the Program delivers a comprehensive range of service types. If a resident receives a specific service through their retirement village service contract (such as laundry services), then HACC will not fund laundry services. However, the person may be eligible for other types of HACC assistance, for example, home nursing etc.[1]

History of respite care use prior to the RVCP is known for 124 clients, of whom only 11 had used respite care, with residential respite being a more common experience than in-home respite.

A waiting for placement indicator was recorded for 130 clients. Twenty-two clients are known to have been on a waiting list for residential aged care; 108 clients are known to have not been on a waiting list (waiting list status of 108 clients is missing or unknown). Sixteen

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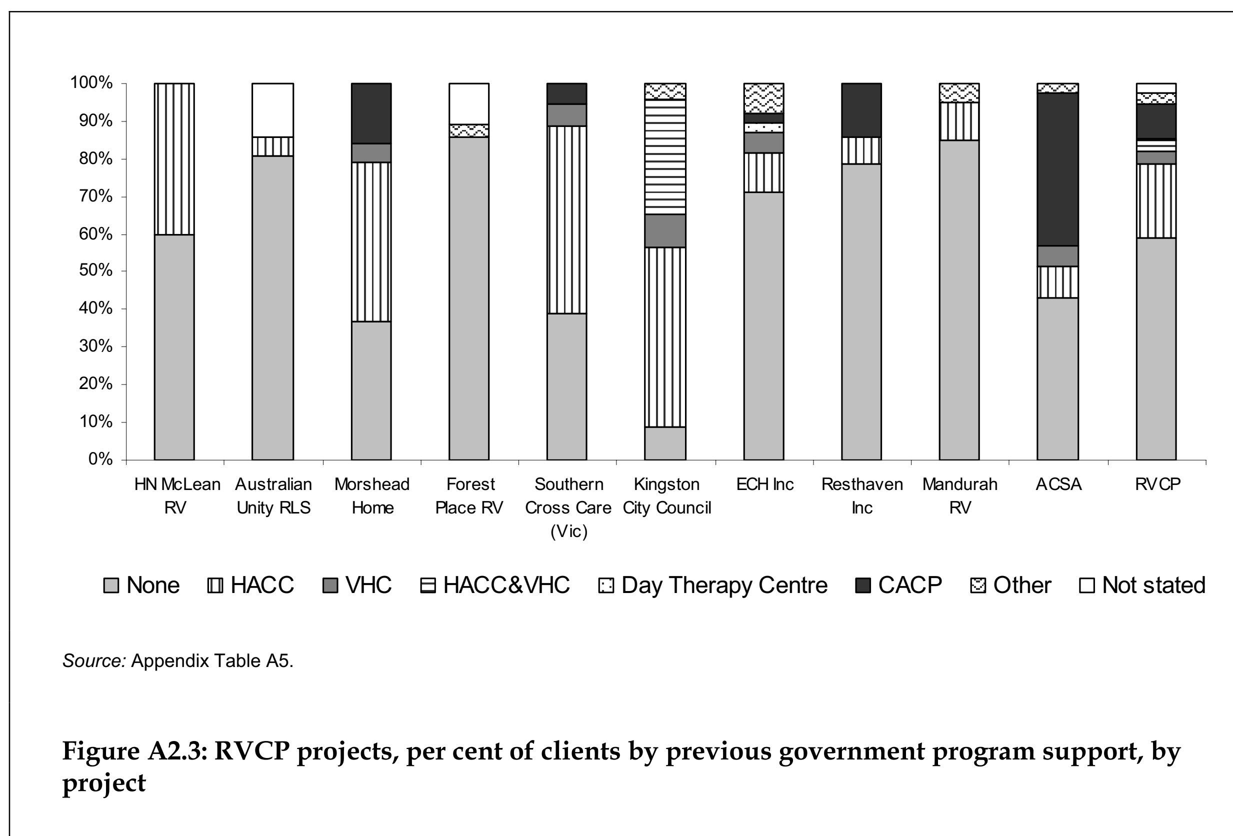
1 The National Program Guidelines for the Home and Community Care Program 2002 state: 'For example, the HACC Program does not generally provide services to residents of aged care homes or to recipients of disability program accommodation support service, when the aged care home/service provider is receiving government funding for that purpose. Nor does it generally serve residents of a retirement village or special accommodation/group home when a resident's contract includes these services…Residents of retirement villages or independent living units are eligible for HACC services except when a resident's contract includes these services'. (p. 9).

clients on a waiting list for permanent placement are recorded as not having used respite care prior to joining the RVCP.

Most clients relied on an Australian Government pension as the primary source of cash income. Primary source of cash income was recorded for 200 clients—54% received the Age Pension, 17% received a pension from the Department of Veterans' Affairs and 2% received the Disability Pension (Appendix Table A4). A higher proportion of superannuants is found in the Forest Place project than in other projects (50% of evaluation clients at Forest Place reported superannuation or annuities as their primary source of income).



Source: Appendix Table A5.

Figure A2.3: RVCP projects, per cent of clients by previous government program support, by project

Referral and assessment

A person needs ACAT approval for low or high level residential care, or equivalent, to be considered for RVCP services. The projects are funded on the basis of a mix of clients with low and high care approvals, with the mix varying across the projects. ACAT approvals for RVCP eligibility purposes include 13 approvals for high care, or 5.5% of clients (Table A2.6).

The projects have used different processes in relation to the sequencing of ACAT assessment and initial needs assessment following a referral and these are outlined under 'Referral and assessment' in the project reports in Part B. A number of factors influenced the timing of initial needs assessment. A resident referred by a third party may need time to consider pursuing the option of a care package, which can lead to delay following a referral; cost was reported to have deterred some people; and in many cases, initial needs assessment was performed only when ACAT approval had been obtained (43% of referrals were received for clients who had not completed ACAT assessment).

Seventy-nine per cent of clients had completed the ACAT assessment that served to confirm eligibility before undergoing an initial needs assessment by an RVCP care manager, typically the project coordinator. Most clients (95%) completed the eligibility ACAT assessment before or within 30 days of initial needs assessment. However, service commencement does not always follow immediately on from initial needs assessment.

Projects were asked to record a service commencement date if the initial needs assessment date did not coincide with service commencement for an individual client. In total, 205 clients (86%) had completed an ACAT assessment within one year prior to commencing RVCP services. Eight clients are recorded as not having a valid ACAT approval at the time that services commenced: these approvals dated back to 1998, 2001 and 2002 and all involved clients who transferred to the RVCP from CACP. A further 25 clients completed ACAT assessment after commencement of RVCP services, in most cases because of delays in obtaining ACAT assessments and the difficulty that this has sometimes caused when a person referred to a project has already completed initial needs assessment.

Project coordinators reported some lengthy delays for ACAT assessment of people who did not have approval before being referred to an RVCP service. It is thought that in many cases a low priority was attached to requests for ACAT assessment of potential clients. The experience of individual projects in facilitating ACAT assessment for the RVCP is outlined in project reports (Part B).

Sources of referral vary by project. Over one-third of clients were referred by staff at a retirement village. Self-referral and referrals from family members were the next most common sources of referral, stemming mainly from promotion of the Pilot in the retirement communities. Most villages or approved providers held information sessions in the early stages of project establishment. Involvement of neighbours and friends in the care of residents is also evident in the pattern of referral.

Table A2.6: RVCP evaluation, number of low and high care ACAT approvals by project

	ACAT approval		
Project	**Low care**	**High care**	**Total**
HN McLean Memorial Retirement Village	18	2	20
Australian Unity Retirement Lifestyle Services	19	2	21
Morshead Home	19	—	19
Forest Place Retirement Village	21	7	28
Southern Cross Care (Victoria)	18	—	18
Kingston City Council	23	—	23
ECH Incorporated	37	1	38
Resthaven Incorporated	13	1	14
Mandurah Retirement Village	20	—	20
Aged Care Services Australia	37	—	37
Total	**225**	**13**	**238**

The ACAT approval used to establish client eligibility does not necessarily reflect a client's needs at a point in time. A client may have completed an assessment some months before

referral to a project and experienced change in the intervening period. Functional measures recorded for the evaluation reveal that a proportion of RVCP care recipients experienced change in functional status (improvement or deterioration) during the evaluation. This has been confirmed by reports of client reassessment and review (by ACAT and/or project coordinators). For example, two Forest Place evaluation clients with low care approval were reassessed by ACAT in April and May of 2005 and approved for high care; five clients with low care approvals in the ECH project were also approved for high care after the evaluation. Routine review of clients in the Resthaven project revealed that four clients with ACAT approval for low care in fact required and were receiving high level care (ACAT reassessment had not been pursued because the project could continue to meet these clients' increased needs).

One or more of the following factors could have contributed to the need for a further ACAT assessment of some clients:

- exit planning for a client whose needs were approaching a level or type of care that could not be appropriately supported in the community or by an RVCP service
- response to a client's expressed preference to prepare for residential placement in the short to medium term
- expiration of 12 months since the last ACAT assessment.

Functional profiles

The evaluation recorded three sets of functional status measure. The first set is the level of core activity limitation experienced by each client. Core activities include self-care, mobility and communication. Level of core activity limitation was reported for 237 clients. These measures were recorded to enable comparison of RVCP care recipients with other groups of care recipients, for example, CACP. A second functional measure is a composite ADL measure of self-care and mobility function from the Modified Barthel Index (MBI). This is a useful numeric score that reflects need for personal assistance. The third measure is a score for functioning in instrumental ADL (IADL) using the OARS IADL scale.

Severe or profound core activity limitation was recorded for 33 clients, representing 14% of the 237 clients with non-missing data. Eighteen clients recorded one severe or profound core activity limitation and 15 recorded two severe or profound core activity limitations (8% and 6% of non-missing values respectively).

Core activity limitation is most prevalent in the areas of self-care and mobility. In both areas, higher proportions of clients fall into the categories of mild to moderate activity limitation (Table A2.7).

Table A2.7: RVCP evaluation, number of clients by level of core activity limitation

	Level of activity limitation					
Core activity	No limitation	Mild	Moderate	Severe or profound	Not stated	Total
Self-care	46	97	73	21	1	**238**
Mobility	30	119	67	21	1	**238**
Communication	177	43	11	6	1	**238**

Projects recorded baseline ADL and IADL scores for clients as at the date of initial needs assessment. The reconstruction of each client's baseline scores drew on the Aged Care Client Record and file notes from screening and needs assessment processes.

ADL scores range from zero to 20, with 20 points representing independence in all self-care and mobility items on the instrument. The IADL scale ranges from zero to 14, with 14 points representing independence in instrumental ADL, such as shopping, meal preparation and medication use.

The ADL profiles of projects differ. Entry scores across the projects ranged from 5 to the maximum possible 20 points, with a median of 17 points. Figure A2.4 shows the distribution of ADL scores by project in the form of a box plot, revealing that both the location and spread of baseline ADL scores differ from project to project. ECH, Mandurah and Southern Cross Care (Victoria) have noticeably higher medians (higher average level of function) and the former two projects also have more homogeneous client groups in terms of ADL functional capacity. Forest Place Retirement Village recorded a noticeably lower median ADL score. MBI distributions for Forest Place and Kingston City Council show a relatively high degree of variation. Low and high outliers, or extreme values, are marked with an asterisk or circle. Most projects have at least one client with an extremely low baseline ADL score compared to the rest of the group.

Entry IADL scores range from zero to 13 points, with a mean of 7.8 points (Table A2.8).

These results indicate wide variation in functional measures of clients entering RVCP projects. All clients had lost some instrumental ADL function; however, the extent of loss varies from needing assistance in just one area of activity (a score of 13 points) to complete dependency.

Table A2.8: RVCP evaluation, baseline ADL and IADL scores

Variable	Number	Minimum	Median	Maximum	Mean	Std dev.
Baseline ADL (MBI)	229	5	17	20	16.3	3.0
Baseline IADL	228	0	8	13	7.8	2.8

Note: Missing baseline ADL scores for nine clients; missing baseline IADL scores for 10 clients.

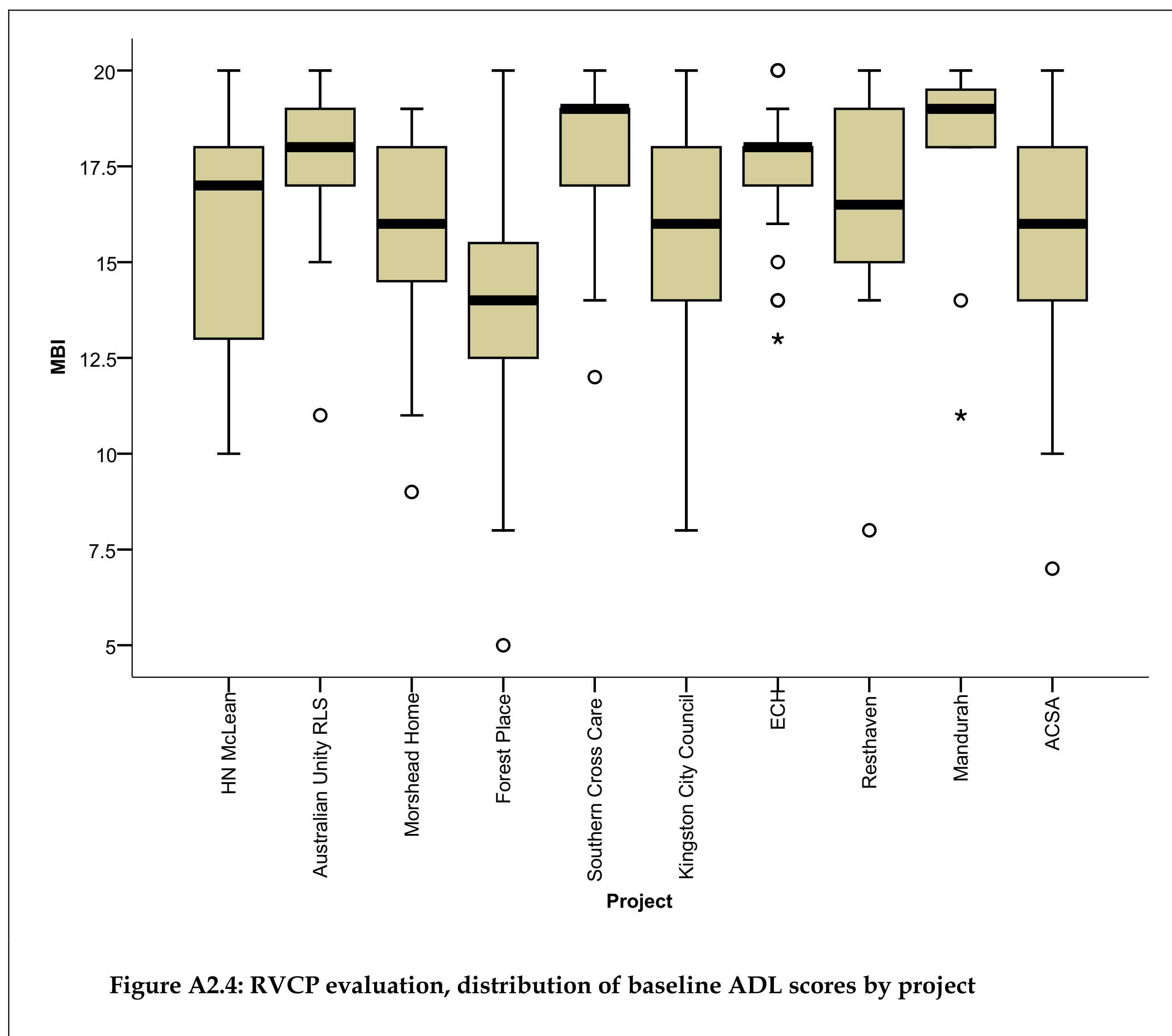


Figure A2.4: RVCP evaluation, distribution of baseline ADL scores by project

Slightly lower numbers of clients recorded ADL and IADL scores at first and second functional assessments (Tables A2.9 and A2.10). The time between assessments varied from client to client, averaging around 16 weeks in most projects. Across the projects, change scores on each scale were distributed symmetrically around a median of zero and showed variation from marked deterioration in functional capacity (minimum change scores of –13 for ADL and –9 for IADL) to marked improvement (maximum change scores of 11 points for ADL and 8 points for IADL).

Table A2.9: RVCP evaluation, summary statistics for ADL change scores: second assessment score minus entry assessment score

Measure	Number	Minimum	Median	Maximum	Mean	Std dev.
Baseline ADL	215	7	17	20	16.36	2.897
Change in ADL	215	–13	0	11	0.218	2.351

Table A2.10: RVCP evaluation, summary statistics for IADL change scores: final assessment score minus entry assessment score

Measure	Number	Minimum	Median	Maximum	Mean	Std dev.
Baseline IADL	214	1	8	13	7.9	2.7
Change in IADL	214	–9	0	8	0.0	1.8

Health profiles

Over 60% of primary health conditions recorded for clients on entry to projects fall into one of four disease categories: diseases of the musculoskeletal system, circulatory system diseases, nervous system diseases and dementia (Table A2.11). Musculoskeletal conditions are the highest frequency primary health conditions, with arthritis and related diseases featuring prominently. Also represented in this category are back problems and osteoporosis. After arthritis, dementia is the most frequently reported single-condition primary health condition.

The preponderance of musculoskeletal disease as a primary health condition is reflected in other indicators recorded for the evaluation. Projects recorded the presence or absence of a select number of physical and sensory conditions for each client, including risk of falls due to impaired gait or balance, paralysis, missing or non-functioning limbs, depression and disorientation. By far the most common of these conditions were risk of fall due to gait or balance abnormality (67% of clients), hearing impairment (38% of clients) and vision impairment (37% of clients).

The number of health conditions per client varied from one to 10. Sixty-three per cent of clients had four or more health conditions at time of entry to a project and approximately 75% of clients were taking four or more different medications (Table A2.12). Health care, particularly medication management, is an important issue for this group.

Table A2.11: RVCP evaluation, number and per cent of clients by disease category of primary health condition

Disease category	Number of clients	Per cent
Diseases of the musculoskeletal system and connective tissue	55	23.1
Diseases of the circulatory system	37	15.5
Diseases of the nervous system	28	11.8
Dementia	25	10.5
Diseases of the respiratory system	17	7.1
Diseases of the eye and adnexa	14	5.9
Neoplasms	12	5.0
Endocrine, nutritional and metabolic disorders	11	4.6
Injuries, poisoning and toxic effects	10	4.2
Other mental and behavioural disorders	8	3.4
Symptoms and signs	6	2.5
Diseases of the digestive system	5	2.1
Diseases of the genitourinary system	3	1.3
Diseases of the ear and mastoid process	2	0.8
Diseases of the skin and subcutaneous tissue	2	0.8
Total stated	235	98.7
Not stated	3	1.3
Total	**238**	**100.0**

Table A2.12: RVCP evaluation, number and cumulative per cent of clients by number of health conditions and number of medications in use at time of entry to RVCP

	Health conditions		Medications	
Count	**Number of clients**	**Cumulative per cent**	**Number of clients**	**Cumulative per cent**
0	—	—	5	2.4
1	16	6.7	7	5.7
2	23	16.4	22	16.2
3	49	37.0	19	25.2
4	62	63.0	29	39.1
5	50	84.0	33	54.8
6	21	92.9	26	67.1
7	7	95.8	23	78.1
8	3	97.1	16	85.7
9	5	99.2	5	88.1
10 or more	2	100.0	25	100.0
Total	**238**	**100.0**	**210**[(a)]	**100.0**

(a) Missing values for 28 clients.

Projects reported client use of medical and hospital services in the 6 months prior to entering the RVCP. These data are sourced from self or informant reports, that is, they are not administrative by-product data. Although the data are thought to be reliable, where reported, the AIHW is unable to confirm that they give complete coverage of the use of medical and hospital services by RVCP clients in the 6 months immediately prior to joining a Pilot project.

Data on medical consultations prior to entry were recorded for 193 clients (missing for 45 clients). It was established that 96 clients had not visited a hospital emergency department and had not been admitted to hospital in the 6 months prior to entry. Another 96 clients had used hospital services in the 6 months prior to entry but details are not available for four of these clients. Use of hospital services in the 6 months prior to entry is unknown for 46 clients.

All care recipients in the evaluation reported use of medical services in the 6 months prior to joining the RVCP and a proportion reported frequent use. According to self-reports, care recipients consulted a medical practitioner outside of a hospital setting on average once a month in the 6 months prior to joining an RVCP project. The reported number of consultations varied from one to 24 per client per 6 months; 16% of the group reported more than 10 medical consultations in the six months prior to joining the RVCP. In addition, 39% of clients reported hospitalisation (urgent/unplanned or planned) in the 6months prior to entry.

Sixty-seven clients, or 28% of the evaluation group, recorded urgent or unplanned hospital admissions in the 6 months before joining the RVCP that contributed to an average of around 18 patient days per hospitalised client over a 6-month period (a total of 90 urgent/unplanned admissions were recorded across the client group). The use of hospital emergency departments by this group of clients in the 6 months prior to joining an RVCP project is recorded as follows:

- 54 clients entered hospital via an emergency department and/or visited an emergency department on other occasions. The number of visits to hospital emergency departments varied from one to 13 per client
- 11 clients did not present to an emergency department
- previous use of emergency departments is not recorded for two clients.

Thus, the group of clients who were admitted to hospital in the 6 months before joining RVCP on an urgent or unplanned basis also made heavy use of hospital emergency departments during that period.

Use of hospital services, including emergency departments, by RVCP clients was tracked for 18 weeks during the evaluation. During this period, 47 clients (20%) recorded a total of 67 urgent or unplanned admissions to hospital, contributing to an average of 12.8 patient days per client. Only three clients are recorded as having presented to an emergency department during this period, one of whom was subsequently admitted to hospital. In the group of clients who were admitted to hospital during the evaluation data capture period are some who had had urgent/unplanned admissions before joining the RVCP and others who had not used hospital services at all before joining RVCP.

In summary, between one-fifth and one-quarter of people in the group can be expected to have unplanned or urgent hospital admissions when tracked for between 4 and 6 months. While the evaluation revealed no strong evidence of a reduced rate of hospital admission, the evaluation data capture period coincided with substantially reduced use of hospital emergency departments (assuming that all events were recorded) compared to self-reports of use prior to joining the RVCP. There were far fewer visits to emergency departments in

absolute terms and relative to the number of unplanned hospital admissions in the corresponding time intervals, that is, approximately 81% of the clients who had urgent/unplanned hospital admissions before joining the RVCP recorded emergency department visits, compared with only 2% (one client out of 47) of clients who recorded urgent/unplanned admissions during the evaluation data capture period.

Emergency department triage is a common pathway to urgent/unplanned hospital admission, the other being general practitioner (GP) consultation. Given the greatly reduced use of emergency departments, we reviewed the entire (self-report) health service use records of RVCP clients who recorded urgent/unplanned hospital admissions during the evaluation. Most clients had records of GP consultations that took place within days of hospital admission. The data provide indications that, at the time of receiving RVCP services, clients were more likely to enter hospital, when acute care was required, through their GP than through emergency department triage. The avoidance of waiting in an emergency department has major benefits for patients and admission via a GP reduces use of hospital emergency departments.

It is not possible to establish a causal link between changed patterns in referral and admission for hospital services because there is no valid comparison or control group with which to compare the reported outcomes for RVCP clients. However, the evaluation has established that during a given period of time a significant proportion of RVCP recipients are at risk of urgent or unplanned hospitalisation and this has implications for use of emergency departments. Quantitative results presented above provide circumstantial evidence of the impact of RVCP services on clients' use of hospital emergency departments and this is supported by qualitative evidence in the form of case studies that highlight the active role of RVCP case managers and care workers in monitoring clients' health status and providing assistance to seek professional help. The reader is referred to case studies and reports in Part B, especially those from HN McLean Memorial Retirement Village (section 1.2); Morshead Home (section 3.2); Southern Cross Care (section 5.2); Kingston City Council (section 6.2); Resthaven (section 8.2); Mandurah Retirement Village (section 9.2); and Aged Care Services Australia (section 10.2), for examples of interactions between RVCP staff and health services, and examples of medication management and the close monitoring of clients following hospitalisation to minimise injury and build confidence.

2.4 Carer profiles

Forty-four percent of care recipients were also receiving assistance from family carers. This section summarises data on family carers recorded for the evaluation to provide a picture of informal care as a source of assistance for the target group.

Among carers with known age, over half were aged less than 65 years during the evaluation, which is consistent with the high representation of sons and daughters caring for a parent (Table A2.13).

Case studies in Part B highlight the involvement of younger family members in decisions surrounding long-term care plus the mutual caring arrangements of couples in retirement villages. Feelings of relief among family members that parents are being cared for appropriately, relief among older people that they present less of a 'burden' to their families, knowledge that assistance is at hand if needed, and the desire to keep couples in self-care units together have emerged from case study reports and the Care Experience Survey (the last part of the questionnaire contains questions for family carers). Aspects of informal care

for RVCP clients are reported in the Care Experience Survey results (Appendix 2) and in case reports in Part B.

Table A2.13: RVCP evaluation, number of carers by age group and sex

	Sex			
Age (years)	**Male**	**Female**	**Not stated**	**Persons**
		(number)		
Less than 35	1	—	—	**1**
35–49	4	12	—	**16**
50–64	6	24	—	**30**
65–74	3	7	—	**10**
75–84	4	8	1	**13**
85+	6	5	—	**11**
Not stated	3	19	1	**23**
Total	**27**	**75**	**2**	**104**
		(per cent)		
Less than 35	1.0	—	—	**1.0**
35–49	3.8	11.5	—	**15.4**
50–64	5.8	23.1	—	**28.8**
65–74	2.9	6.7	—	**9.6**
75–84	3.8	7.7	1.0	**12.5**
85+	5.8	4.8	—	**10.6**
Not stated	2.9	17.3	1.0	**22.1**
Total	**26.0**	**72.1**	**1.9**	**100.0**

— Nil.

Assessment of carer strain was included in the evaluation protocol because of the widely reported association between carer strain and long-term care outcomes. It is also informative to examine informal care arrangements and their effects within retirement communities. Sixty-one carers completed the Caregiver Strain Index (Robinson 1983) at a baseline assessment, either at the start of the evaluation or at entry to a project, according to when the RVCP recipient commenced services. Where possible, the assessment was completed approximately 16 weeks later. Final assessments were often not performed for carers whose care recipient was discharged unexpectedly or under difficult circumstances, for example, death or admission to hospital.

Almost half (49%) of the baseline CSI scores screen positive for carer strain and a similar proportion (51%) of baseline scores for carers with a repeat assessment indicate carer strain at the time of the assessment. The distribution of change scores (final CSI score minus baseline CSI) has a median of zero and a mean of –1.2, that is, a distribution centred at zero (no change) and skewed by one or more carers who experienced a marked reduction in strain over the measurement period (Table A2.14). The mean change score of –1.2 points on the CSI is statistically significant at the 5% level of significance ($t = -3.076$, prob < 0.01). Among carers who completed baseline and final assessments, a lower proportion (30%) screened positive for carer strain at the final assessment than at initial assessment.

Table A2.14: RVCP carers, baseline and change scores for Caregiver Strain Index

Variable	Number	Minimum	Median	Maximum	Mean	Std dev.	Positive screen (number)
Baseline CSI (all carers with baseline CSI)	61	0	6	16	6.0	3.5	30
Baseline CSI (carers with baseline and final CSI)	43	0	7	12	5.9	3.4	22
Change in CSI between baseline and final assessments	43	–7	0	3	–1.2	2.5	13

2.5 Summary

The RVCP has targeted very old and predominantly female residents in retirement villages. The majority of recipients at the time of the evaluation were living in independent living units and did not have access to care services from their retirement village prior to the RVCP. Residents in serviced apartments who received a minimal level of domestic assistance (for example, two hours of house cleaning and laundry per week) were paying for that service to be provided in addition to the cost of accommodation.

Over 80% of care recipients lived alone and 44% had a family carer, who was most often a son or daughter who lived in another household. These two characteristics distinguish the care recipient group from the CACP recipient population, for example, where there are higher rates of family carer availability and carer co-residency (AIHW 2004a). Prior to the RVCP, assistance from non-resident family members was the most common source of assistance to RVCP recipients.

In most projects, the RVCP is the first experience of government-funded community care for between 60% and 80% of care recipients.

A high proportion of RVCP recipients are heavy users of health services, particularly pharmacy and medical services. Sixty-three per cent of clients had four or more health conditions at time of entry to a project and approximately 75% of clients reported taking four or more different medications.

Approximately 14% of recipients experienced severe or profound limitation in the core activities of daily living (self-care, mobility and communication). For the majority of RVCP recipients, the major needs for ongoing assistance are in the areas of instrumental activities of daily living.

3 A comparison of RVCP with mainstream care packages

One of the aims of the evaluation was to identify the novel features of RVCP packages and highlight whether and how they might differ from care packages delivered through the Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) programs.

The RVCP was designed to enable providers to deliver services across the range of care needs. Across the board, 20% of RVCP places are funded for high care and 80% for low care. Acceptance of a person for an RVCP package is subject to ACAT approval for at least low level residential care. While the high care proportion of a project's place allocation varies from project to project, the Pilot gave all providers the capability to manage a client group with diverse levels of need for assistance that span service levels seen in CACP and EACH. Fourteen per cent of evaluation participants had a severe or profound level of core activity limitation. For the majority of RVCP recipients during the evaluation, the need for assistance was related to instrumental activities of daily living (IADL include domestic chores, travelling away from home, meals, shopping, medication use, telephone use and management of personal finances) rather than self-care and mobility needs. Leaving aside 10 clients with missing baseline scores, all clients needed assistance in at least one IADL and 84% of clients had IADL scores of 10 points or fewer out of 14, equating to complete dependency in two or more IADL or at least partial dependency in more than two IADL.

CACP aims to deliver planned and coordinated packages of care to help older people with moderate or severe disabilities remain living in their own homes. CACP services offer a range of assistance including help with personal hygiene, social support, transport, food services and gardening. Older people are referred to an Aged Care Assessment Team to determine eligibility for a CACP. On 30 June 2004, 25,722 people aged 65 years or over were registered CACP care recipients (AIHW 2005). Based on results of a CACP Census in 2002, over 80% of CACP recipients aged 65 years or over had a severe or profound core activity limitation, both overall and in each 5-year age group (AIHW 2004a).

The EACH program is designed to deliver to home-based care recipients a standard of nursing and personal care that is equivalent to high level residential care. In 2003–04, over 900 EACH packages were available for people to receive this type of care in their homes through 56 approved service providers nationally (DoHA 2005b). An older person must be assessed and approved by an Aged Care Assessment Team in order to access an EACH package. A census of EACH conducted by the AIHW in 2002 revealed that 100% of recipients experienced severe or profound limitation in self-care (98%of recipients also had a severe or profound mobility limitation).

This chapter examines the main features of RVCP, CACP and EACH packages using RVCP evaluation data and published data from the EACH and CACP censuses of 2002.

3.1 Novel features of RVCP packages

A number of RVCP service providers are also approved CACP providers and have been able to comment on differences between the two models of care provision and how the RVCP has

enabled them to meet the needs of clients participating in the pilot. New providers have focused their discussions on how the RVCP has enabled them to meet the needs of individual clients.

Aspects of service provision that differentiate RVCP packages from mainstream program delivery were found to be primarily related to the targeting of residents in retirement villages, service level flexibility, and the service mix.

Targeting

Service providers value the targeted nature of the RVCP because they believe that residents in retirement villages have trouble accessing mainstream care packages.

Cost efficient service delivery is a demonstrated benefit of narrow targeting and this was found to have advantages for service providers and care recipients. Specifically, a co-located care recipient group removes or minimises staff travel costs, which has the potential to increase the amount of direct care per dollar spent. These efficiencies appear to be greatest when there is an on-site and/or dedicated RVCP staff. Where the RVCP is integrated into a service delivery system for (multiple) other programs, similar efficiencies are possibly only achieved if a critical number of care recipients are co-located in the participating villages.

Two main benefits to care recipients arise. During the evaluation it was apparent that any delays in client commencement were related to ACAT assessment, rather than package availability. Thus, eligible residents have benefited from virtually immediate service delivery, which is unlikely to have been the case for a relatively high proportion of these recipients given prevailing waiting lists and priorities for mainstream packages. Second, the RVCP has encouraged retirement villages to establish care package services that they did not previously operate. In some RVCP models, care recipients benefit from a familiar, potentially more stable, staff, and a personalised level of service delivery made possible by on-site service provision. At relatively low cost, on-site staff can make frequent short visits for monitoring, medication management, and social support.

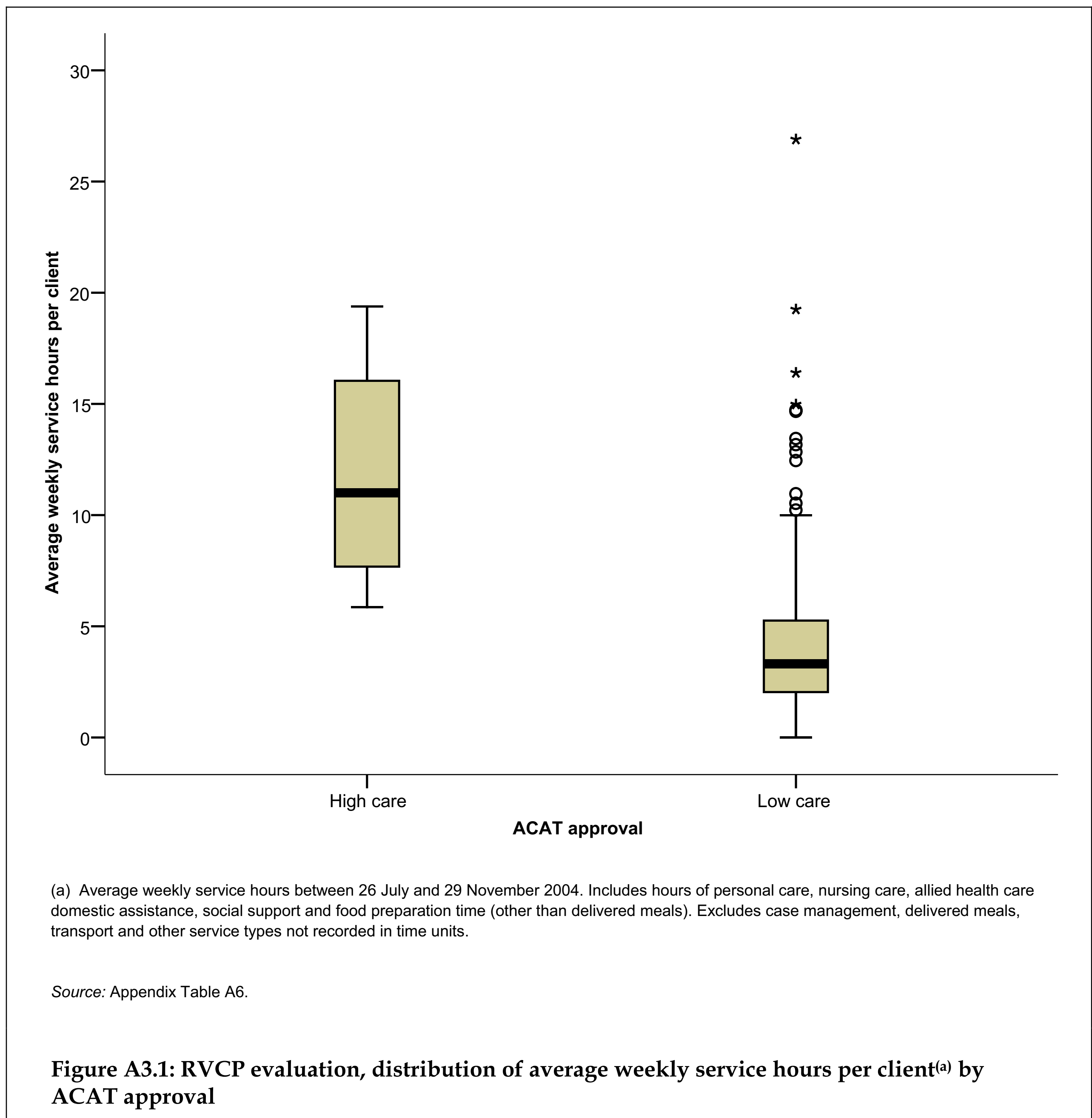
The evaluation found no evidence of widespread levels of existing services to residents in independent living units from their villages other than in the form of accommodation. The Care Experience Survey indicated that some RVCP recipients had been purchasing services privately but had remaining unmet needs. Only in the case of care recipients in serviced apartments does an RVCP package add to an existing level of care service, albeit minimal, for example, 2 hours of domestic and laundry assistance per week, the cost of which is covered by the care recipient. Depending on the facilities within a village, a retirement village service provider may be able to realise savings in the delivery of packages, for example, where food services can be delivered from a co-located aged care facility or where village residents have easy access to on-site medical and nursing services. Not all villages provide on-site after-hours assistance so that this facility in a care package is also site-specific.

Service level flexibility

Service providers attribute their ability to adjust a client's care plan to cover increasing care needs to the RVCP funding model that allows a provider to pool the resources allocated for low and high care recipients. This is said to be more difficult to achieve with a CACP client group unless the provider has access to multiple sources of funding (such as CACP in addition to HACC and/or National Respite for Carers Program funding) that can be drawn

on to deliver a package of services to a care recipient in a seamless manner. In the RVCP, the service level can be adjusted from low to high level care in response to a client's changing needs without the need for reassessment by ACAT and/or a change of service provider.

The distribution of average weekly service hours per recipient in the RVCP by ACAT approval offers a useful illustration of service level flexibility (Figure A3.1). RVCP recipients in the evaluation who joined a service with ACAT approval for high care received between approximately 6 and 20 hours of direct care per week on average, not counting ancillary services such as delivered meals and transport.



(a) Average weekly service hours between 26 July and 29 November 2004. Includes hours of personal care, nursing care, allied health care domestic assistance, social support and food preparation time (other than delivered meals). Excludes case management, delivered meals, transport and other service types not recorded in time units.

Source: Appendix Table A6.

Figure A3.1: RVCP evaluation, distribution of average weekly service hours per client[(a)] by ACAT approval

A maximum of 26.9 hours of assistance on average per week in the course of the evaluation was recorded by one client with ACAT approval for low care and several other clients

recorded averages of 17 to 19 hours of assistance per week, excluding case management and ancillary services. Some of these clients were eventually reassessed by an ACAT; others continued to be cared for at home with RVCP services and were not reassessed despite high need and/or sharp increases in need for assistance.

Approximately 75% of recipients with low care approval received around or less than 5 hours of direct care per week excluding ancillary services but a proportion of 'low care' clients received 10 or more hours of care per week. In fact, the service distribution for the top utilisation quartile of nominally 'low care' recipients overlaps the service distribution of 'high care' clients. Some RVCP recipients received a level of service that, in terms of hours per week, is commensurate with a typical EACH package.

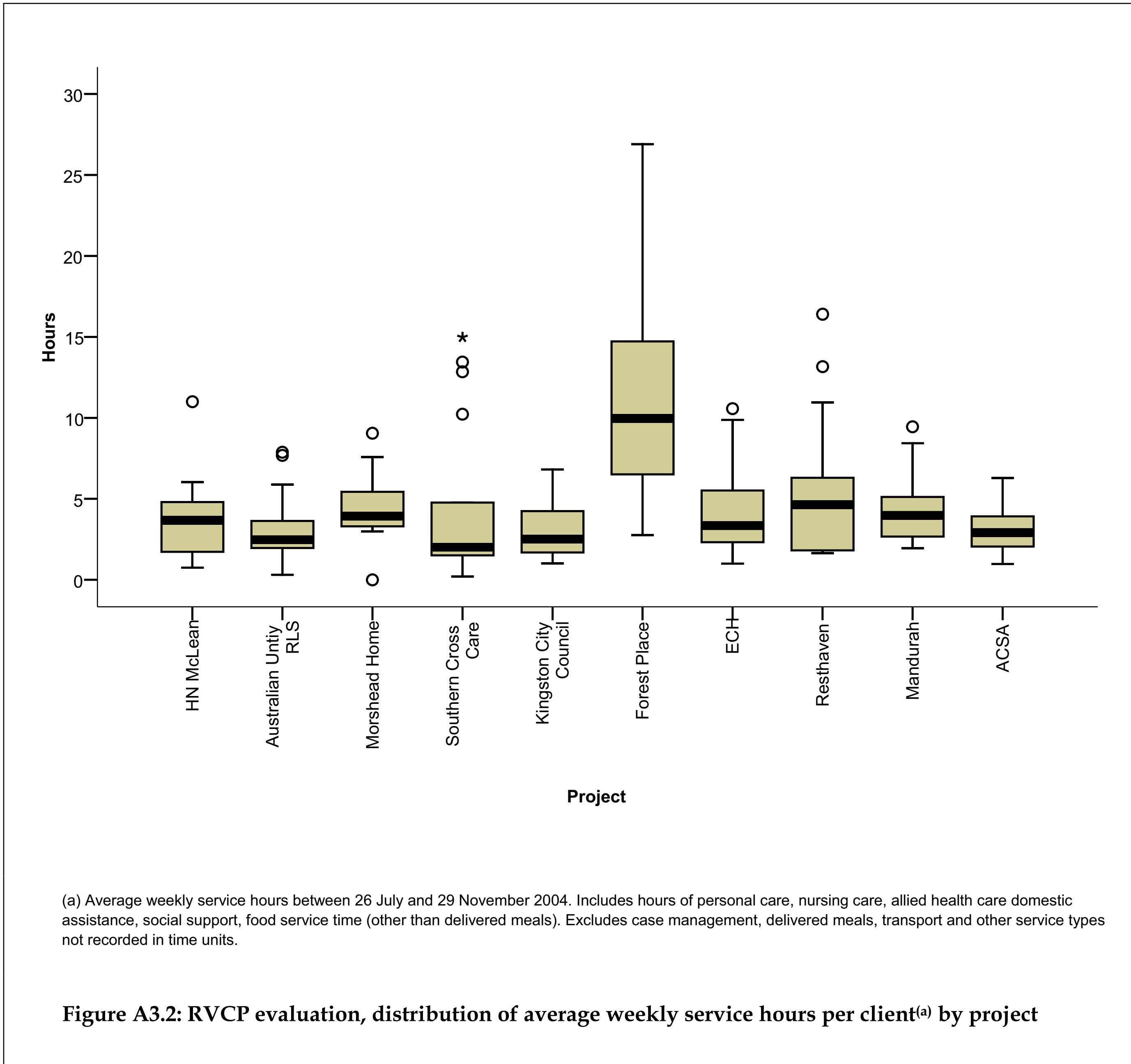
Where a provider achieves this level of flexibility an RVCP package provides for greater continuity of care than a typical CACP package.

Service levels varied across the projects during the reporting period; it is not known whether the observed differences wholly reflect differences in patterns of support needs of the client groups or also different levels of service flexibility. Distributions of amounts of assistance per client in each project are depicted in Figures A3.2 and A3.3. Recorded service units for the main types of assistance delivered by projects that were recorded in time units—personal assistance, domestic assistance, nursing and allied health care, social support and in-home respite—have been combined to produce a baseline measure of average weekly service hours delivered to each client in the reporting period. The distribution of average weekly service hours per client within each project is depicted in Figure A3.2. Figure A3.3 shows the per client distribution of the main types of ancillary services delivered by projects on a per client basis (number of delivered meals and number of one-way transport trips per week). A range of other types of assistance were delivered by projects but either in very low amounts per week or to very few clients (full services summaries can be found in Appendix Tables A7 and A8).

More homogeneous and generally lower service hours were seen in ACSA, Kingston City Council, and Australian Unity RLS projects in the reporting period. In the Mandurah Retirement Village, Morshead Home, HN McLean Retirement Village and ECH Inc projects, 75% of care recipients received an average of up to 5–6 hours of assistance per week but some clients received an average of around 10 hours of assistance per week. Southern Cross Care (Victoria) delivered an average of 5–6 hours to most clients, but a small number of very high care clients in one village (all high care packages in this project were allocated to one site) received higher hours of assistance, in the order of 10–15 hours per week. Resthaven Incorporated recorded greater variation in average weekly service hours for the middle 50% of the group than the aforementioned projects, a slightly higher median of average weekly service hours (around 5 hours) and some very high service use clients who received an average of 15 or more hours of assistance per week. Forest Place Retirement Village reported service weekly hours with a higher median of approximately 10 hours per week and a very wide range in service utilisation per client, up to an average of 27 hours per week. Forest Place reported a client group with very high self-care and mobility support needs, that is, low Modified Barthel Index scores (Forest Place had access to higher income from client co-payments than other projects due to a different co-payment structure that helps to support a higher needs group).

Patterns of delivery of ancillary services do not alter findings based on average weekly service hours. Projects with higher average weekly hours of service and greater variability in weekly hours of assistance per client have tended to also deliver higher numbers of delivered meals per week (Forest Place Retirement Village, Resthaven, Morshead Home and

Mandurah Retirement Village; Figure A3.3). Higher per client levels of transport assistance were observed in the Resthaven and Mandurah projects, both located outside major metropolitan areas.



(a) Average weekly service hours between 26 July and 29 November 2004. Includes hours of personal care, nursing care, allied health care domestic assistance, social support, food service time (other than delivered meals). Excludes case management, delivered meals, transport and other service types not recorded in time units.

Figure A3.2: RVCP evaluation, distribution of average weekly service hours per client[(a)] by project

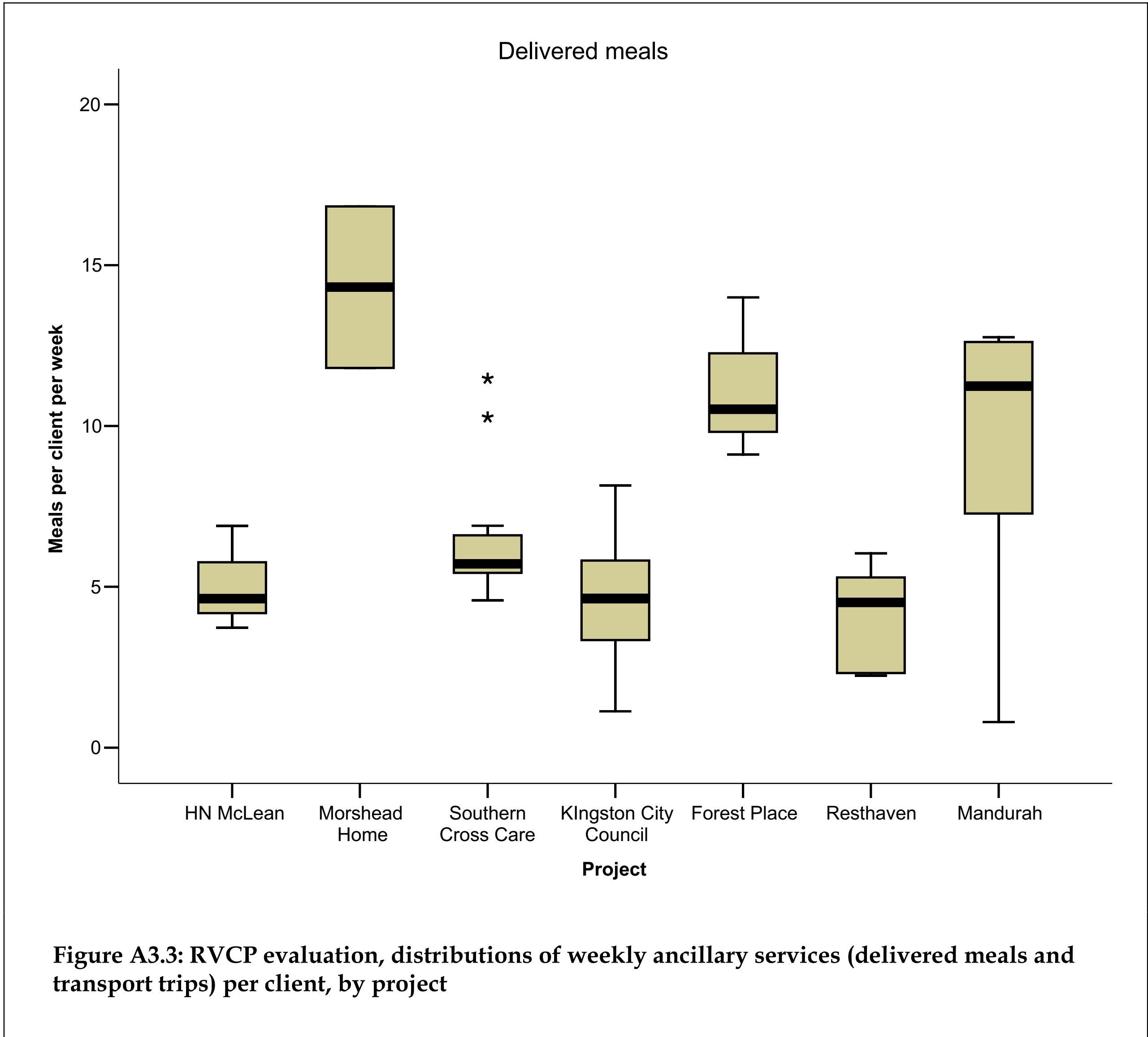


Figure A3.3: RVCP evaluation, distributions of weekly ancillary services (delivered meals and transport trips) per client, by project

(continued)

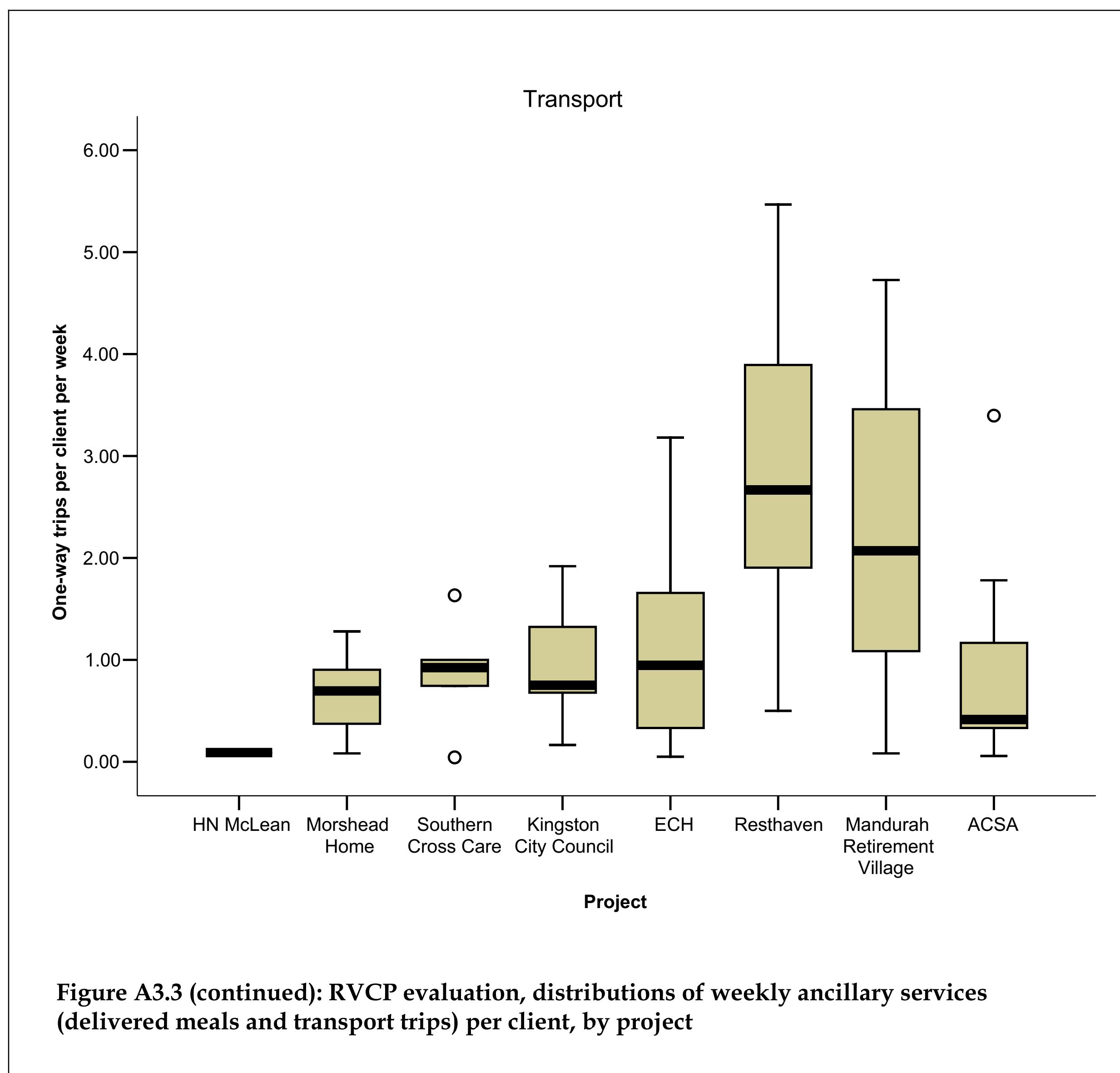


Figure A3.3 (continued): RVCP evaluation, distributions of weekly ancillary services (delivered meals and transport trips) per client, by project

Service mix flexibility

Service providers remarked on the value of being able to offer clients a comprehensive range of services in a seamless fashion and singled out nursing and allied health care for special mention. Nursing and allied health care can be made available in an EACH package, but not CACP. Not all projects delivered nursing and allied health care in the reporting period, which could be because none of the care recipients at the time needed these services. In addition, some RVCP recipients retained existing private or other arrangements while receiving RVCP services, including for nursing and allied health care.

The importance of nursing and allied health care to even a low care client should be viewed in the context of the health condition and health service utilisation profiles of the target

group. Chapter 2 described the group as very old, including a relatively high proportion of people at risk of falls and related injury, and exhibiting high health service utilisation, including medication use. The ability to access nursing and allied health care on behalf of package recipients strengthens the RVCP provider's ability to manage clients' changing needs, particularly when change is related to physical illness or injury, and recovery after a period of hospitalisation.

From a client's perspective, one provider manages the full range of services received.

Project coordinators also suggested that on-site RVCP care workers have been able to deliver a form of slow stream rehabilitation for clients in recovery by providing guidance or physical mobility assistance for regular, short walks in the village precinct. Frequent pop-in visits help to build confidence and maintain social contact when a client can't physically leave home for long periods. Some RVCP models lend themselves to frequent monitoring of clients more than others. During the evaluation, projects with dedicated RVCP care workers and those in which the RVCP service operates within one village using existing infrastructure articulated a higher level of personalised service than projects where the RVCP is incorporated into a service delivery system for other programs. Thus, in addition to pooled funding arrangements and service mix, familiarity between service provider, care worker and care recipient and their close proximity in the retirement village setting appears to be an important factor.

Other and intangible benefits of the RVCP

Greater invigilation of clients could have contributed to a lower rate of emergency department presentations per unplanned hospital admission observed during the evaluation compared to earlier reports of clients (refer Chapter 2: section 2.3 ('Health profiles')). One-quarter to one-third of clients reported urgent or unplanned hospital admissions or a fall with injury, respectively, in the 6 months before joining an RVCP service. These events may increase an older person's risk of premature entry to residential care if appropriate support is not available. One case study provided to the evaluation highlights the anxiety experienced by family members when an older person suffers acute illness and hospitalisation. Another case study shows how an RVCP care worker suspected a medical condition was contributing to a care recipient's decline and this led to timely referral to a GP and appropriate primary care management of the condition. RVCP services have provided reassurance to families and engendered confidence in the knowledge that their relatives are able to recover safely at home. It is not so much that the RVCP has fostered true innovation in care; rather, that resources allow for an appropriate response to a client's changing circumstances.

Service providers and care recipients through the Care Experience Survey mentioned the intangible benefits of having staff on-site in villages. A 'caring presence' is said to engender feelings of anticipated support in the wider village communities. Neighbours and friends of RVCP recipients have expressed feelings of relief (that a friend is receiving assistance) and confidence that support is available to residents if and when needed.

3.2 A comparison of service delivery in RVCP, CACP and EACH

Section 3.1 described the novel features of RVCP packages and alluded to some of the main differences between the RVCP and CACP. This section compares service utilisation data

from the RVCP evaluation and censuses of CACP and EACH recipients conducted in 2002. The censuses are the only detailed and comparable data sources currently available on CACP and EACH recipients.

Data limitations

Detailed patterns of service utilisation by type of assistance among EACH and CACP recipients are not available in administrative data collections. CACP and EACH service utilisation data and care recipient profiles were collected in censuses conducted by the AIHW in 2002 (AIHW 2004a, 2004b). EACH program coverage has expanded since the censuses, which captured data on just 288 EACH recipients; hence the 2002 censuses do not necessarily reflect more recent patterns of EACH service delivery. The census data are used here to compare RVCP, CACP and EACH packages.

In drawing comparisons it is important to bear in mind some differences in data collection methodology. EACH and CACP census data were collected over respective one-week periods, whereas RVCP service profiles were compiled from data collected over a period of up to 18 weeks for each evaluation client. Services such as case management, forms of nursing care such as wound management, and even transport services may be more likely to appear in a care recipient's service profile if services are recorded over a longer period of time. Second, RVCP projects recorded time spent on initial needs assessment and the number of events associated with follow-up assessment, care planning and coordination but were not required to record case management time units on a continual basis. To do so would have caused a high response burden over an extended period, with a risk that the resulting data would be of dubious quality. It is possible to report the proportion of RVCP clients who received follow-up assessment or care planning/coordination during the evaluation period but there are no estimates of the time spent on these activities. The CACP census revealed that CACP recipients with one severe or profound core activity limitation receive approximately half an hour of case management time per week; two to three severe or profound core activity limitations are associated with approximately three-quarters of an hour of case management per week. These data can be used as an upper bound on case management time for RVCP recipients, recalling that cases of severe or profound core activity limitation among RVCP recipients at the time of the evaluation tended to involve one or at most two areas of activity limitation.

Level and type of assistance

Estimated average (mean or median) weekly service hours per client for the main types of direct assistance measured in time units[2], excluding ancillary services and case management, are considerably higher for EACH recipients (mean 17.6 hours) than CACP recipients (mean 6.1 hours) and RVCP evaluation clients (mean 5.2 hours) (Table A3.1). Allowing for ancillary services and estimated case management time, the RVCP evaluation recorded marginally lower weekly hours of service per recipient than the CACP census. Hours of care, however, may not fully represent the cost of care, the total amount of assistance delivered, nor the full value of care provided to the care recipient.

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2 Personal assistance, nursing care, allied health care, domestic assistance, food service other than delivered meals, social support and respite care.

Table A3.1: RVCP evaluation clients, CACP and EACH 2002 census populations: per cent of care recipients and average[a] weekly service units per care recipient in receipt of each type of service[(a)]

	RVCP			CACP			EACH	
	Recipients	Service units		Recipients	Service units		Recipients	Service units
	%	Mean	Median	%	Mean	Median	%	Mean
				Hours service unit				
Personal assistance	65.9	2.6	2.0	53.6	2.3	2.0	89.2	9.3
Nursing care	25.3	1.7	1.3	. .	. .	. .	53.8	2.0
Allied health care	17.0	0.2	0.1	. .	. .	. .	13.2	1.3
Domestic assistance	91.3	1.8	1.6	82.6	2.3	2.0	65.6	2.3
Food service other	28.8	1.5	1.3	28.8	1.7	1.3	36.0	3.4
Social support	40.2	0.9	0.5	59.7	2.2	1.8	47.2	2.7
Respite care	3.9	2.8	2.5	4.5	3.3	2.5	37.5	4.8
Case management	91.7	See note	See note	73.1	1.0	0.8	87.5	1.6
Total hours per week		**5.2[(b)]**	**3.7[(b)]**		**6.1[(b)]**	**5.5[(b)]**		**17.6[(b)]**
				Number service unit				
Delivered meals	30.1	7	6	21.0	6	5	11.1	5
Transport trips	39.7	1	1	35.7	3	2	9.0	3

(a) Mean and median service units reported for RVCP and CACP; mean service units reported for EACH.

(b) Case management time is included in the calculation of CACP and EACH weekly service hours but is not included in RVCP weekly service hours. With this exception, median and mean total weekly service hours per client cover commensurate service types.

Note: RVCP projects recorded a median of 2.5 hours per client for initial needs assessment (range 1.0 to 25.0 hours); ongoing contact between a care manager and client was recorded for 93% of clients, at an average of one contact every 3 weeks. These services are not included in the average Total hours per week figures for RVCP clients.

. . Not applicable.

Sources: AIHW analysis of RVCP evaluation database (see Appendix Tables A6 and A7); AIHW 2004a:Table A2.15 (CACP); AIHW 2004b:Tables 2.4 & 2.5 (EACH).

The mix of different types of assistance is an important factor and was found to differentiate RVCP from CACP packages. One in four evaluation clients received nursing care and 17% of clients received specified forms of allied health care during the reporting period. These service types are not funded by the CACP program and CACP care recipients in need of nursing or allied health care would normally access these services through Home and Community Care or private channels. For example, the AIHW has found that around 35% of CACP recipients also receive HACC-funded services, including nursing care (AIHW: Karmel & Braun 2004). Depending on how these types of assistance are sourced, for example, via HACC or private means, the total cost to government of supporting a CACP recipient could be higher than the CACP subsidy. Flexibility to provide these more expensive types of service in an RVCP care package means that RVCP packages may be more costly to deliver for roughly the same number of hours of care.

RVCP average service delivery levels during the evaluation for personal assistance and food services were commensurate with CACP results. On a per client basis, average domestic assistance per week is slightly lower in the RVCP. The main differences are lower average levels of social support and transport services in the RVCP compared to CACP. It is

reasonable to speculate that these differences might be related to service delivery efficiencies that can be realised in servicing some retirement communities. For example, RVCP recipients at Forest Place Retirement Village have ready access to on-site nursing, medical care and pharmacy. Retirement villages with a strong social program might reduce the need for these services. Anecdotally, many retirement village residents have strong social ties with neighbours and enjoy peace of mind from living within a retirement community, which possibly reduces the need for social support services. However, this cannot be assumed to exist and need for peer participation was mentioned as one factor that causes some residents to seek placement in a low care facility.

Table A3.2 facilitates a comparison between the individual projects and the CACP service utilisation profile. Based on mean weekly service hours per client and allowing a margin for case management and service coordination time, we observed the following patterns of project service delivery relative to CACP:

- ECH, Mandurah Retirement Village, Morshead Home and Southern Cross Care delivered weekly hours of assistance equivalent to an average CACP package.
- ACSA, HN McLean Retirement Village, Kingston City Council and Australian Unity RLS delivered weekly hours of assistance somewhat less than an average CACP package.
- Forest Place Retirement Village and Resthaven delivered higher weekly hours of assistance than an average CACP package.

Across the RVCP, higher proportions of recipients received an average of up to 2 hours of assistance per week (22.4%) or more than 2 hours but less than 4 hours (35.5%) than in the CACP census population (8.3% and 20.7% respectively).

Overall, it was demonstrated that an RVCP service can deliver the types of assistance available to EACH recipients and up to the level of an EACH package. The more typical RVCP pattern has been for approximately CACP-level weekly hours of assistance with scope to offer nursing and allied health care. A higher proportion of very low service use clients in some RVCP projects is most likely due to RVCP targeting and could possibly reflect an historical trend for higher needs residents in independent living units to opt for residential care.

Table A3.2: Number and per cent of clients by mean weekly hours of service received, by RVCP project and CACP care recipient populations[(a)]

Hours/week	HNM	AU RLS	MOR	FP	SCC	KCC	ECH	RI	MRV	ACSA	Total RVCP	Total CACP
							(number)					
>0–2	8	6	—	—	8	9	7	4	1	8	51	2,109
>2–4	5	10	6	2	3	8	16	2	10	19	81	5,258
>4–6	5	2	3	—	2	4	6	3	5	8	38	7,160
>6–8	1	2	2	8	—	2	4	2	2	1	24	5,232
>8–10	—	—	1	6	—	—	4	—	2	—	13	2,452
>10	1	—	—	12	4	—	1	3	—	—	21	2,451
Total care recipients	**20**	**20**	**12**	**28**	**17**	**23**	**38**	**14**	**20**	**36**	**228**	**24,662**
							(per cent)					
>0–2	40.0	30.0	0.0	—	47.1	39.1	18.4	28.6	5.0	22.2	22.4	8.6
>2–4	25.0	50.0	50.0	7.1	17.7	34.8	42.1	14.3	50.0	52.8	35.5	21.3
>4–6	25.0	10.0	25.0	—	11.8	17.4	15.8	21.4	25.0	22.2	16.6	29.0
>6–8	5.0	10.0	16.7	28.6	—	8.7	10.5	14.3	10.0	2.8	10.5	21.2
>8–10	—	—	8.3	21.4	—	—	10.5	—	10.0	—	5.7	9.9
over 10	5.0	—	—	42.9	23.5	—	2.6	21.4	—	—	9.2	9.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Mean hours	3.2	2.7	5.4	12.4	4.9	2.8	5.0	7.4	4.5	3.8	5.2	6.1
Median hours	2.5	2.7	4.4	12.3	2.2	2.0	4.0	5.9	4.4	3.6	3.7	5.5

(a) Services measured in time units, defined equivalently in the RVCP evaluation and CACP 2002 census.

Notes

1. Rounding of percentages may cause columns to not sum to exactly 100.0%.

2. HNM—HN McLean; AURLS—Australian Unity Retirement Living Services; MOR—Morshead Home; FP—Forest Place; SCC—Southern Cross Care; KCC—Kingston City Council; ECH—ECH Inc.; RI—Resthaven Inc; MRV—Mandurah Retirement Village; ACSA—Aged Care Services Australia.

— Nil.

Source: AIHW (2004a): Table A2.9 (CACP).

3.3 Principal findings

Levels of service to RVCP recipients observed during the evaluation range from a minimal level of assistance with instrumental activities of daily living (domestic assistance, shopping and meals, etc.) to service akin to an EACH package.

Providers have demonstrated a capacity to respond to clients' changing needs without being constrained by level of ACAT approval at entry (low or high care) and without requiring reassessment by ACAT.

The RVCP has enabled providers to deliver more comprehensive and more flexible care packages than is possible through CACP. Provision of nursing care and allied health care when needed is a highly valued aspect of RVCP packages.

Some pilot models have delivered a level of personalised service that would be difficult to replicate without on-site care recipients. In particular, there are indications that frequent short visits from on-site staff have provided preventive health care for some care recipients and are a particularly effective means of medication management for older people.

4 Impact of RVCP services on need for residential aged care

4.1 Introduction

The evaluation has considered a range of evidence to assess whether RVCP services reduce the need for older people in retirement villages to enter residential care. This chapter examines the experience of participants in the evaluation in an absolute and comparative sense and concludes with a discussion of implications for the bundling of community care and retirement village accommodation that have been highlighted in the pilot.

We conclude that when services deliver client-centred care with a genuine commitment to ageing in place the packages can help people to avoid or delay entry to residential care. The circumstances that have led some package recipients to move to a low care facility include a need for more assistance than was available from an RVCP service, poor continuity of care, service unpredictability, and limited out-of-hours assistance. The observed rate of transfer to residential aged care facilities was high relative to transfer rates reported for CACP recipients but the possible influence of different social dynamics of the two groups needs to be considered.

The national evaluation was designed with awareness that the impact of RVCP services on client outcomes needed to be assessed from data collected over a relatively short timeframe and without a control group benchmark of need in the target population. Activities of daily living were selected as a key intermediate outcome variable because of their central role in stability of residence at older ages (Lawton 1983, Gill et al. 1996, and Miller et al. 1999 cited in Lichtenberg et al. 2000). A first question to be answered in relation to reduced need for residential aged care is: *Do RVCP services deliver care according to measured ADL needs of clients (and can RVCP services support clients with increasing ADL support needs)?* A positive answer would provide evidence of the potential for RVCP services to reduce one important area of need at older ages that is known to pose a risk for entry to residential care. Section 4.2 considers whether RVCP services have addressed care recipients' ADL support needs.

A second area of investigation is the short- to medium- term accommodation outcomes for RVCP recipients in the national evaluation (section 4.3). By June 2005, 18% of the group had entered permanent residential aged care. Approximately 56% of these admissions were for low care, which raises the question of why some people chose a low care facility over a continuing care package. Responses to the Care Experience Survey give some answers as to why some people do not see an RVCP package as a long-term alternative to residential low care. At the same time, other consumers say that they are able to avoid using residential care because of an RVCP package. Clients, family members, project coordinators and retirement villages have reported on the improvements in clients' circumstances from having a care package and the positive flow-on effects for family carers and retirement village communities. Section 4.4 examines a range of relevant responses to the Care Experience Survey.

A third question is how to judge *reduced* need at a cross-sectional level. Is the observed rate of entry to residential aged care in the RVCP high, low or as expected? Since there is no control group in the evaluation, we look to results from the Aged Care Assessment Program and Community Aged Care Packages to provide context for interpreting pilot results. We speculate that the characteristics and circumstances of older people in retirement villages might place them at higher risk of entry to residential aged care than older people living in private residences.

Sections 4.2 and 4.3 examine, respectively, the evidence on intermediate outcomes (provision of ADL support and expressed levels of anticipated support) pertaining to accommodation status and the actual short to medium term accommodation status of evaluation participants. Section 4.4 explores feedback from consumers to explain the range of experiences of care recipients and family members.

Section 4.5 concludes the chapter with a brief discussion of strengths, weaknesses and unexpected outcomes.

4.2 Addressing ADL support needs

In designing an evaluation framework, the possibility of low rates of admission to permanent residential care within the relatively short timeframe available for evaluation was carefully considered. Indeed, it turned out that most of the recorded admissions to residential care occurred between December 2004 and April 2005, which was after the primary data capture period.

The evaluation was designed to collect measures of need for assistance in ADL and IADL to provide intermediate outcome measures related to the risk of admission to residential care. Other known risk factors such as medication use, number of health conditions, primary health condition and so on were also recorded in client profile records. RVCP service utilisation by individual clients was recorded during the evaluation and averaged over the reporting period to estimate mean weekly hours of service excluding case management and ancillary services. The data were analysed to answer the question '*Do RVCP services deliver care according to measured need for ADL assistance?*'.

Multiple linear regression analysis was used for this investigation, setting mean weekly service hours as the dependent variable and selected client characteristics including age, sex, living arrangement, carer availability, health conditions and baseline ADL and IADL measures as independent (predictor) variables. Data definitions for variables included in the analysis appear in Appendix Table A9. Several models were analysed in a stepwise fashion to test independent variables and remove variables that were not statistically significant. Testing was performed at the 5% level of significance. The PROC GLM procedure in the Statistical Analysis System Version 8.12 (SAS Institute) (SAS 1999) was used for regression analysis. Only main effects models were analysed because the small samples at levels of the independent variables precluded an investigation of interaction effects.

Due to confounding between ACAT approval type and project membership (more than half the clients with ACAT approval for high level residential care were in the Forest Place Retirement Village project), it was necessary to split the data set by type of ACAT approval and separately analyse records of clients with low and high care approvals.

Data for clients who entered projects with an ACAT approval for low level residential care or community care equivalent were initially analysed by regressing weekly service hours on the 'full' set of independent variables, leaving out project membership. There is a known association between project and the distribution of average weekly service hours per client (that is, between project and the dependent variable) but project membership is confounded with carer availability and living arrangement. There is also an association between living arrangement and carer availability. It was therefore necessary to examine the association between average weekly service hours and each of the client characteristic variables before entering project membership into the regression model. An initial model analysed on 180 records for clients with ACAT approval for low level residential care and non-missing values for all independent variables in the model revealed statistically significant associations between average weekly service hours and each of four independent variables: living arrangement, carer availability, baseline ADL and baseline IADL (Appendix Table A10: ACAT low care initial model). Higher mean weekly service hours were associated with living alone, not having a family carer, and lower ADL and IADL scores at entry to a project. This model explained only 28% of variance in mean weekly service hours per client and the estimated regression coefficients that quantify the association between mean weekly service hours and each independent variable may therefore not be reliable.

On entering a set of indicator variables to represent project membership in addition to the four independent variables found to be significant in the initial regression model, the proportion of explained variance in mean weekly service hours per client increased to 42%. Adjusting for project membership, living arrangement, baseline ADL score and baseline IADL score remain statistically significant but carer availability is not significant at the 5% level of significance (variables and corresponding levels of significance for ACAT low care models are given in Appendix Table A10). Project membership is highly significant, confirming exploratory findings of different distributions in mean weekly services hours across the projects (Figures A3.2–A3.3) but also reflecting the different patterns of carer availability in individual projects (in particular, Resthaven and Mandurah Retirement Village recorded relatively low rates of carer availability compared to other projects).

Most importantly, the significance of ADL and IADL scores is evidence that RVCP projects were delivering service levels commensurate with baseline measures of need for assistance in activities of daily living.[3] Assuming these variables are indirect measures of risk of admission to residential aged care, and given the low availability of co-resident family carers for RVCP recipients, the results indicate that RVCP service provision contributes to reduced risk of admission to residential care facilities. According to the final model for RVCP clients with ACAT approval for low level residential care:

- Clients who were living alone received an estimated average of 1.27 more hours of service per week compared to clients who were living with others.
- For every one-point decrease below the group average score on the ADL scale at entry to a project, a client received an estimated additional 0.33 hours of service per week on average.

3 Only baseline ADL and IADL scores were entered because random patterns of missing scores from subsequent functional assessments reduced the effective sample size for analysis.

- For every one-point decrease below the group average score on the IADL scale at entry to a project, a client received an estimated additional 0.27 hours of service per week on average.

Almost 60% of variance is unexplained by this model leaving open the possibility of other predictors of weekly service hours that have not been recorded and analysed. Furthermore, a number of the independent variables are inter-correlated and these effects cannot be disentangled from project membership. Project membership is an important predictor because of the different models of RVCP service provision and differing levels of experience among providers in the Pilot.

Chapter 3 reported that mean weekly service hours received by clients who entered the RVCP with ACAT approval for low care varied to the extent that some nominally 'low care' clients had received a level of service that matched or exceeded service levels for ACAT high care clients. This provides further evidence that RVCP services have been matched to clients' measured levels of need. Moreover, the use of ADL scales as measures of need for support among RVCP recipients has revealed wide variation in support needs among clients with ACAT low care assessment; in the RVCP, one of the benefits is the availability of high level care in the community to clients with ACAT approval for low level residential care but whose needs increase over time.

For the small number of clients who entered RVCP projects with ACAT approval for high level residential care, IADL score alone was found to be a significant predictor, explaining 72% of variance in mean weekly service hours during the evaluation. For every one point below the group mean IADL score (as at entry), mean weekly service hours increase by an estimated 2.4 hours (Appendix Table A10: ACAT high care). Note that this result is based on a sample of only 13 clients whose service hours ranged from 11.8 to 19.4 hours on average per week. The emergence of IADL score, but not ADL score, as a significant predictor most likely reflects greater homogeneity in levels of self-care and mobility (ADL) functioning among RVCP clients with ACAT approval for high level residential care compared to the large and relatively ADL heterogeneous group of RVCP clients with ACAT approval for low level residential care. The strong association IADL score and mean weekly hours of service confirm that for this group too, RVCP service levels increase in line with increasing measures of need for assistance.

RVCP services have therefore addressed ADL and IADL limitations in low and high care clients and in so doing have targeted an area of need that is a primary reason for many older people entering residential aged care.

The evaluation found that RVCP services accept clients with varying levels of need for support in ADL. At time of follow-up, mostly completed in June 2005, 161 clients were still with an RVCP service and 157 of these continuing clients had valid ADL measures recorded at entry. Within this group, 112 clients (71%) had entered the RVCP with moderate dependency in self-care and/or mobility and another two clients (1%) registered severe dependency on entry (Table A4.1). Average duration in the RVCP at time of follow-up was 443 days (range 227 to 629 days). Forty-three continuing clients as at June 2005 had only slight or no loss of ADL function at time of entry but some loss of functioning in instrumental ADLs. In this group, 29 people (67%) experienced either complete loss of function in two instrumental ADL or partial loss of function in three or more instrumental ADL. Altogether, 143 of the 157 continuing clients with valid entry measures of ADL function were still at home and receiving support for slight to moderate impairment in self-care or mobility function, or moderate to severe impairment in instrumental ADL function.

Table A4.1: RVCP evaluation, number of clients by level of dependency in ADL at entry and continuing clients as at June 2005 by level of dependency in ADL at entry and final assessments (number and per cent)[(a)]

Level of dependency in ADL	All clients at entry	Continuing clients	
		Entry assessment	Second assessment
		(number)	
Independent	22	15	17
Slight dependency	36	28	32
Moderate dependency	166	112	106
Severe dependency	5	2	—
Total valid ADL scores	*229*	*157*	*155*
Missing values	9	4	6
Total	**238**	**161**	**161**
		(per cent)	
Independent	9.6	9.6	11.0
Slight dependency	15.7	17.8	20.6
Moderate dependency	72.5	71.3	68.4
Severe dependency	2.1	1.3	—
Total (valid ADL scores)	**100.0**	**100.0**	**100.0**

(a) Dependency level defined by the following classification of 20-point Modified Barthel Index scores: 0–4 = total dependency; 5–8 = severe dependency; 9–18 = moderate dependency; 19 = slight dependency; 20 = independent (Shah et al. in McDowell & Newell, 1996).

— Nil.

Eleven clients who entered the RVCP with ACAT approval for low care experienced an increase in care needs to the equivalent of high care and these clients were still with an RVCP service in June 2005. In addition, 8 out of 13 evaluation clients who entered an RVCP service with ACAT approval for high level residential care were still at home with a care package in June 2005 (Table A4.2), a median of 589 days since service commencement (range 237–615 days). Four ACAT high care clients who entered residential high care had been maintained in the RVCP for a median of 413 days (range 139–533 days).

Among clients who were still using RVCP services at follow-up and who completed two ADL assessments (155 clients in total), 23 people registered a change in level of dependency in self-care and mobility between entry to an RVCP service and their final assessment for the evaluation including nine who recorded an increase in self-care and/or mobility support needs and 14 who recorded a decrease. Two clients who entered the RVCP with severe dependency in ADL had improved to moderate dependency by the time of their second ADL assessment.

To summarise, a range of individual experiences has been observed and the data confirm that:

1. RVCP services are able to support clients with increasing care needs
2. some recipients show improved ADL functioning while receiving RVCP services.

A second analysis explored possible associations between client accommodation status at follow-up and the set of socio-demographic variables and functional measures collected for the evaluation, including measures of change in an individual's ADL support needs over

time. The purpose of this exercise was to see whether there is any pattern in the actual use of residential care services among RVCP recipients. No robust explanatory model for accommodation status was found; in particular, measured need for assistance in ADL at either entry or final assessment was found to be uncorrelated with accommodation outcome. Marked decline in ADL or IADL function is not evident in the repeated measures for clients who moved to residential care. For example:

- 23 clients with complete data who entered a low care facility recorded stable functioning in ADL between entry and final assessments (moderate, slight or no dependency) or a change from slight to moderate dependency in ADL (two clients)
- 15 clients with complete data who entered a high care facility recorded stable functioning in ADL between entry and final assessments (moderate, slight or no dependency)
- 28 out of 38 clients with complete data who entered a residential care facility recorded no loss in instrumental ADL function or improved function between entry and final assessments.

This could be due to the timing of assessments because final assessments were not often performed close to the time of separation from a package.

The only socio-demographic variable found to be correlated with accommodation outcome is DVA pension status. The 41 care recipients with a DVA pension as their primary source of income represented 17% of the evaluation group but 35% of recorded admissions to permanent residential aged care (42% of admissions to low level residential care and 26% of admissions to high level residential care). Fifteen DVA pensioners had entered an aged care home by date of follow-up, 10 of whom entered low level residential care. This group comprised six males and nine females. Bi-variate comparisons revealed no obvious differences in recorded socio-demographic or health-related measures between Department of Veterans' Affairs pensioners and other care recipients. Comparing DVA pensioners who entered aged care facilities with DVA pensioners who were continuing in the RVCP similarly revealed no significant differences in average age, or baseline ADL score. However, the group who transferred from the RVCP to residential aged care did record a lower average IADL score on entry to the RVCP. DVA pensioners are represented in most projects but appear in higher numbers in two projects in particular. Failing any other plausible explanation from available data the observation in relation to DVA pension status might reflect project-specific rates of admission to residential aged care.

It is widely recognised that for many people an acute health event is the key factor in entry to residential care and a proportion of RVCP recipients who entered residential aged care recorded urgent or unplanned admissions to hospital and/or high use of medical services during the reporting period and just prior to entering an aged care facility. Eleven of the 19 people who entered high level residential aged care (58%) fall into this category based on data recorded for the evaluation. High use of medical and hospital services or urgent/unplanned admissions were recorded for 7 of the 24 people who entered a low care facility (29%), suggesting that this was less often a contributing factor for admissions to low level compared to high level residential care.

The reasons for people transferring from an RVCP package to residential care are multifaceted. Some important but unknown factors might not be well reflected in the evaluation data; others may not have been detected because of the complex interplay of multiple client characteristics and local conditions. The reasons stated by respondents to the Care Experience Survey who chose to transfer from the RVCP to residential care are covered in section 4.4.

Table A4.2: RVCP evaluation, number and per cent of clients by ACAT approval and location at follow-up, June 2005[(a)]

	Location at follow-up									
	At home			Residential aged care				Other		
	With formal care	No formal care or care not stated	Total	Low care	High care	Respite	Total	Hospital	Deceased	Total
ACAT approval on commencement	(number)									
Low care	155	8	*163*	24	15	1	*40*	9	13	**225**
High care	8	—	*8*	—	4	—	*4*	—	1	**13**
Total	**163**	**8**	**171**	**24**	**19**	**1**	**44**	**9**	**14**	**238**
	(per cent)									
Low care	68.9	3.6	*72.5*	10.7	6.7	0.4	*17.8*	4.0	5.8	**100.0**
High care	61.5	—	*61.5*	—	30.8	—	*30.8*	—	7.7	**100.0**
Total	**68.5**	**3.4**	**71.9**	**10.1**	**8.0**	**0.4**	**18.5**	**3.8**	**5.9**	**100.0**

(a) Morshead Home, ACT, completed follow-up in August 2005. Only one additional admission to residential aged care had occurred since 30 November 2004.

— Nil.

4.3 Accommodation outcomes

At time of follow-up, mostly completed 10–11 months after the start of the evaluation, in total 72% of clients were found to be living at home in the community, including 68% who were still receiving RVCP services, and 18.1% had entered permanent residential care (Table A4.3). A further 3.8% of clients (nine people) were in hospital and some of these people were reported to be waiting for placement.

All admissions to permanent residential aged care among clients with ACAT approval for high care were high care admissions. Among the 38 clients with ACAT approval for low care, 23 entered a facility at low care level and 15 entered at high care level. Admissions to residential low care represent approximately 56% of all admissions to permanent residential care.

On average, the continuing clients had spent 457 days with an RVCP service at time of follow-up (Table A4.4). RVCP recipients who moved into residential aged care transferred after an average of 327 days with an RVCP service, although there is a considerable range in the RVCP subsidy periods of this group, from 50 to 570 days. RVCP recipients who entered residential high care spent an average of 324 days on an RVCP package.

Figure A4.1 plots the 'survival' experience of the evaluation group, where 'survival' is a technical term to mean not having entered residential care. In a high proportion of cases, the observed duration of RVCP service in fact represents a censored observation[4] because service would most likely continue beyond the date of follow-up. The vertical axis represents the proportion of the group who are not in residential care. The curves (survival experience of males and females are plotted separately) show how this proportion changes over time, where time is measured in number of days since joining a project. An observation censored at 300 days, for example, indicates that a person was observed to be with a project for 300 days which is when follow-up occurred but the person continued on a package for more than 300 days, or that an event such as death or a move out of area occurred at that point. Given a longer period of follow-up some clients with censored observations would be observed to stay in the community for longer. The plots show that the likelihood of moving to residential care is relatively low up to 300 days with an RVCP service. After 300 days males appear to face an increasing rate of transfer; a similar change in rate of transfer occurs for female recipients at around 500 days since RVCP service commencement. An estimated 60% of RVCP recipients would be expected to be living in the community some 600 days after service commencement (or to have died in the interim).

4 The term 'censored' is used in statistical analysis to describe a length of stay or period of service use that is artificially constrained by a set 'end date' of a study or some unexpected event, whereas in reality the period of service continues or was truncated without the event of interest having occurred (in this case, entry to residential care).

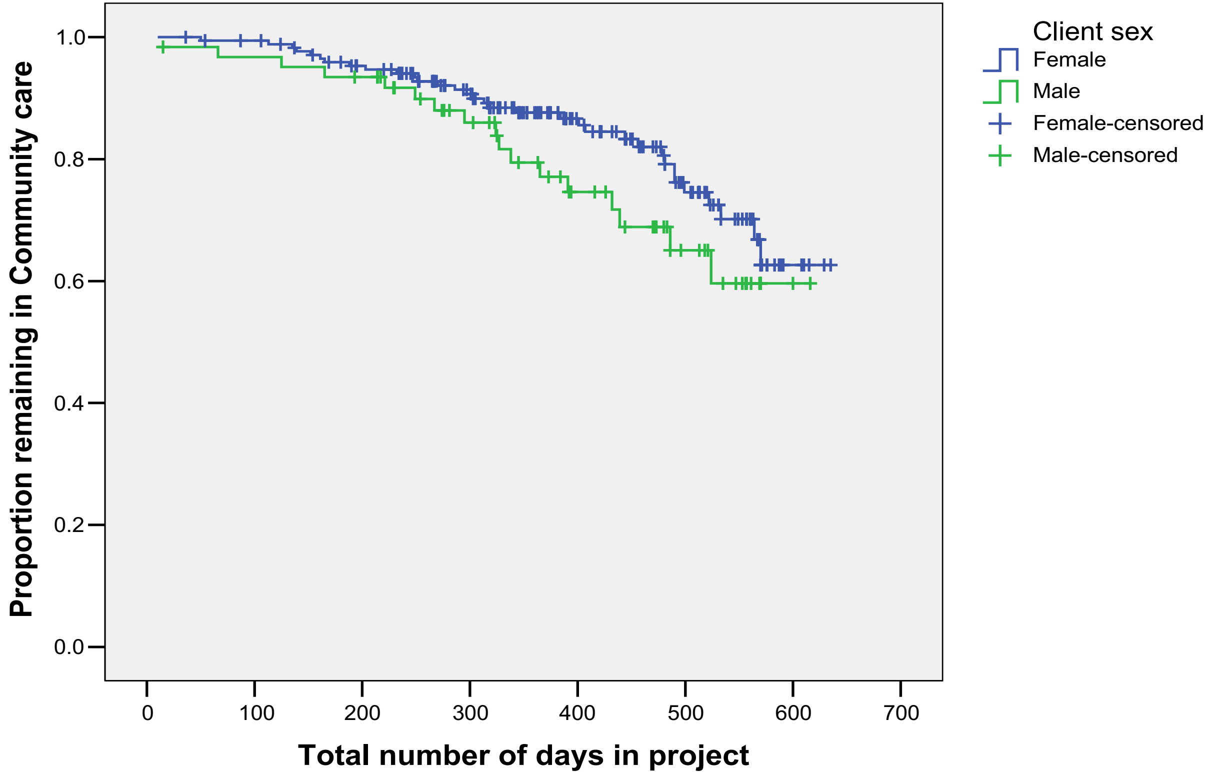


Figure A4.1: RVCP evaluation, proportion of evaluation participants remaining in the community by number of days since initial needs assessment

Table A4.3: RVCP evaluation, number and per cent of clients by location at follow-up by project, June 2005[(a)]

	Community care				Institutional care					
Project	RVCP	Home no formal care	Home with HACC	Home, care not stated	Hospital	RAC—high	RAC—low	Respite care	Deceased	Total
					(number)					
HN McLean Memorial Retirement Village	15	—	—	1	1	—	2	—	1	20
Australian Unity RLS	12	2	—	—	—	5	1	—	1	21
Morshead Home	10	—	1	—	2	—	3	—	3	19
Forest Place Retirement Village	18	—	—	—	2	4	—	—	4	28
Southern Cross Care (Victoria)	15	—	—	1	—	1	1	—	—	18
Kingston City Council	15	—	—	1	—	1	5	—	1	23
ECH Incorporated	27	—	—	—	1	5	3	1	1	38
Resthaven Incorporated	11	1	—	—	—	—	2	—	—	14
Mandurah Retirement Village	11	—	—	—	—	3	4	—	2	20
Aged Care Services Australia	27	2	1	—	3	—	3	—	1	37
Total	**161**	**5**	**2**	**3**	**9**	**19**	**24**	**1**	**14**	**238**
					(per cent)					
HN McLean Memorial Retirement Village	75.0	—	—	5.0	5.0	—	10.0	—	5.0	100.0
Australian Unity RLS	57.1	9.5	—	—	—	23.8	4.8	—	4.8	100.0
Morshead Home	52.6	—	5.3	—	10.5	—	15.8	—	15.8	100.0
Forest Place Retirement Village	64.3	—	—	—	7.1	14.3	—	—	14.3	100.0
Southern Cross Care (Victoria)	83.3	—	—	5.6	—	5.6	5.6	—	—	100.0
Kingston City Council	65.2	—	—	4.4	—	4.4	21.8	—	4.4	100.0

(continued)

Table A4.3 (continued): RVCP evaluation, number and per cent of clients by location at follow-up by project, June 2005[(a)]

	Community care				Institutional care					
Project	**RVCP**	**Home no formal care**	**Home with HACC**	**Home, care not stated**	**Hospital**	**RAC—high**	**RAC—low**	**Respite care**	**Deceased**	**Total**
ECH Incorporated	71.1	—	—	—	2.6	13.2	7.9	2.6	2.6	100.0
Resthaven Incorporated	78.6	7.1	—	—	—	—	14.3	—	—	100.0
Mandurah Retirement Village	55.0	—	—	—	—	15.0	20.0	—	10.0	100.0
Aged Care Services Australia	73.0	5.4	2.7	—	8.1	—	8.1	—	2.7	100.0
Total	**67.7**	**2.1**	**0.8**	**1.3**	**3.8**	**8.0**	**10.1**	**0.4**	**5.9**	**100.0**

(a) Morshead Home, ACT, completed follow-up in August 2005. Only one additional admission to residential aged care had occurred since 30 November 2004.

— Nil.

Table A4.4: RVCP evaluation, duration of RVCP service by accommodation status at follow-up

		Observed duration of RVCP service (days)		
Location at follow-up	**Number of clients**	**Minimum**	**Median**	**Maximum**
At home				
On RVCP	161	214	457	635
Other government support program	2	198	381	568
No government support program or not stated	8	54	187	546
Total	*171*	*54*	*445*	*635*
In residential aged care				
Respite care	1	436	436	436
Permanent low care	24	125	333	570
Permanent high care	19	50	324	564
Total	*44*	*50*	*327*	*570*
Other				
Hospital	9	10	249	495
Deceased	14	15	242	518
Total	**238**	**10**	**404**	**635**

How does the observed rate of entry to residential care in RVCP compare?

This section considers the overall rate of entry to residential care observed in the Pilot, using results from the CACP program by way of comparison. Rates of transfer to residential aged care from within different care package programs need to be compared within the context of the support needs profiles of the care recipient groups. We first briefly highlight similarities and differences in key characteristics of RVCP and CACP recipients and consider the proportion of each group at risk of entry to residential aged care because of severe or profound core activity limitation, hence a need for regular and ongoing assistance.

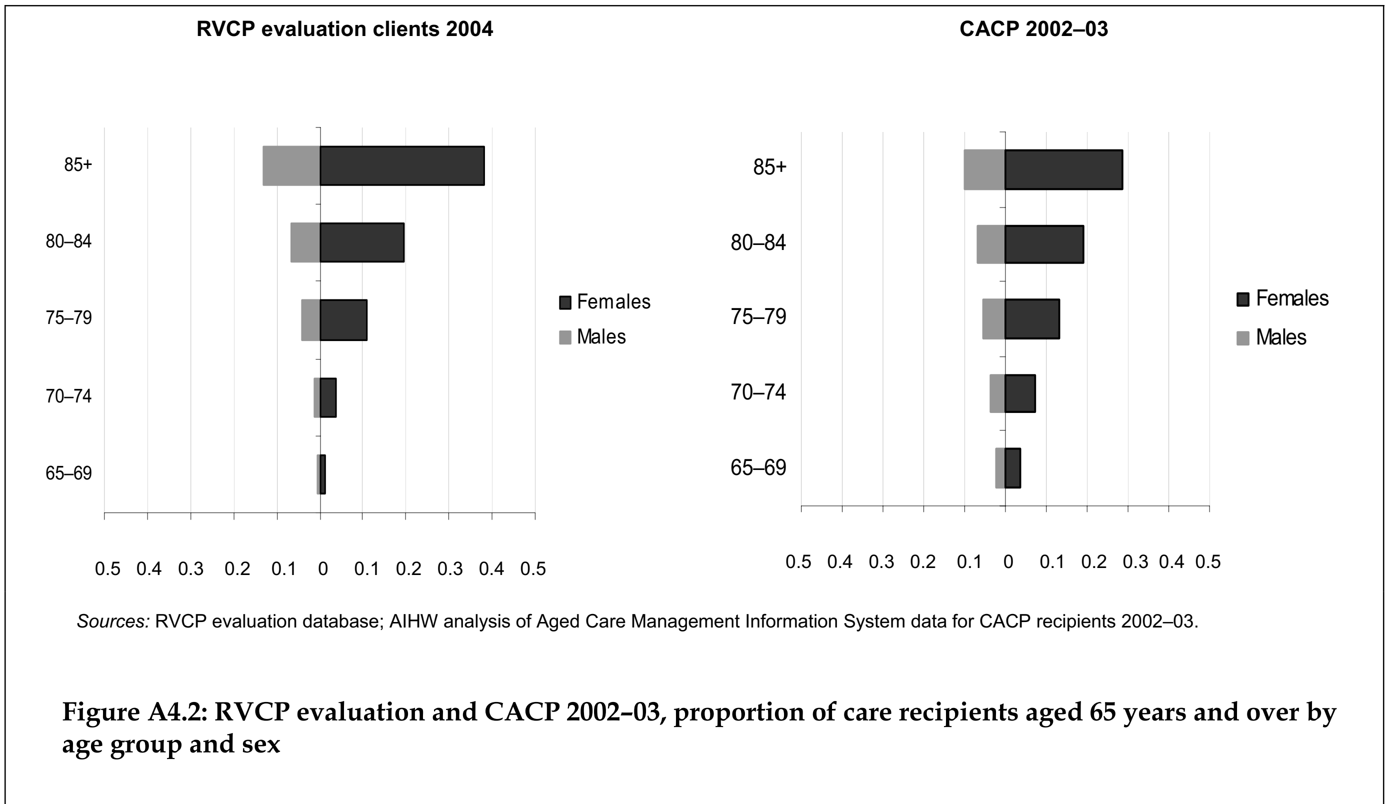
The RVCP evaluation group has a similar age and sex structure to the CACP recipient population but living arrangements and carer availability in the two groups differ (Table A4.5 and Figure A4.2). Forty-four per cent of evaluation participants had a carer but only 26% of carers lived with the RVCP recipient, that is, an estimated 11% of RVCP recipients had a co-resident family carer. In the 2002 CACP population, approximately 57% of recipients aged 65 years or over had a carer and around 50% of carers lived with the CACP recipient i.e. around 28% of CACP recipients in 2002 had a co-resident family carer (AIHW 2004a), highlighting that a higher proportion of CACP recipients may have access to higher levels of informal care compared with the observed group of RVCP recipients. The types of assistance provided in most RVCP packages are similar to those provided through CACP.

Table A4.5: RVCP evaluation participants and CACP recipients aged 65 years or over, percentage of care recipients by sex, living arrangement, carer availability and proportion aged 85 years or over

					Carer availability	
Care recipient group	**Males**	**Females**	**Age 85+**	**Lives alone**	**Has a carer**	**Co-resident carer**
RVCP	26	74	51	81	44	11
CACP	28	72	39	50	57	28

Sources: RVCP evaluation database; AIHW 2005:Table A7 & 2004a:Table A1.14 (CACP).

Rates of severe or profound core activity limitation in the two groups differ. A person who experiences severe or profound activity limitation in one of these areas will typically require supervision or assistance on at least a daily basis. Considering care recipients aged 65 years or over with a subsidy period of up to 440 days (the maximum subsidy period for evaluation clients in the reporting period), the rate of severe or profound core activity limitation for the CACP recipient population is almost double the observed RVCP rate (Table A4.6). The RVCP has also produced a care recipient group with a lower rate of severe or profound core activity limitation when compared to the estimated older household population in receipt of any type of formal service (Table A4.6). On the basis of comparative levels of core activity limitation alone, a higher rate of transfer from CACP services than from RVCP services to residential aged care might be expected. Measures of core activity limitation and ADL impairment measure need for instrumental assistance but do not measure other needs associated with peer participation and feelings of confidence and security which can contribute to an older person's choice of residential placement.



Sources: RVCP evaluation database; AIHW analysis of Aged Care Management Information System data for CACP recipients 2002–03.

Figure A4.2: RVCP evaluation and CACP 2002–03, proportion of care recipients aged 65 years and over by age group and sex

Discussions for the evaluation highlighted that feelings of isolation or insecurity at home, a diagnosis of dementia, or a need for 24-hour supervision increase the likelihood that an older person will enter residential care. Dementia was recorded as the primary health condition of 10.5% of RVCP recipients in the evaluation. The evaluation did not capture dementia as a secondary condition or as a suspected condition. The CACP census found that just over 18% of CACP recipients in 2002 had a report of dementia from a medical practitioner or an ACAT (AIHW 2004a). Data are not readily available to compare the social support needs of RVCP and CACP recipients. The RVCP service utilisation profile shows a lower level of social support delivery than was revealed by the CACP census, but measures of service utilisation are imperfect measures of support needs.

Linkage of CACP and residential care data records undertaken by the AIHW shows that 1,189 people aged 65 years who were CACP recipients in the quarter October to December 2002 separated from a package service and entered residential aged care within 90 days (Karmel 2005). This was from a total of 26,457 older CACP recipients in the quarter (AIHW analysis of CACP data for 2002–03). In other words, an estimated 4.5% of CACP recipients in the December 2002 quarter entered a residential care facility (Karmel reported similar results for other quarters).

Table A4.6: Age–sex-specific rates and crude rates of severe or profound core activity limitation (CAL) among RVCP evaluation participants, CACP recipients in 2002, and the estimated national household population of older formal care recipients (SDAC03)

	SDAC03	CACP	CACP subsidy period ≤ 440 days	RVCP
	Number of people with severe or profound CAL per 1,000 care recipients			
Males				
65–69	352.94	819.17	811.66	0.00
70–74	406.52	828.02	821.98	666.67
75–79	431.30	833.87	828.80	300.00
80–84	438.46	830.75	840.56	125.00
85+	534.81	846.52	850.57	161.29
Females				
65–69	269.74	826.80	819.94	333.33
70–74	386.77	827.44	817.23	222.22
75–79	363.82	834.08	828.88	115.38
80–84	498.89	846.69	843.43	130.43
85+	604.95	881.68	866.28	100.00
Crude rate	**434.03**	**849.88**	**843.14**	**140.43**
Age–sex standardised rate	**434.03**	**840.20**	**834.82**	**200.75**

Notes:

1. Care recipients aged 65 years or over.
2. Direct standardisation to the age–sex structure of SDAC03.

Sources: AIHW analysis of 2003 ABS Survey of Disability, Ageing and Carers confidentialised unit record file (SDAC03); AIHW analysis of CACP 2002 Census data; RVCP de-identified unit records.

An equivalent calculation was performed on RVCP evaluation data. The evaluation included 222 active RVCP recipients in the quarter October to December 2004. This covers 207 recipients who were active on 1 October and another 15 people who joined the RVCP between 2 October and 11 November 2004, the latest date of entry recorded for evaluation participants. Separations during the same quarter included four deaths and 12 admissions to residential aged care services. The number of evaluation participants 'at risk' of entering residential aged care during the quarter by virtue of being in the community during the quarter and remaining alive until 31 December 2004 was 218 people. Thus, 5.5% of participants between 1 October and 31 December 2004 left an RVCP service during the quarter to enter an aged care facility.

The October to December 2004 cohort of RVCP evaluation participants registered nine deaths and 40 admissions to residential aged care to June 2005. Excluding deaths, 18.8% of the group entered residential aged care over the period of follow-up, that is, approximately the same overall rate as for the 238 evaluation clients.

Allowance should be made for potential sampling error: the estimated rate of transfer to residential aged care among RVCP recipients comes from a relatively small group of care recipients observed over a short timeframe. Rates of entry to residential care will fluctuate from quarter to quarter and a cluster of care recipients at very high risk who enter residential care within a short time interval can influence small sample estimates. A 95% confidence interval for the quarterly rate of admission to residential care among RVCP recipients based

on the observed results is 2.5% to 8.5% and there is thus a wide margin for sampling error. The AIHW suggests that the observed rate of transfer to residential care is of practical significance mainly because 56% of admissions of evaluation clients to permanent residential care between the start of the evaluation and June 2005 were for residential low care.

The evaluation team sought the advice of service providers on how residential low care compares with care packages in a retirement village setting, that is, what might be the 'pull factors' of a residential setting for members of the target group who need low level care?

Psycho-social factors are thought to play a large part in the decisions of some people to move to residential care. A low care facility typically offers opportunity for communal dining, group activities and outings for the 'older old' that are not always available in a retirement village. Frequent visits from RVCP staff, up to three times daily, might not satisfy an individual's need for social participation with peers and the wider community.

These observations are consistent with the fact that ACAT recommendations for low-level residential care more generally are often based on psycho-social need as well as physical support need (LGC 2002:55). Results of the Aged Care Assessment Program in 2000–01 showed a higher proportion of ACAT clients living in independent living units or granny flats (46.3%) compared with those living in a house or flat (33.6%) received a long-term living arrangement recommendation for residential care. Most of the difference is due to proportionately more recommendations for residential low care for people in self-care units and granny flats (31.0% versus 18.2% of clients living in a house or flat; LGC 2002:Table 17b). The evidence points to the possibility of a different set of driving forces for older people in independent living units within retirement villages.

RVCP project coordinators mentioned in their discussions with the evaluation team that retirement village residents tend to be very forward thinking—'planners' was the term often used. Given the observed pattern of separation from RVCP and notable differences in historical patterns of ACAT recommendation for people in independent living units, it is tempting to speculate that the fact that older people in retirement villages have already left the family home might mean they are generally less averse to changing residence than care package recipients in private residences. A range of self-selection factors that arise from the 'push factors' for retirement village accommodation—planning for the future, living alone, more limited family and social resources, worry about being or becoming a 'burden' to younger family members, lack of confidence in managing a house and garden, higher perceived need for social interaction outside of family, and willingness to trade stability of residence for other lifestyle choices in early retirement—might distinguish this group in terms of their perception of residential low care. Anxiety about safety and fear of crime are not uncommon responses to living alone in the community and may contribute to relocation decisions.

That a relatively high proportion of older residents in retirement villages do not have a co-resident family carer and the dynamics of non-resident younger family members caring for parents as well as their own families could also contribute to choices for residential care.

The above discussion speculates on individual need factors that would influence decisions of RVCP recipients to move from an independent living unit in a retirement village to an aged care facility, particularly among those recipients who moved to a low care facility. Any systematic differences in the life experience, social resources, attitudes and preferences between older people living in retirement villages and older people at home in the community might help to explain the observed higher rate of transfer to residential aged care among RVCP recipients compared with CACP recipients (noting the lower ADL support needs profile among RVCP recipients overall). RVCP evaluation data provide no evidence of

an association between entry to residential care and level of ADL support needs, yet responses to the Care Experience Survey from people who transferred from an RVCP package to a low care facility tended to focus on their physical support needs not being met. In contrast, some RVCP recipients with high ADL needs continued to be supported at home with an RVCP package. A complex interaction between physical support needs and psycho-social factors involving care recipients and, in some cases, family carers, seems likely. Small sample sizes within projects and the relatively short evaluation timeframe make it impossible to discern any patterns that would relate service quality to outcomes among those clients with higher ADL support needs.

There may be potential for care packages in retirement villages to further prevent or delay admission to residential care but this will require a clearer picture of consumers' perceptions of care packages in the retirement village setting compared with residential low care accommodation. Flexible, client-focused ADL support and opportunity for peer participation such as communal dining and age-appropriate group activities and outings in addition to social support from staff are thought to be key ingredients for reducing the need for residential care in the target group.

4.4 Consumer feedback

Care Experience Survey results include reports from clients and family carers that RVCP services have made it possible for some people to remain at home for longer. Here we report on responses to selected survey questions on the topic of need for assistance and need for residential care.

Respondents were asked to indicate areas of unmet need for assistance prior to the client joining the RVCP, their level of satisfaction with specific aspects of service, and whether an RVCP service is considered to offer an adequate level of care for the foreseeable future. Anticipated support is evident in consumer feedback as well. Responses to the survey go directly to the question of whether RVCP services help to reduce need for residential care from a consumer perspective. The survey also throws light on why some RVCP recipients have turned to residential care.

Providing assistance in areas of prior unmet need

Only 35 respondents to the Care Experience Survey (20%) indicated that the client had received regular help at home with everyday activities from staff of their retirement village prior to the RVCP. Most of these clients were living in serviced apartments. Living in an independent living unit in a retirement village rarely carries an entitlement to care provision and for the majority of RVCP recipients, the Pilot has been their first experience of a care service associated with the retirement village.

The main sources of regular help at home with daily activities prior to RVCP were mainstream programs, mostly Home and Community Care, and care from family, mostly non-resident sons and daughters.

One hundred and twenty-two survey respondents (69%) indicated that the RVCP recipient was not receiving enough assistance before commencing with an RVCP service (56 respondents indicated needs in all surveyed areas were being met prior to RVCP). For each surveyed area of assistance, one-third to one-half of respondents who indicated a need in

that area said that needs were being met by all available sources of assistance prior to RVCP (Appendix 2: Table 5). For example:

- 144 people said the care recipient had needed domestic assistance prior to RVCP but at that time only 51 were receiving enough help with domestic chores
- 116 people said the care recipient needed help to get to medical appointments, but only 52 of these people received enough of this type of assistance before the RVCP
- 67 people said the care recipient needed help to take medications but only 33 were thought to be receiving enough help with medication use before RVCP.

The areas that recorded the highest number of care recipients with prior unmet need calculated as a percentage of 178 survey respondents include domestic assistance (52%), transport assistance (45%); help to see a doctor when necessary (36%); and accompaniment at home and in the community (34%) (Appendix 2: Table 5).

Eighty per cent of people who answered the question on whether the RVCP meets all previously unmet need for assistance responded positively (Appendix 2: Table 7). In three projects a lower proportion of respondents (60–75%) indicated the service had provided adequate assistance in all areas of previously unmet need but in each case the results are based on a very small sample (ACSA, Western Australia; Morshead Home, Australian Capital Territory; and Southern Cross Care, Victoria).

A proportion of responses to open questions contain direct references to packages helping people to stay at home. Care recipients referred explicitly to their increased ability to remain at home because of instrumental support, monitoring, and feelings of increased safety and security that came from knowing regular assistance is available. Relatives reported on the feeling of relief that they have been relieved of some or much of the burden of caring for a parent or other older family member (sample responses in Box 4.1).

The novel features of RVCP service provision as outlined by service providers are also mentioned in consumer feedback. Care recipients value frequent visits from staff, regular assistance with medications and the 'on-site' nature of RVCP service delivery.

Survey responses and reports from project coordinators describe the anticipated support effect of care packages in retirement villages. Some clients said that they were relieved to no longer feel a burden to family and neighbours and others said that it's reassuring to know that more help would be available if their needs increase. Project staff repeated positive comments from other residents in villages—relief that a neighbour is well cared for and confidence in the knowledge that services are available if they themselves need help in the future.

These observations are reflected in reports from service providers and case studies of individual clients that describe in detail the benefits of care packages (Part B).

Seventy-two per cent of carers and relatives who completed the carer section of the Care Experience Survey questionnaire said that the RVCP was a suitable care option for the foreseeable future (Appendix 2: Table 14).

When residential care is viewed as the only option

Over half of the admissions to permanent residential aged care among evaluation participants were for low care (58% of the admissions that occurred in the quarter to 31 December 2004 and 55% of all admissions among evaluation clients to June 2005). The experience of people who entered a low care facility after an RVCP care package is of

primary interest to the evaluation because a flexible care package is intended to substitute for residential low care at a minimum.

Fourteen questionnaires completed during the period of RVCP service were received from members of this group. These responses highlight that changing care needs and/or service disappointment influenced the decision to move to a residential care facility. Lack of predictability in staffing and service delivery and support on weekends, public holidays and in the evenings were common themes in these responses. Family carers have clearly played a central role in assisting care recipients with decisions about long-term care arrangements.

Box 4.1: Care Experience Survey, comments on the value of RVCP services

Comments from clients:

[Previously] 'being unable to peg items on a line, no longer have to struggle to get the wet washing to the Laundromat…[now] can stay in own unit.'

'That I am able to stay in my own unit, without going into a nursing home.'

'All the services are provided in the apartment. The staff are caring and they take the pressure out of the day to day living.'

'Feeling safer and able to remain in my home. Taking the burden out of the day, having assistance with cleaning & cooking.'

Daily assistance with showering 'takes some of the strain off of wife.'

'I hope that pilot program assistance would allow me to remain in my home.'

One client with prior unmet needs in all areas reported that RVCP was meeting all needs and was a good long-term care option.

Another client who prior to RVCP needed additional nursing care and assistance with medication use said the RVCP service was meeting needs in both areas.

Comments from carers and relatives:

'Greater invigilation has helped a lot.'

'Less worry that his needs may not be met and that assistance is always close at hand.'

'The additional help has achieved our initial goals, service has been excellent…the pilot has been very helpful as previously stated has taken [away] some of the stress of day-to-day care needed.'

'Regular assistance increases confidence. Client needs time to understand how or what to ask for to meet needs…supervisor takes personal interest and gets to know client so that client is comfortable requesting assistance. Daily assistance is good for family peace of mind.'

'Respite and the pressure off me for personal care.'

Asked whether there are any negative aspects of the RVCP service: 'Only that it is a Pilot. Hopefully it will become a permanent program.'Asked about positive aspects of the RVCP service: 'Able to live independently at home. Services offer dignity to client. A lot of pressure lifted off relatives.'

'Needs have changed and we do not think the program could have provided the kind of help Dad now needs, but we feel it did help to delay his admission to a nursing home.'

Prior to RVCP, one gentleman was not receiving any formal assistance but needed help with domestic chores, home maintenance, transport, sourcing aids & equipment, help to see the doctor and help to take medication. The primary carer, a daughter, remarked that her hope was for 'HELP – as I was not receiving any help and I was travelling down to his place every night to set up meals, doctor's appointments, shopping, house cleaning. Relief to attend to my own family needs. They were feeling abandoned. [RVCP service] alleviates stress from all the other family members and residents as he has someone in all the time.'

Selected quotations appear below to demonstrate the factors that differentiate in people's minds an RVCP service from residential low care.

Increasing care needs

'Mum's dementia slipped dramatically so family felt that Mum required full-time assistance through hostel care' [family carer].

'Needs have changed and we do not think the program could have provided the kind of help Dad now needs, but we feel it did help to delay his admission to a nursing home' [family carer].

'Retirement village staff always helpful but could only provide limited care. As his health deteriorated he needed extra help—spent extended time in hospital—nursing home was the next option' [family carer].

'At the present time "yes". However if my Mother's health deteriorates the services will need to be altered and or increased' [family carer].

Service disappointment

'Erratic times (particularly night ones) and change of personnel made it difficult for them to know who was coming and when. Some were very good, others only did barely enough' [family carer].

'Probably enabled husband to stay at home an extra 6 to 8 months by giving Mum some respite from daily care of my father, but it was still not quite enough and he has had to move to a nursing home. They found the inconsistent time of care and constant change of carers hard to deal with (their only real criticism)' [family carer].

'Problems with staff—limited ideas and changing staff' [relative].

'Changes in staff unsettling for my uncle' [family carer].

'Staff is excellent, however not enough staff to fulfil needs' [care recipient].

'It helps but not as much as I hoped'—this care recipient ticked unsatisfactory for personal assistance, mobility assistance, home maintenance, social support and participation but valued the monitoring of medication use and access to emergency support. At the time of completing the survey, the recipient was unsure whether the package was a viable form of long-term care.

Inadequate assistance outside normal business hours

'It helps but not enough—weekend help is still needed and help needed on public holidays. Weekend/evening & emergency assistance unsatisfactory. Not a long-term option because if incontinence was an issue during day or night no help would be to hand' [care recipient].

'At times needed more help such as over weekends—only minimal staff. Excellent arrangements during the week but weekend and evening emergency assistance less than satisfactory' [care recipient].

RVCP recipients with a Department of Veterans' Affairs (DVA) pension as their main source of income are over-represented in the people who moved to a low care facility during the reporting period. The evaluation group included 41 people with a DVA pension as the primary source of income (20.4% of evaluation clients who reported primary source of income and 17.2% of all evaluation clients). Ten of these RVCP recipients entered residential low care (42% of admissions to residential low care) and five entered residential high care (26% of admissions to residential high care). Regression analysis of the data did not produce

useful models for accommodation outcome but DVA pension status consistently emerged as a significant variable (at the 5% level of significance), suggesting that the observed higher rate of transfer from package care to residential care among DVA clients is not due to chance alone. Analysis of the data revealed no significant differences between DVA pensioners and other evaluation participants on key socio-demographic characteristics or dependency measures recorded for the evaluation (for example, age, sex, living arrangement, carer availability, ADL and IADL scores) that might explain the different accommodation outcome profiles.

Many DVA pensioners access subsidised assistance through the Veterans' Home Care and DVA home nursing programs but none of the DVA pensioners in the RVCP who entered residential care and who had completed the Care Experience Survey indicated that client co-payment for RVCP service was a deterrent to continuing with a care package (one question in the Care Experience Survey addresses the level of client co-payment). The issues raised by some DVA pensioners and family members in relation to RVCP care packages not being a viable long-term care option are the same issues of service level and quality mentioned by other RVCP recipients who moved to a residential facility. It therefore remains open to conjecture why DVA pension status was correlated with residential care outcome in this evaluation of RVCP services.

Individual need factors and service quality factors have led some people to choose residential care in preference to continuing with an RVCP care package. If care packages in retirement villages are to have maximum impact on the utilisation of residential aged care services within the target group there needs to be commitment to consistent service quality, especially surrounding the predictability of service times and staffing arrangements, responsiveness to clients' changing needs, and adequate provision for assistance outside normal business hours. As a client's care needs increase these aspects of service delivery become increasingly critical to enabling the person to remain at home in a retirement village. The importance of responsive client-centred service in achieving successful outcomes in community care is not unique to the RVCP in the sense of its relevance to all community-based care for older people.

4.5 Other considerations

This evaluation is an assessment of care packages in retirement villages and not of retirement villages *per se* but the financial arrangements that people enter into when they move to a retirement village carry implications for the potential of care packages integrated with an accommodation service to reduce the need for residential aged care. The evaluation is required to report on strengths and weaknesses highlighted by the pilot and this calls for a wider perspective on the targeting of care packages to retirement village residents.

Care and commerce

A basic premise for this discussion is that regardless of whether village ownership lies within the for-profit or not-for-profit sector, many or most villages are managed as commercial enterprises in which consumer interests are balanced with business objectives. The main legal structures or types of agreements that operate between residents and the owner or operator of a retirement village include leases, licenses, body corporate units and strata titles, company titles and unit trusts (Law Institute of Victoria website, 2005). A resident who enters a retirement village through a lease, license, company share purchase or

unit trust purchase does not own their unit in the conventional sense. In leasing and licensing arrangements a resident typically pays an ingoing contribution, part of which is returned on departure from the village.

The financial viability of a retirement village often depends on unit turnover because deferred management fees levied on residents may be released only when a resident leaves the village. Additionally, under some contractual arrangements capital gain on a unit is the entitlement of the retirement village owner rather than the resident. From a purely commercial standpoint, it is not clear that ageing in place would always be supported even if funding were available to increase service delivery for a package client. Discussions between the AIHW evaluation team and retirement village operators revealed that a waiting list for units may cause business imperatives to take precedence over the preferences of the individual resident and the range of options made available to them. A three-year assisted living demonstration project in the United States has similarly highlighted residency tenure, inter alia, in relation to relocation criteria (Munroe & Guihan 2005). That study reported inconsistencies in the disclosure, consumer understanding and acceptance, and application of termination of residency criteria. Thus, while the availability of community care packages can assist residents in retirement villages to avoid or delay entry to an aged care home, consideration needs to be given to the implications of commercial operating environments on the extent to which use of residential aged care services would be reduced in a mainstream service context.

Projects in the RVCP represent a range of models of service provision in combination with retirement village ownership and/or management interest. Resthaven Incorporated and Kingston City Council delivered services into retirement villages owned and operated by other organisations. In other projects the RVCP service provider had ownership and/or management interest in the participating village or villages. The model represented by Resthaven and Kingston City Council shows greater separation of care service provision and financial interest in the operation of villages while retaining the benefits of co-located care recipients.

Unused capacity

Narrow targeting can result in unused capacity unless allocations are closely matched to levels of need in the target group. All but one RVCP project reported a cash surplus in the reporting period. The AIHW is aware that in most projects the financial results for the quarter ending 31 December show the continuation of a trend of surplus funds since projects commenced operations. Flexible care enables a provider to operate more packages than the number of allocated places if this is within financial capacity. If this result reflects levels of demand and eligibility for packages within the target population then it suggests any future allocation model for a bundled service would need to be sensitive to levels of need in the target population.

Needs-based priority

Some retirement village operators are established CACP providers and in this respect the RVCP does not set a precedent in care package delivery. The new concept is the targeting of retirement village residents. A number of ACAT staff expressed reservations about the pilot concept because it appears to offer eligible clients a different level of service priority. It is felt that immediate package delivery might not have occurred in many cases had general waiting

list priority applied. The issue for ACATs is not assessment outcome but package availability in the wider population context.

A few RVCP service providers have remarked on the difficulties faced by village residents in accessing assistance through mainstream programs. They believe this occurs because of a common misconception among community service providers (outside of the RVCP) that people living in retirement villages are 'cared for' by staff in the village. The evaluation did not set out to address the access question but it needs to be visited in view of the pilot results. The only evaluation participants who were receiving care services from their retirement village prior to the RVCP were paying for assistance under a service contract in addition to their accommodation costs. People in independent living units by definition make their own care arrangements, as would someone in a private residence. The only readily available services to residents in self-care units in the RVCP pool are formal information and guidance services in some villages and goodwill. Before receiving an RVCP care package, people either received no assistance, informal care from a relative or friend and/or formal assistance through private arrangement or mainstream care program (in most cases HACC).

Rates of previous formal service use among RVCP recipients are not high: overall, 58% of people in the evaluation did not receive assistance through government support programs before the RVCP but the proportion was as high as 80% in some projects. Some ACAT members were aware that people in serviced apartments face access barriers when community service agencies make inappropriate judgments about existing service provision. When asked the question, ACAT staff expressed no awareness of widespread difficulties for people in independent living units. Previous patterns of formal service use perhaps need to be viewed in the context of the needs profile of the care recipient group.

The Pilot has produced a care recipient group with a lower needs profile compared with CACP recipients. RVCP service providers contend that over time the needs profile would change as people age and experience greater need for assistance. Maturation of a care recipient population in a hypothetical mainstream program modelled on the RVCP would depend on the motivation of each provider to continue to support clients with increasing needs within the limits of available funds. It is not clear to the evaluation team that all potential providers in the retirement villages sector would enact the same level of commitment to ageing in place seen in the Pilot.

Chapter 3 described the strengths of service delivery within retirement villages and it is no doubt of long-term value to care recipients who are able to access a care package sooner than might otherwise be possible. The main identified weaknesses include a greater incentive to allocate a package with case management capacity to some clients who might be equally well served by a HACC service in order to fill available places and the quarantining of packages to a narrowly defined target group that has not demonstrated a needs profile to match that of the wider population of package recipients.

One way to address these weaknesses is to approve more retirement village operators for general care package delivery, maintaining needs-based access through the Aged Care Assessment Program. At the present time, CACP does not afford the degree of flexibility in the RVCP so that many of the strengths of the RVCP would not be retained under this proposal. However, this raises a philosophical question that is beyond the scope of this report. Another possible mechanism for an equivalent mainstream program is vigilant program management for close monitoring of levels of service delivery.

A fundamental question that remains unanswered is whether any difficulty in accessing care packages that is experienced by older people in independent living units is associated with

place of residence, as contended by some RVCP providers, or mainly other factors including needs-based priority. The RVCP model of dedicated allocation requires careful estimation of need in the target population, ongoing monitoring of outcomes and service levels and service provider commitment to the principles of flexible care and ageing in place.

4.6 Principal findings

RVCP packages reduce the need for older residents of retirement villages to enter residential care by addressing ADL/IADL and social support needs and by providing other services not available through Community Aged Care Packages such as nursing and allied health care, as discussed in Chapter 3.

Evaluation data provide some indication that people in retirement villages face a relatively high risk of entry to residential care that does not appear to be related to physical support needs. Approximately 42% of RVCP recipients who transferred to residential aged care had made heavy use of general practitioner services and/or recorded urgent/unplanned hospital admissions prior to aged care admission. Acute health events or otherwise unstable medical conditions are therefore implicated in these admissions. Heavy use of health services in the period immediately prior to admission was recorded for relatively fewer people who entered low level residential are (29%) compared to those who entered high level residential care (58%).

A relatively low proportion of RVCP recipients have access to ongoing, regular care from family and this likely contributes to a relatively high rate of transfer from RVCP care packages to residential care. Just 11% of RVCP recipients had a co-resident family carer compared to an estimated 28% of CACP recipients; in total, 44% of RVCP recipients had a relative or friend carer, compared to 57% of CACP recipients. Moreover, a high proportion of RVCP recipients live alone (81% of evaluation participants) and psycho-social factors are known to be a major consideration in decisions to enter aged care facilities.

Consumer feedback reveals that close attention needs to be paid to consistency of staffing, service quality and out-of-hours assistance if care packages are to offer consumers an attractive alternative to residential services.

The evaluation has highlighted issues of unused capacity and needs-based priority in relation to a targeting scheme that is based on accommodation setting.

5 Sharing the cost of care

5.1 Main sources of project income

Projects reported Australian Government flexible care subsidy and client co-payments as the two main sources of income for delivery of RVCP services (Table A5.1). Australian Government payments are calculated at the current rate for low and high care places, averaged across the place allocation. Operational guidelines for the RVCP indicate the Australian Government's preference that projects put in place arrangements for client co-payments, following the same principles as for community care more generally:

(a) If the care recipient's income is less than or equates to the amount of the maximum basic rate of pension, the fee must not exceed 17.5% of the amount of the maximum basic rate of pension.

(b) Where the care recipient's income is greater than the maximum basic rate of pension, the fee must not exceed 17.5% of the amount of the maximum basic rate of pension plus 50% of the income in excess of the maximum basic rate of pension.

Co-payment amounts vary across the projects and between clients in a project. Most projects have offered discounted fees to a proportion of clients. Australian Unity Retirement Lifestyle Services caps client co-payments at $50.00 per week and assesses capacity to pay within this limit. Forest Place Retirement Village charges up to $24.00 per day. Around half of Forest Place clients paid $5.00 per day; these were clients whose primary source of income was the Age Pension. Other Forest Place clients, mostly self-funded retirees, paid between $9.00 and $24.00 per day. Other projects adhere to the standard community care co-payment rate and allow discounts for clients who would face difficulty meeting this amount.

Other forms of client contribution

In addition to direct financial contribution to an RVCP project, a client may contribute to the cost of overall care by continuing with established private arrangements. Varying numbers of clients were reported to have received services from other providers while receiving service from an RVCP package. Some of these services are of the type not provided by the RVCP, for example, medical consultation (122 clients) or geriatrician consultation (10 clients). In other cases, clients have sourced assistance of the type that could potentially be provided through the RVCP from other than the RVCP service. In this category the most common types of assistance recorded as being arranged independent of the RVCP service include:

- podiatry (33 clients)
- delivered meals (17 clients)
- physiotherapy (10 clients)
- other unspecified types of allied health care (12 clients)
- recreation and leisure programs (10 clients)
- nursing care (eight clients).

The financial arrangements for acquisition of these services were not ascertained.

In addition, there is the contribution from those spouses, adult children and friends who provide ongoing regular assistance, which can take the form of both in-kind and financial assistance. The value of this assistance is acknowledged although no attempt was made to quantify levels of informal care available to RVCP recipients during the evaluation.

Table A5.1: RVCP projects, mean daily project income during evaluation by source of income (flexible care subsidy and client co-payment)

	Daily payment (per client)			
Project	**Australian Government flexible care subsidy[(a)]**	**Number of client co-payment records**	**Mean client co-payment amount (min.–max.)**	**Combined mean payment amount**
HN McLean Memorial Retirement Village	$51.34	20	$1.43 ($0–2.85)	$52.77
Australian Unity Residential Lifestyle Services	$43.69	21	$6.10 ($0–7.00)	$49.79
Morshead Home	$41.31	19	$5.64 (uniform)	$46.95
Forest Place Retirement Village	$52.06	28	$10.39 ($2.00–24.00)	$62.45
Southern Cross Care (Victoria)	$41.31	18	$4.87 $2.85–5.43	$46.18
Kingston City Council	$39.06	23	$4.75 ($2.80–5.61)	$43.81
ECH Incorporated	$43.07	38	$1.83 ($0.71–5.42)	$44.90
Resthaven Incorporated	$68.07	14	$2.91 ($1.00–4.69)	$70.98
Mandurah Retirement Village	$57.78	20	$4.75 $4.00–5.00	$62.53
Aged Care Services Australia	$51.34	37	$4.79 $1.60–5.65	$56.13

(a) Australian Government payment figures were supplied by the Department of Health and Ageing and pertain to the financial year 2004–05. These figures are averaged across high and low care places in each project. In some instances figures differ from amounts reported by the project.

5.2 Income and expenditure

Projects provided occupancy and financial reports for the quarter ending 31 December 2004. These reports cover occupancy, income and expenditure for all care recipients active in the quarter (that is, not just those who participated in the evaluation).

Projects were given an opportunity to review the results as presented below and provide corrections if it became obvious that material amounts of expenditure had not been reported. The AIHW has concluded that reports of total expenditure and total expenditure on services (next section) are a reliable indication of activity in the quarter. The one area in which some systems may lack the sophistication required for reporting financial results to the evaluation is in the allocation of expenditure to service categories. This can be particularly problematic where staff perform multiple functions, such as a personal care assistant or respite care worker who also provide domestic assistance.

The Australian Government paid $1,062,998.95 in subsidy payments to RVCP projects in the quarter. Discrepancies exist between the official subsidy payment figures and reports from the projects. For the purposes of comparing income and expenditure this report uses the flexible care subsidy income reported by projects but acknowledges that the reported amounts vary from official figures by as much as 18% (Table A5.2). Attempts to reconcile the project reports to official figures where the variance could have a material impact on the analysis of financial results were unsuccessful.

Morshead Home did not report total flexible care subsidy payments for the quarter ending 31 December 2004 and is therefore excluded from some of the income and expenditure analysis that follows. Excluding the Morshead Home RVCP, projects reported a combined total income from flexible care subsidy of $993,122.22 compared with an official figure of $975,597.15.

Seven projects reported receiving income from client co-payments in the December quarter, to a combined total of $75,573.00.

Based on project-reported income from flexible care subsidy payments and client co-payments, total new income for nine projects in the December quarter was $1,068,695.20. A distinction needs to be made between new income and total available funds. Three projects reported a combined carryover from the September quarter of $109,915.00. Taking this into account, available funds in the December quarter across the nine projects totalled $1,178,610.20. The same nine projects reported a combined total expenditure in the quarter of $728,863.

Six of the nine projects that reported financial results for the December quarter did not report carryover funds, yet based on the December quarter financial results it is reasonable to assume that at least some of these projects would have generated a surplus in the September quarter. It was therefore necessary to use only new income in the December quarter in the analysis of financial results rather than include carryover funds for three projects only. Thus, it is entirely plausible for a project to report expenditure in excess of new income for the quarter.

Table A5.2: Official and project-reported flexible care subsidy payments, by project, quarter ending 31 December 2004

	Official subsidy amount ($)[(a)]	Reported subsidy amount ($)[(b)]	Difference as % of official subsidy
HN McLean Memorial Retirement Village	94,572.89	94,465.60	–0.1%
Australian Unity Retirement Living Services	84,679.63	82,538.00	–2.5%
Forest Place Retirement Village	125,718.64	126,863.96	0.9%
Kingston City Council	76,165.23	89,838.00	18.0%
Southern Cross Care (Victoria)	94,588.91	98,873.00	4.5%
ECH Incorporated	132,224.90	134,272.66	1.5%
Resthaven Incorporated	84,068.10	83,998.00	–0.1%
Mandurah Retirement Village	95,562.61	94,115.00	–1.5%
Aged Care Services Australia	188,016.24	188,158.00	0.1%
Subtotal (not including Morshead Home)	*975,597.15*	*993,122.22*	*1.8%*
Morshead Home	87,401.80	n.a.	n.a.
Total (including Morshead)	**1,062,998.95**	**n.a.**	**n.a.**

(a) Subsidy amounts supplied by Department of Health and Ageing.

(b) Subsidy amounts reported by RVCP-approved providers.

n.a. Not available.

Table A5.3 shows the proportions of income from flexible care subsidy and client co-payments during the December quarter, by project. Client co-payments contributed between 3.3% and 16.4% of project income. This table also shows expenditure as a percentage of new income, where expenditure is separated into expenditure on client services, and total project expenditure. Projects were requested to report direct care expenditure, net of overheads so that the impact of overhead costs for these types of services could be assessed. Mandurah Retirement Village reported services expenditure inclusive of operating expenses and other overheads and therefore expenditure on services as a proportion of total expenditure at Mandurah is not comparable to the reports from other projects.

Most projects reported a cash surplus in the December quarter without taking into account any carryover funds from the September quarter. Projects drew on between 56% and 88% of income for the quarter (Table A5.3). The degree of variation in financial results for the quarter is likely to be partly attributable to different accounting systems. Further, these results relate to a specific and limited time period that might not reflect the pattern of expenditure at different points in the financial cycle, for example, when annual insurance premiums fall due. It is also clear that the timing of the evaluation fairly early in the life of projects has implications for financial performance. Most providers were still at the stage of gauging how to manage the project budget with a view to being able to maintain clients as their care needs increased over time and of allowing the financial situation to stabilise to best judge how many unfunded clients could be carried.

Income and expenditure per client service day

Expenditure per client service day in each project was estimated to investigate patterns in the cost of supplying care.

Occupancy rates fluctuate over time as clients enter, exit and take leave from a project. Projects are unlikely to report 100% occupancy consistently over time. A comparison of allocated place days and actual client service days provides a picture of this pattern over time. The number of place days in a given period of time was calculated by multiplying the project's number of allocated places by the number of days in the quarter. The number of client service days is the accumulated number of days in the quarter that each care recipient was actively receiving services, summed over the number of active care recipients. Place days may be unoccupied if there is a gap between the exit of one client and the commencement of the next client who is allocated a package, or if a client is on leave from the project (for example, hospital or holiday leave).

Financial and occupancy results for the December quarter of 2004 were used to calculate project income, total expenditure and services expenditure per client service day, graphed in Figure A5.1. Projects are ordered by increasing value of average weekly hours of service per client in the reporting period, excluding case management and ancillary services such as transport and delivered meals that were not recorded in time units. Average weekly service hours were calculated over all evaluation participants. Projects reported income and expenditure covering all RVCP recipients in the quarter. Income per client service day is a function of the proportion of high care places allocated to a project, level of client co-payment and occupancy.

Table A5.3: RVCP projects, per cent of total income by source of income and expenditure (direct care and total) as a per cent of new income for the quarter, by project, quarter ending 31 December 2004

	Source of income as per cent of total income				Expenditure as a per cent of new income for the quarter		
Project	Australian Government	Client co-payments	Other[(a)]	Total	Direct care expenditure[(b)]	Total expenditure	Surplus[(c)]
HN McLean Memorial Retirement Village	100.0	—	—	**100.0**	48.4	83.9	16.1
Australian Unity RLS	87.5	9.5	3.0	**100.0**	46.1	78.8	21.2
Morshead Home	n.a.	n.a.	n.a.	**n.a.**	n.a.	n.a.	n.a.
Forest Place Retirement Village	83.6	16.4	—	**100.0**	37.2	59.9	40.1
Southern Cross Care Victoria	90.2	9.8	—	**100.0**	48.8	73.2	26.8
Kingston City Council	94.4	5.6	—	**100.0**	47.8	69.2	30.8
ECH Incorporated	95.9	4.1	—	**100.0**	32.7	55.9	44.1
Resthaven Incorporated	92.5	7.5	—	**100.0**	50.6	65.8	34.2
Mandurah Retirement Village	96.7	3.3	—	**100.0**	. .[(d)]	101.6[(e)]	–1.6[(e)]
Aged Care Services Australia	92.3	7.7	—	**100.0**	67.6	88.5	11.5

(a) Per cent of total income in the quarter derived from other sources (includes interest).

(b) Expenditure on direct care services as percentage of new income reported in quarter. New income includes flexible care subsidy and client co-payments. Carryover funds from the previous quarter are not included in the calculations because only three projects reported carryover but there is reason to believe that other projects may have generated a surplus in the September quarter based on December quarter financial reports.

(c) Surplus calculated as percentage of new income in the December quarter, i.e. excluding funds carried forward from the September quarter.

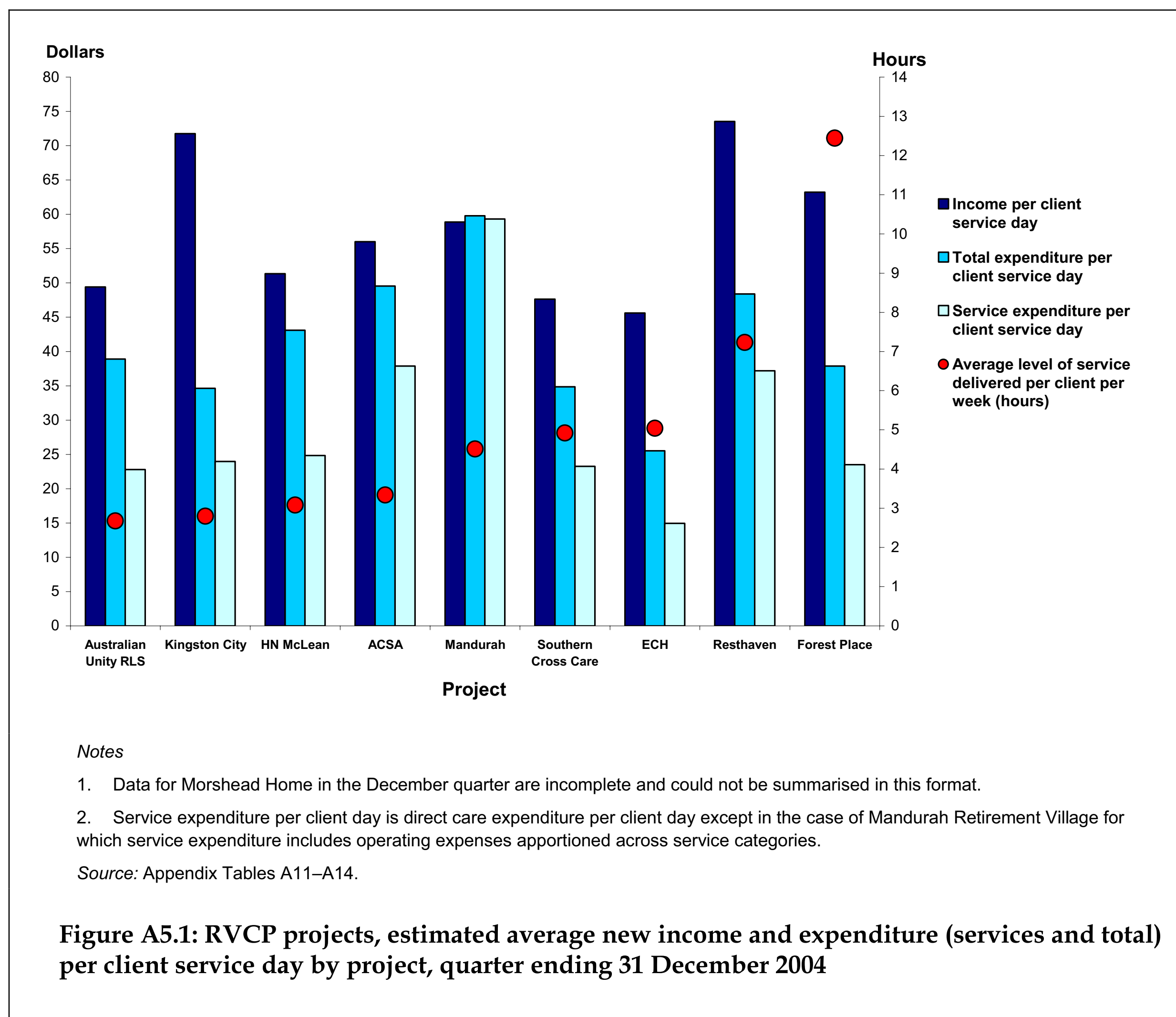
(d) Mandurah Retirement Village apportioned overhead costs to service categories and therefore the reported expenditure against each service category is not limited to direct care expenditure.

(e) Mandurah Retirement Village did not report carryover funds from the September quarter. A project may be able to expend more than new income in a quarter if there is carryover income from previous quarters.

— Nil.

n.a. Not available.

Source: Appendix Tables A13 and A14.



Notes

1. Data for Morshead Home in the December quarter are incomplete and could not be summarised in this format.
2. Service expenditure per client day is direct care expenditure per client day except in the case of Mandurah Retirement Village for which service expenditure includes operating expenses apportioned across service categories.

Source: Appendix Tables A11–A14.

Figure A5.1: RVCP projects, estimated average new income and expenditure (services and total) per client service day by project, quarter ending 31 December 2004

There is no obvious relationship between mean weekly service hours per client and expenditure on services per occupied place day in the quarter, averaged over all care recipients. Assuming all overhead costs are included, most projects could have delivered a higher level of service to existing clients or operated more packages had there been a need to do so. In addition, there are multiple factors which affect the efficiency with which projects are able to deliver services. For example:

- economies of scope—some projects are able to leverage existing infrastructure and/or share resources with other programs to a greater extent than others
- economies of location—some projects have care recipients co-located at one site whereas others are servicing a care recipient group distributed across multiple sites, a factor which may increase the cost of overheads on a per-place basis
- price differentials for services in different geographic locations.

A different picture might emerge from results over a longer reporting period and with a maturing client base. It is in the nature of pilots that they are in the 'start up' or early states of a new kind of service delivery.

5.3 Principal findings

Australian Government flexible care subsidy is the main source of income for RVCP projects; client co-payments contributed between 3.3% and 16.4% of income to projects in the quarter ending 31 December 2004.

Projects have adhered to preferred policy for the charging of client co-payments and have waived or reduced co-payment amounts on a case-by-case basis. Forest Place Retirement Village has derived a significantly higher proportion of RVCP project income through client co-payments (and delivered the highest average weekly service hours in the pilot).

Care recipients contribute financially and in kind to the provision of care. A proportion of those who participated in the evaluation were receiving assistance from sources other than an RVCP project while simultaneously receiving RVCP services (in most cases, allied health care, nursing care, and food services were sourced via other established arrangements and paid for in part or in full by a care recipient or family member). Care from family and friends also plays a major part in the total amount of care that many RVCP recipients receive.

During the reporting period, most projects generated a cash surplus and the AIHW is aware that this has been a trend from quarter to quarter since projects were established. Projects reported that the capacity to respond to clients' changing needs is a major benefit of the RVCP and it is clear that this was possible within set funding limits and for the care recipient group at the time of the evaluation. Most providers were still at the stage of gauging how to manage the project budget with a view to being able to maintain clients as their care needs increased over time and of allowing the financial situation to stabilise to best judge how many unfunded clients could be carried.

The financial results offer some perspective to findings in the Care Experience Survey for people who moved to residential low care. It is assumed that most of these people would make a much higher financial contribution towards their care in a residential setting. Likewise, service providers have reported financial capacity to increase levels of service and/or offer an expanded range of services. That some clients chose to move to residential low care in preference to continuing with a flexible care package (which should be able to deliver service equivalent to high care) indicates that financial constraints are not the sole or main reason that a package does not deliver the level and type of service required or desired by some clients to remain at home. Consumer feedback contains reports of poor capacity to deliver certain types of assistance, support of people with dementia and their carer, and out-of-hours assistance, for example. It is likely that the range of services and level of service offered by a project depends to a large degree on the provider's experience, access to existing infrastructure, and service linkages.

6 Conclusion

RVCP pilot services have targeted very old residents of retirement villages (average age 85 years) for the delivery of care packages. Seventy-five per cent of RVCP recipients who participated in the national evaluation were female and 81% of recipients lived alone. An estimated 14% of RVCP recipients at the time of the evaluation experienced severe or profound core activity limitation and therefore always or usually required supervision or assistance with self-care and or mobility. The ongoing support needs of most RVCP recipients during the evaluation related primarily to instrumental activities of daily living—housework, shopping, meal preparation, transportation, social participation and medication use.

With the exception of those at Forest Place Retirement Village, most packages have been delivered to residents in independent living units. Only at Forest Place Retirement Village have residents in serviced apartments been exclusively targeted for project services. For around half of RVCP recipients the Pilot has been a first experience of assistance from government support programs but in some projects up to 80% of recipients were not receiving assistance through government support programs prior to the RVCP. In addition, receipt of RVCP services has been the first opportunity for residents in independent living units to receive ongoing, regular assistance at home from, or in connection with, their retirement village. Residents in serviced apartments receive RVCP services in addition to a basic level of domestic assistance that they pay for under a retirement village service contract.

Forty-four per cent of evaluation participants were receiving regular and ongoing assistance from a relative or friend while receiving RVCP services and 77% of family/friend primary carers whose care recipient participated in the evaluation did not live with the RVCP recipient. Thus, the predominant pattern of informal care provision in the target group is non-resident sons and daughters (61% of carers) followed by co-resident spouses or partners (22% of carers).

The evaluation has considered the key issues to be addressed in the light of three main sources of information:

1. The support needs and service utilisation profiles of RVCP recipients.
2. Reports from service providers on the operation of RVCP care package services.
3. Feedback from care recipients and family carers on their RVCP experience.

6.1 Key issues

Issue 1: The novel features of RVCP packages vis-à-vis Extended Aged Care at Home packages (EACH) and Community Aged Care Packages (CACP)

Four novel features of RVCP packages were identified:

- The targeting of residents in retirement villages has enhanced access to care packages for the target group. It is concluded that a significant proportion of RVCP recipients have received a coordinated package of care at an earlier stage in the care needs continuum than might otherwise have been the case.
- RVCP service providers are able to offer per client weekly hours of service that range across levels of service seen in CACP and EACH packages. Some projects demonstrated this capacity during the evaluation, while service hours in other projects were mainly confined to a typical CACP package level of service.
- RVCP packages can offer a more comprehensive service mix than CACP by the inclusion of nursing and allied health care. One in four RVCP recipients received some amount of nursing care during the evaluation. Thus, an RVCP service can offer the types of assistance available through EACH packages to clients according to their levels of need at a particular point in time, rather than according to a nominal level of care or package construction.
- On-site staff or a dedicated team of RVCP care workers has enabled some projects to deliver a personalised level of service that has high preventive care and social support value for care recipients at relatively low cost. This takes the form of frequent, short visits to care recipients (for example, up to three times daily) to check on condition, assist with medications and, where necessary, provide guidance or physical assistance to promote mobility; the cost of providing this level of assistance is made more feasible by the co-location of care recipients.

These features are variously apparent across the 10 projects. Australian Unity RLS, Southern Cross Care (Victoria) and ACSA reported expenditure on a limited range of services, focusing primarily on personal assistance, domestic assistance and one other type of assistance, for example, food service or social support. For ACSA and Southern Cross Care the RVCP appears to have operated as an extension of the organisations' existing CACP service delivery program. Australian Unity RLS delivered a quite basic type of service during the evaluation period. Australian Unity RLS had no previous experience in care package delivery and the project does not appear to have had access to existing aged care infrastructure for the delivery of RVCP services. With maturity this project could potentially develop a more comprehensive package service, although the large geographic catchment area is likely to limit its capacity to deliver a highly personalised service under the current service coordination model. HN McLean Retirement Village, Forest Place Retirement Village, Kingston City Council, Resthaven Inc., ECH Inc. and Mandurah Retirement Village reported more diverse patterns of expenditure on client services. In the Morshead Home project,

consortium members have operated independently and the service expenditure profiles for two members are quite different.

It appears that differences in service activity profiles are related to differences in the existing service infrastructure and networks of RVCP providers.

Projects that integrated the RVCP into an existing service delivery system, for example, RVCP, CACP and/or HACC service delivery using a shared staff base, did not articulate the same level of personalised service described by projects with a dedicated team of RVCP workers.

Issue 2: Whether recipients of RVCP packages of care have a reduced need to enter residential aged care as a result of receiving the package

There is conflicting evidence on the issue of reduced need to enter residential aged care facilities. In the positive, many respondents to the Care Experience Survey (care recipients and family carers) indicated a firm belief that RVCP packages help recipients to remain at home for longer and view packages as a suitable care option for the foreseeable future. The evaluation found that overall levels of service utilisation during the reporting period were commensurate with measures of need for ADL support. Thus, there is evidence that RVCP projects have addressed one important area of need that is a known risk for entry to residential aged care. Also in the affirmative, eight of the 13 evaluation participants who commenced RVCP services with ACAT approval for high level residential care were still with the Pilot at time of follow-up and a further 11 participants were still receiving RVCP services despite being reassessed by ACAT to residential high care level, or having reached that level of care need without having to be reassessed.

Conflicting evidence was found in a comparison of rates of entry to residential care among RVCP and CACP recipients. Approximately the same rate of transfer to residential care was observed in the RVCP evaluation group as has been reported for CACP recipients, yet the RVCP has serviced a recipient group with a significantly lower overall rate of severe and profound core activity limitation. Moreover, 18% of evaluation participants had entered an aged care home by the time of follow-up and more than half of the people who transferred from an RVCP service to a residential aged care service entered a low care facility. Survey responses from some of the clients who eventually entered residential low care suggest that some RVCP packages were not sufficiently responsive to help people avoid admission to residential care but that they helped to delay entry.

Qualitative differences between package recipients in the wider community and eligible recipients in retirement villages possibly contribute to a higher risk of entry to residential aged care for the latter. The fact that the newly launched RVCP did not source a higher needs profile group is noteworthy. This may reflect historical patterns of care transitions in retirement village communities and it is not entirely clear whether these are primarily driven by consumer preference, operational aspects of the retirement village industry and/or factors relating to packaged care supply and demand. The residential accommodation outcomes of the Pilot suggest that it may not be a simple case of packaged care supply and demand. A full exploration of these sorts of issues is beyond the scope of the evaluation.

Issue 3: Whether more retirement village residents than before have the option of being cared for at home as a result of the Pilot

It is concluded that more retirement village residents than before do indeed have the option of being cared for at home as a result of the Pilot. Up to 80% of care recipients in some projects were not previously receiving package care or other form of assistance through government support programs prior to the Pilot. The vast majority of RVCP recipients were not receiving assistance with daily activities from or in conjunction with their retirement village prior to the Pilot. Those who were previously receiving ADL assistance were paying for a minimal level of domestic assistance from village staff but not enough to support a high needs client at home. Serviced apartment residents in the evaluation include individuals with some of the higher levels of ADL impairment in the evaluation cohort. The Pilot has given members of the target group a new care option.

There is strong evidence of the benefits of instrumental support at home and of the benefits of anticipated support even among RVCP recipients who were receiving relatively low levels of care. Results from the Care Experience Survey convey a high degree of acceptance of RVCP services among care recipients and family members. Care recipients reported feeling 'cared for' and 'secure' and expressed relief at not having to depend on the goodwill of others. They valued the sense of being able to manage at home and they liked the regular contact with familiar staff that the RVCP brings. Family carers who participated in the evaluation, many of whom were non-resident sons and daughters, expressed reduced anxiety through the knowledge that there is a reliable source of assistance for their elderly loved one. Case studies provide further testimonial of the benefits of the Pilot for care recipients and families. Anecdotal evidence of anticipated support in the wider retirement communities as a result of the RVCP has also emerged. Staff commented on increased social participation in the villages and a heightened sense of security among residents who are not receiving RVCP services that are thought to be associated with general awareness of the RVCP.

Project coordinators and managers of retirement villages were extremely positive about being able to provide timely, appropriate support to residents. In most projects the allocation of packages has been well matched to actual demand. Promotional campaigns in villages have raised awareness not only of the availability of care packages, but also of the existence and purpose of ACAT assessment, how to access ACAT services, and other types of care that are available to older people in the community.

Recipients and their families clearly articulated their increased opportunity of being cared for at home as a result of RVCP care packages in the Care Experience Survey. It is clear that for some members of the target group, seemingly simple forms of assistance such as hanging out the laundry or help to get to medical appointments engenders confidence in their ongoing capacity to remain in an independent living unit.

This conclusion should not be seen as a contradiction of evaluation findings in relation to reduced need for residential aged care. There is reason to believe that older, frail people in retirement villages as a group are risk averse in their planning for future care. Combined with overall lower access to informal care from co-resident spouses and partners and a higher exposure to neighbours and friends of long-standing leaving the village setting to enter residential low care, we speculate that the RVCP target group may be at a relatively high risk of entry to residential care. These sorts of factors are not fully reflected in measures of instrumental support need. In this sense, care packages offer increased security and

confidence. Over time there may be potential for care packages to alter what appear to be pre-existing dynamics in favour of the residential model for care at the lower end of the care needs continuum.

Finally, records that indicate a shift from use of hospital emergency departments to primary care providers prior to receipt of acute care suggests that flexible care packages with case management can strengthen links between community care providers and health providers. The monitoring capacity demonstrated in a number of projects clearly provides increased assistance to clients needing to access medical services and this could lead to more timely intervention for major health events. Since such events are a major risk factor for older people entering residential aged care, the indicative findings in this area show considerable promise.

Issue 4: The extent to which government and package recipients share the cost of supplying care

Package recipients have shared the cost of supplying care in three ways: co-payments to RVCP service providers; continuity of existing service arrangements for some clients to supplement an RVCP package, either a serviced apartment service or private arrangements for nursing and allied health care; and informal care from relatives and friends to supplement an RVCP package. Client co-payments as a proportion of project income varied across the projects during the reporting period, from 3.3% to 16.4%. One project with a relatively high proportion of superannuants charged higher levels of client co-payment than projects with primarily Age Pensioners.

In the quarter ending 31 December 2004 most projects did not expend the total amount of income and most accumulated large cash surpluses. This quarter's results are known to be a continuation of an established pattern of financial results across the projects.

6.2 Pilot strengths and weaknesses

The Pilot's greatest strength appears to be a weakness in the wider service context. By giving residents of retirement villages dedicated access to care packages, a high proportion of residents have gained access to a flexible care package at a relatively early stage of the care continuum. It is a significant benefit for those care recipients to have obtained a package that theoretically can grow in response to changing needs. Anticipation of future support engenders a sense of confidence and presents to care recipients a real alternative to residential aged care. RVCP models that operate with a dedicated staff and within just one or a small number of villages have demonstrated a high level of service flexibility and personalised care for package recipients.

However, the RVCP locks comprehensive care packages into a narrowly defined target group and from a system-wide perspective narrow targeting without careful attention to needs-based allocation might be seen to result in inefficient allocation of resources. The full capacity of packages in most projects was not being utilised at the time of the evaluation because most recipients either did not need or did not receive the levels of service that packages are funded to deliver.

Some Aged Care Assessment Teams raised the issue of equity in resource allocation as it relates to narrow targeting.

During the evaluation, most RVCP recipients were observed to receive a level and mix of services similar to a CACP. Calculated over all clients, median weekly hours of service per client in the RVCP evaluation, excluding case management and ancillary services, was 3.5 hours (mean 4.8 hours), but there was considerable variation between the projects' mean weekly service hours per client. Twenty-five clients recorded an average of 10 or more hours of service per week. Allowing for an estimated weekly case management time of approximately 30 minutes per client per week, and the availability of more costly types of care such as nursing and allied health care from some RVCP services, it is concluded that there is not a great deal of difference in the cost to service provider to deliver an RVCP or a CACP package to the 'typical client'. Over a third of continuing CACP recipients in a quarter receive HACC services in addition to CACP services (including but not limited to HACC-funded nursing care; AIHW: Karmel & Braun 2004). This, in addition to the provision of assistance by family carers for a high proportion of CACP recipients, helps to explain how the CACP program supports a high proportion of recipients with severe or profound core activity limitation. Most RVCP services would be able to deliver flexible, responsive care within CACP-level funding including client co-payments, given the client support needs profile observed in the evaluation. However, the CACP program does not deliver nursing care or allied health services so that the RVCP is an advantage over traditional CACP services.

In the present needs-based priority system, a higher number of CACP packages in a region would not automatically provide more packages for retirement village residents unless they were specifically targeted at the retirement village sector. The Pilot has demonstrated a capacity within the sector to establish and operate care package services (Morshead Home, a new entrant to government-funded care package delivery through the Pilot, had also previously operated a private package service for residents). The current system of funding for community care places the allocation with the approved provider and it is not clear how to avoid unused capacity in such a narrowly targeted program while retaining service flexibility. Countries that have experimented with optional cash payment or care package provision for long-term community care have found that older people at the lower end of the care continuum tend to prefer cash payments to make their own care arrangements (OECD 2005). While this funding model appears to be ideally suited to the objective of efficiently increasing access to services within a narrow target group, it is not currently a feature of the Australian system of community care.

In conclusion, current CACP-funding arrangements would have enabled most RVCP providers to deliver the demonstrated levels of assistance for the care recipient group observed during the evaluation but CACP guidelines would provide for a more limited range of services.

Part B

Project reports

1 HN McLean Memorial Retirement Village

1.1 Project description

HN McLean Memorial Retirement Village was approved to operate a 20-place RVCP project in the northern New South Wales town of Inverell. HN McLean Memorial Retirement Village Pty Ltd is the approved provider and coordinating organisation for the project and an experienced provider of aged care services in the region. This project involves service provision and coordination by an established aged care provider to five not-for-profit organisations encompassing all the retirement village residents in Inverell. Services are delivered to clients who live in the HN McLean Memorial Retirement Village and to clients in five independently owned retirement villages—Cooinda, MacIntyre Homes for the Aged, St Mary's Accommodation Centre and Mrs Colin Campbell Legacy Homes.

Inverell is a town of some 10,000 people in country northern New South Wales, seven hours by road from Sydney and four hours from Brisbane. Local government services a population of approximately 16,000 people.

HN McLean Memorial Retirement Village Pty Ltd has been operating since the early 1950s and is an established provider of aged care services in the New England region. The organisation currently operates a variety of facilities and services:

- 80-bed nursing home (including a dementia-specific unit)
- 53-bed hostel
- 13-bed low care dementia-specific unit
- 15 retirement village independent living units
- 16 CACP (five Indigenous-specific)
- Day Therapy Centre
- 11 additional independent living units and a 13-bed low care wing are under construction.

HN McLean has a full-time staff educator, and employs staff trained in dementia care and behaviour management. Carer and family support programs are attached to both dementia units. A pool of aids and equipment is available to residents for loan.

A total of 115 independent living units are located in the villages serviced by the HN McLean RVCP project including:

- 15 units at HN McLean Retirement Village
- 30 units at Cooinda
- 50 units comprising MacIntyre Homes for the Aged, all managed by voluntary staff
- 10 units at St Mary's Accommodation Centre operated under the auspice of the St Vincent de Paul Society
- 10 units at the Mrs Colin Campbell Legacy site.

Most facilities have few or no paid staff, few common areas, and little organised activity for residents. Apart from those at HN McLean Memorial Retirement Village, residents do not have access to an emergency call system. There are no serviced apartments in the catchment area (some have recently opened in Tamworth, which are the first of their type in New England). The RVCP coordinator noted that people living in private homes in the area seem to be prioritised for access to services because it is assumed that retirement villages provide support and services to residents. This is generally not the case, especially for residents in self-care units.

Some RVCP clients used to receive HACC services, but these are mostly people with higher care needs. Home Care, the largest HACC provider in New South Wales, has allegedly 'shut the door' to new clients and is reverting to very low levels of service, for example, two hours of housework per fortnight, leaving a gap for people with medium to high care needs. Carers sometimes call HN McLean Memorial Retirement Village in desperation because they are unable to cope. Some residents are receiving HACC services but their needs exceed the amount of service that is available through that program. There were six names on the HN McLean CACP waiting list at the time of the evaluation site visit.

Health services in the area are also said to be limited. In mid-2004, there were no bulk-billing general practitioners in the area. A geriatrician visits once a week but it is difficult to get an appointment. There is no psycho-geriatrician based in the area, no local mental health unit that provides services specifically for older people, and it is difficult to access dementia services. Telehealth is in its infancy, and was not available in New England in 2004. Residents often need to travel to Tamworth, Newcastle, Sydney or Brisbane for hospital and medical treatment, greatly increasing out-of-pocket expenses and the physical and emotional effort involved in accessing health care.

Table B1.1: Areas of unmet need in the local population

Unmet need	Services available
EACH-type care packages	Throughout the New England Health Region there are no high care places other than the current project. The RVCP has provided five high care packages for the local community.
Transportation	RVCP provides the capability to transport clients to local medical appointments. However more funds are required for the transportation of clients to specialist appointment in major centres.
Case management	RVCP provides the allocation of a case management service allowing for the coordination of service delivery in an effective and efficient way. Previously most of these clients would be on a waiting list for a CACP or be receiving HACC services not under a case management model.
Equipment	RVCP provides clients with the availability of a large range of equipment. Purchases have included items such as wheelchairs, walkers, bath seat, rails and assistive eating aids. While some equipment is available through Community Health and local pharmacies, this often attracts a cost and most of the target group is financially disadvantaged.
Continence management	Extensive waiting lists, said to be of approximately two years, for the Program of Appliances for Disabled People (a New South Wales Government program), places extensive financial burden on clients due to the high cost of incontinence pads, for example, some clients are spending $13 for a pack of pads up to five times a week (which represents a large proportion of the pension).
Integration and coordination	Through case coordination, RVCP packages clients are able to receive a combination of services. This is achieved through strategic partnerships with other programs or organisations.

Source: HN McLean written response to topics for discussion between project coordinators and the AIHW evaluation team.

The RVCP coordinator reported that the age profiles across retirement villages taking part in the project are similar. Many clients have frequent hospital admissions, consequently their care needs tend to 'spike' after each acute episode. There are no self-funded retirees in the project. A number of clients have dementia.

Some clients have been hesitant to take up an RVCP package because of factors such as:

- loyalty to existing service providers and staff (in some cases the project has entered into brokerage arrangements to ensure staff continuity)
- fear of change
- anxiety about being able to pay the co-payment
- historical perception of HN McLean as a 'nursing home'
- inter-agency competitiveness and territorialism.

HN McLean undertook approximately 2 months' full-time work on the project proposal, liaising with other village operators and visiting every resident in the participating villages to survey needs and likely commitment. Early promotion of the project helped to avoid delays in filling places once packages became available.

The evaluation team was unable to travel to Inverell and instead held a teleconference in July 2004 with HN McLean management and the RVCP coordinator. At that time all places were filled and two supplementary places were being carried by HN McLean Memorial Retirement Village in order to meet demand within available resources. The project operates a waiting list. People on the waiting list are referred to New South Wales Home Care for HACC services, but these are not always immediately forthcoming.

The RVCP coordinator stays in touch with people on the waiting list and makes some home visits. Waiting list clients and their carers are eligible to take part in the support groups operated by HN McLean. HN McLean RVCP also tries to organise respite services for these people. Despite the availability of these 'stopgap' services, the coordinator expects residents on the RVCP waiting list to have different outcomes to RVCP care recipients.

The project maintains a good relationship with the discharge planner at Inverell District Hospital and attends regular meetings. Hospitals notify the coordinator when an RVCP client is hospitalised. Clients have their needs reassessed after hospitalisation and the care manager and the discharge planner work together to organise appropriate services for clients on their return home. However, clients may also be sent to hospitals in Tamworth, Newcastle, Sydney, Brisbane or Toowoomba, and it can be more difficult to coordinate discharge planning in these circumstances.

The project is staffed by HN McLean's existing workforce, though some services such as allied health care, some domestic assistance and personal care are brokered. Three care managers work on the project and other HN McLean community programs (mainstream and Indigenous CACP). An average ratio of case managers to clients of one care manager per 10 care recipients appears to be effective and manageable.

It can be difficult to attract appropriately qualified staff in a rural area. In particular, the project has experienced difficulty finding staff available to work after hours and on weekends, or on a casual on-call basis. Fortunately, HN McLean has access to a pool of qualified and skilled workers and invests heavily in staff training. For example, it operates an education centre in conjunction with the University of New England, which provides management training and Certificate III in Aged Care Nursing.

The community nursing service is very important to the RVCP project. Community nurses provide clients with nursing care as part of their normal work. HN McLean also employs nurses. There are currently no male care workers available to the project.

RVCP packages can provide a higher level of care than a CACP. In general, though, HN McLean views RVCP clients and mainstream package clients as similar in terms of care profile, and it can be difficult to distinguish between a CACP and an RVCP package recipient in practice. The coordinator reported that it can be easier to cater for a high-care client through the RVCP because the physical environment of village units is often more suitable than many private residences.

ACAT views an RVCP package as similar to a CACP, though the project is also servicing a small number of clients with higher needs equivalent to an EACH client. Case management delivered by the project reduces the burden on ACAT, which is valued. The ACAT also reported that case management performed by the project reduces carer strain and hospital use. The RVCP coordinator reported that the project is relieving some of the pressure on the HN McLean hostel as there are thought to be fewer people waiting for a bed since the project commenced services.

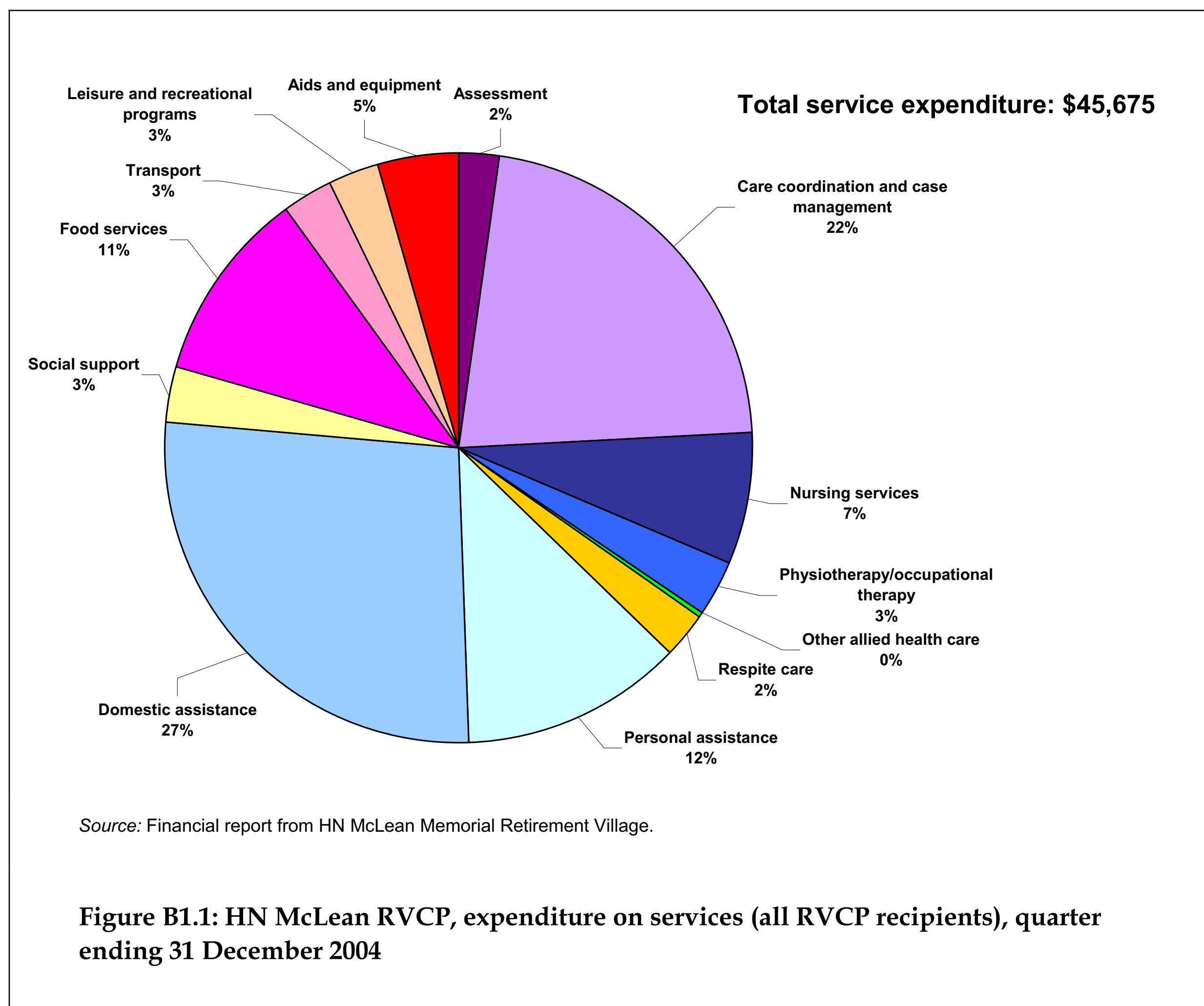
In the New England area, retirement villages are mostly operated by small not-for-profit organisations and there are no real networks or linkages between them. It is difficult to say how many retirement village residents there are in total as there is no central repository of information. This could prove to be a barrier to any roll-out of the project in the area. It is thought that a considerable amount of ground work and central coordination would be required.

Risk factors for continuing care

Risk factors which may preclude a client's participation or require a client to leave the project include problem wandering and other behavioural symptoms of dementia that require constant supervision and/or involve risk to the client, staff or other residents; a high need for nursing care; and a need for equipment that cannot be met because of the physical environment of the client's accommodation.

Profile of expenditure on services for care recipients

The project reported expenditure on a diverse range of assistance, including standard in-home services, nursing care and allied health care, transport and leisure programs (Figure B1.1).



Source: Financial report from HN McLean Memorial Retirement Village.

Figure B1.1: HN McLean RVCP, expenditure on services (all RVCP recipients), quarter ending 31 December 2004

1.2 Case studies

The project coordinator provided the following examples of client and family experiences in the project.

- 'Carers have made positive comment on the post-hospitalisation care that has been received for two of our clients. Because of the ethos of short-term hospitalisation these two clients were in need of extensive services after returning home. These were case managed in a "needs-over-time" basis and services were gradually withdrawn as the client gained back their independence. Carers were relieved that this had been done in a professional and "needs-based" manner without having to place demand on the family.'
- 'After the death of another client, housekeeping services were maintained until his widow was able to accept the loss of her husband and relatives were able to travel from long distances to take over support. The wife expressed gratitude that she had not been "left in the lurch".'

1.3 Client profiles

HN McLean RVCP provided evaluation data for 10 male and 10 female care recipients.

Age and sex

Care recipients who participated in the evaluation had an average age of 80 years (ages range from 62 to 92 years). Six clients were aged 85 years or over (Table B1.2).

Table B1.2: HN McLean RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
Less than 65	—	1	1
65–74	1	2	3
75–84	8	2	10
85+	1	5	6
Total	**10**	**10**	**20**
		(per cent)	
Less than 65	—	5.0	5.0
65–74	5.0	10.0	15.0
75–84	40.0	10.0	50.0
85+	5.0	25.0	30.0
Total	**50.0**	**50.0**	**100.0**

— Nil.

Language and communication

Five clients were reported as having little or no effective means of communication (spoken or non-spoken). The other 15 clients had effective spoken communication and all were proficient in English.

Accommodation and living arrangement

Most HN McLean clients were living alone in an independent living unit (Table B1.3). Three clients were living in a private residence at the time of referral to the project.

Years at usual place of residence ranged from less than one to 19 years, with a mean of 4.7 years. Two clients had been living in their retirement village for 10 or more years.

Table B1.3: HN McLean RVCP, number of clients by usual accommodation setting, living arrangement and accommodation setting at time of referral to RVCP

	Usual living arrangement			
Accommodation setting	**Alone**	**With family**	**Total usual accommodation**	**Accommodation at referral**
Private residence	1	—	1	3
Retirement village—independent living	15	3	18	16
Retirement village—supported accommodation	1	—	1	1
Total	**17**	**3**	**20**	**20**

— Nil.

Carer availability

Fifteen clients had a carer, twelve of whom did not live with the RVCP recipient (Table B1.4). Based on non-missing age values, carer age ranged from 32 to 77 years with a mean of 60 years. Two carers were aged 75 years or over (Table B1.5).

Table B1.4: HN McLean RVCP, number of clients by carer availability, carer relationship to client and co-residency status

Carer relationship to client	Carer lives with client	Carer does not live with client	Total
Spouse or partner	3	2	5
Son or daughter	—	9	9
Son- or daughter-in-law	—	1	1
Total clients with a carer	*3*	*12*	*15*
Clients without a carer	. .	. .	*5*
Total clients	**. .**	**. .**	**20**
Per cent of clients with a carer	. .	. .	75

— Nil.

. . Not applicable.

Table B1.5: HN McLean RVCP, number of carers by age group and sex

Age (years)	Males	Females	Persons
25–44	1	—	1
45–54	1	3	4
55–64	—	3	3
65–74	—	3	3
75–84	—	2	2
Not stated	—	2	2
Total	**2**	**13**	**15**

— Nil.

Income and concession status

Government pensions were the primary source of cash income for all clients (Table B1.6). All but two clients held a health care concession card. Seventeen clients received a discounted weekly contribution rate to participate in the RVCP.

Table B1.6: HN McLean RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number	Per cent
Principal source of cash income		
Age Pension	17	85.0
DVA pension	3	15.0
Total	**20**	**100.0**
Health care concession card holder	18	90.0
RVCP concession status	17	85.0

Previous use of government-funded community care programs

More than half of the clients were not receiving assistance from government community care programs before the RVCP (Table B1.7). Home and Community Care had been providing assistance to eight clients prior to RVCP. Respite care was used by two carers in the twelve months prior to joining the project and eight carers said they had not needed to access respite care.

Table B1.7: HN McLean RVCP, number of clients by use of government support programs prior to RVCP

Previous use of support programs:	Number of clients	Per cent
No recorded program support prior to RVCP	12	60.0
Government support program		
Home and Community Care	8	40.0
Total with previous government support	*8*	*40.0*
Total	**20**	**100.0**
Use of respite care in the 12 months prior to RVCP		
Respite care used	2	10.0
Respite care needed but not used	4	20.0
Respite care not needed	8	40.0
Not stated	6	30.0
Total	**20**	**100.0**

Three clients were on a waiting list for residential aged care during the evaluation.

Referral and assessment

HN McLean RVCP received referrals from a greater number of sources than most other projects. This is the only project to report referrals from general practitioners during the evaluation (Table B1.8).

Table B1.8: HN McLean RVCP, number of clients by source of referral

Referral source	Number of clients
HN McLean MRV	6
Other community services	5
Aged Care Assessment Team	3
Hospital	2
General practitioner	2
Family member	1
Friend	1
Total	**20**

On receipt of a referral the project coordinator would conduct a brief screen using a client profile instrument that covers medical history, social history, medication use, existing social support, potential barriers to care, and activities of daily living. If appropriate, the client would then be referred to an ACAT.

Ten clients had completed an ACAT assessment before commencement of services (Table B1.9). Two clients had ACAT approval for high care.

Table B1.9: HN McLean RVCP, number of clients by days between completion of ACAT assessment and service commencement

Completion date of ACAT assessment	Number of clients
Before service commencement	
0–20 days	1
21–30 days	2
31–90 days	3
91–180 days	2
181–365 days	—
Over 1 year	2
Total	*10*
After referral to RVCP	
Between 12 and 53 days after service commencement	10
Total	**20**

— Nil.

The project enjoyed a good working relationship with the one ACAT member who had responsibility for all aged care assessments in the area. In assessing potential clients, the ACAT member considered the complexity of client care needs, carer availability (in-home carer, no carer, working carer, etc.) and dementia status. Some early referrals to ACAT were rejected, but this was resolved through education. Subsequent referrals to the ACAT were appropriate. No client referred by an ACAT was rejected as unsuitable by the project. In cases where a client needed an immediate assessment, for example, following an acute illness, there were sometimes minor delays due to there being only one ACAT assessor. It was noted that in the earlier days of the project, ACAT often approved clients for flexible care and/or residential respite care only, giving no indication of low or high care equivalence.

Generally, the project has found the ACAT to be responsive and helpful.

The care of 12 clients was managed by a multidisciplinary team. A ‘case coordinator qualified assistant in nursing care’ supervised the care of the other eight clients.

Care planning was intensive in the first 3–4 weeks following acceptance of a client. Care plans were reviewed at 3, 6 and 12 months.

Health conditions and health status on entry

The number of health conditions recorded for HN McLean clients ranged from one to seven. Seventeen clients had three or more health conditions at entry to the RVCP. Table B1.10 lists the primary health conditions recorded for HN McLean RVCP clients.

Table B1.10: HN McLean RVCP, number of clients by primary health condition at entry

Primary health condition	Number of clients
Transient cerebral ischemic attacks	3
Chronic lower respiratory disease	3
Arthritis and related disorders	3
Other diseases and disorders of the musculoskeletal system & connective tissue	3
Malignancy	2
Diabetes mellitus—Type I or II	2
Dementia in Alzheimer’s disease	2
Other specified diseases and disorders[(a)]	2
Total	**20**

(a) Includes psychoses and depression, Parkinson’s disease.

Seven clients were both hearing and vision impaired at entry to the project and 15 clients were assessed as being at risk of falls due to impaired gait or balance (Table B1.11).

Table B1.11: HN McLean RVCP, number of clients by presence of selected health conditions at entry

Health condition	Number of clients
Impaired gait or balance—at risk of falls	15
Hearing impairment	11
Vision impairment	10
Both hearing and vision impairment	7
Total or partial paralysis	2
Diagnosis of depression	6
Disorientation/confusion	4

Clients were taking between zero and 13 different types of medication at entry to the RVCP, with a mode of six medications recorded by six clients. Seventeen clients were taking five or more different types of medication.

Most clients rated their health status at the baseline assessment as fair or poor (Table B1.12).

Table B1.12: HN McLean RVCP, self-assessed health status

Self-assessed health status	Number of clients
Excellent	1
Very good	4
Good	3
Fair	7
Poor	5
Total	**20**

Level of core activity limitation

Five clients were assessed as having a severe or profound level of core activity limitation at the initial assessment. Two clients experienced severe or profound limitation in both self-care and mobility. Moderate to profound levels of core activity limitation were observed mainly in the areas of self-care and mobility (Table B1.13). Most cases of severe or profound activity limitation were seen in the area of self-care (bathing or showering, dressing, grooming, eating and drinking, and toilet use).

Table B1.13: HN McLean RVCP, number of clients by level of core activity limitation at entry

	Level of activity limitation				
Core activity	No limitation	Mild	Moderate	Severe or profound	Total
Self-care	11	1	3	5	**20**
Mobility	7	4	7	2	**20**
Communication	18	1	1	—	**20**

— Nil.

Use of medical and hospital services prior to entry

Baseline profiles contain information about a client's use of medical and hospital services in the 6 months prior to entering the RVCP—the 'pre-entry period'. Data are missing for several clients. This is not necessarily because the clients have no medical or hospital service use history—missing values can be due to difficulty in obtaining the information.

Twelve clients were recorded as having visited a medical practitioner at least once in the pre-entry period. The reported number of visits to a medical practitioner in this period varies from one to 12 per client. Of the two clients who reported 12 medical consultations, one had sustained a fall with injury and one client had had both planned and unplanned admissions to hospital, accumulating 21 days for unplanned admissions alone. Cumulatively, 11 clients recorded 60 visits to a medical practitioner outside of a hospital setting over an estimated 1,980 person days.

Eight clients contributed to a total of 23 hospital admissions in pre-entry periods. Two clients had planned admissions only. The remaining six clients with one or more hospital admissions recorded either solely unplanned/urgent admissions, or both unplanned/urgent and planned admissions.

Conditions recorded as occasioning admission to hospital for HN McLean clients in the pre-entry period include:

- psychoses and depression or mood affective disorders
- fracture of lower leg and foot
- acute lower respiratory diseases
- heart disease.

Five clients had been rendered immobile and without assistance for more than 30 minutes during the pre-entry period. Four clients had suffered a fall with injury.

1.4 Client assessment results

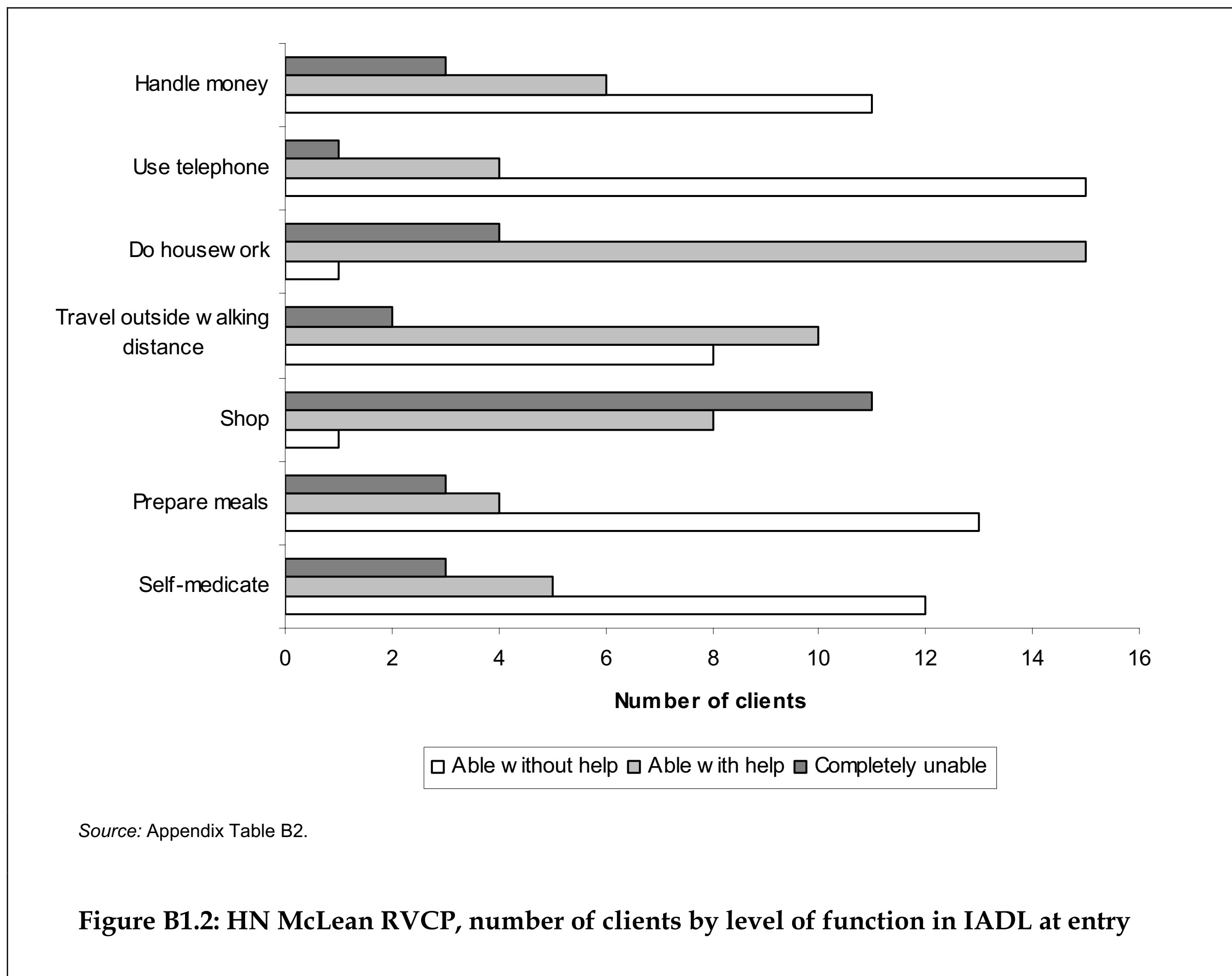
Activities of daily living

At entry to the project, five or more clients were fully dependent in continence management, bathing, dressing and grooming (Appendix Table B1). Baseline Modified Barthel Index (MBI) scores range from 10 to 20 out of a total 20 points.

According to a classification scheme for Barthel Index scores (Shah et al. 1989), five clients were assessed as falling into the category of severe dependency in ADL when they entered the project. The remaining clients were either moderately dependent (11 clients), slightly dependent (two clients) or independent (two clients) in ADL on date of entry. The mean baseline score is 15.8 points with a standard deviation of 3.3 (median 17 points), that is, the middle of the distribution of MBI scores lies in the range of moderate dependency in ADL (Table B1.14).

Most clients were either independent in most IADL at their baseline assessment or were able to complete IADL tasks with help (Figure B1.2). On average, clients were completely dependent in one out of seven IADL, which is comparable to other RVCP client groups (one

client was completely dependent in five IADL in addition to high dependency in ADL). The median baseline score on the OARS IADL scale for IADL is 10 points, with scores ranging from 3 to 12 out of a possible maximum of 14 points. Baseline results indicate that all HN McLean RVCP clients had lost some IADL function and that there is considerable variation in the extent of functional loss among clients entering the project. Housework is the one area of activity in which most clients recorded functional loss.



Source: Appendix Table B2.

Figure B1.2: HN McLean RVCP, number of clients by level of function in IADL at entry

Final assessments were conducted on average 15.7 weeks after entry.

Changes in the MBI between baseline and final assessments range from –3 (a 3-point decline in ADL function) to 5 points (a 5-point improvement in function). The median change score is zero (Table B1.14), indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments. Of the clients who recorded a non-zero change score, most remained at the same level of dependency (mild, moderate or severe).

The median change in score on the OARS IADL scale between baseline and final assessments is zero. Variation in change scores for the IADL range from –6 to 2 points (Table B1.14). Forty-two per cent of clients registered a decline in IADL function between their baseline and final assessment.

Table B1.14: HN McLean RVCP, summary measures for MBI and OARS IADL baseline and change scores[(a)]

	Number of clients	Median	Mean	Standard deviation
ADL				
Baseline MBI	19	17	16.1	3.1
Change in MBI	19	0	-0.1	1.8
IADL				
Baseline OARS IADL	19	10	9.0	2.2
Change in OARS IADL	19	0	-0.7	1.8

(a) Score at final assessment minus score at baseline for an individual client.

Cognitive function

HN McLean RVCP reported baseline Mini-Mental State Examination (MMSE) scores for five clients.[1] The MMSE is a brief test of a person's orientation to time and place, recall ability, short-term memory and arithmetic ability and is often used as a screen for loss of cognitive function (McDowell & Newell 1996). The test generates a score out of 30 if all items are completed.

Baseline scores range from 21 to 29 points (mean 25.4; standard deviation 3.4; median 26.0). Cut-points proposed by Uhlmann & Larson (1991) to account for educational attainment were applied to the recorded MMSE scores, revealing that one client who completed the test may have had mild cognitive impairment at the time.

1.5 Carer assessment results

Six carers rated their own health status at baseline assessment. Four reported good to excellent health and two carers reported a fair state of health.

All six carers completed the Caregiver Strain Index at their baseline assessment to generate a mean score of 5.2 (median 4) with a standard deviation of 2.3 points. Scores range from 3 to 9 points. Two carers recorded scores on or above the case threshold for carer strain of 7 points, indicating a likely need for considerable support to sustain their caring roles.

1 MMSE is an optional assessment in the national evaluation.

1.6 Accommodation outcomes

By completion of follow-up (14 June 2005), 15 clients remained in the project and two clients had entered an aged care facility (Table B1.15).

Table B1.15: HN McLean RVCP, number of clients by discharge outcome, 14 June 2005

	Number of clients	Per cent
At home		
With RVCP	15	75.0
With HACC	—	—
Without formal services	—	—
Not stated	1	5.0
Total at home	*16*	*80.0*
Institutional care		
Hospital	1	5.0
Residential aged care total	2	10.0
Low care	2	10.0
High care	—	—
Total in care	*3*	*15.0*
Deceased	1	5.0
Total	**20**	**100.0**

— Nil.

2 Australian Unity Retirement Living Services

2.1 Project description

Australian Unity Retirement Living Services (NSW) Pty Ltd is the approved provider for a 53-place RVCP project, which operates in retirement villages spread over a geographic area stretching from the Central Coast to the Southern Highlands of New South Wales. The project was established on 29 March 2004 and started delivering services to clients on 13 April 2004.

Australian Unity Retirement Living Services (Australian Unity RLS), formerly known as Residential Lifestyle Services Pty Ltd, owns, manages and markets retirement accommodation throughout New South Wales and Victoria. The RVCP project is Australian Unity's first venture into Australian Government aged care program delivery.

Australian Unity RLS has the largest allocation of places among the RVCP projects (53 places including eight high care). Pilot services were initially introduced into four villages on the Central Coast—Elderslee Village, Kiah Lodge, Karagi Court at Bateau Bay, and Lakefront Village at Toukley. Subsequently, services were introduced to Willandra Village and Willandra Bungalows at Cromer, a northern beachside suburb of Sydney, Greglea Village at Penshurst and, by August 2005, to Mt Eymard Village at Bowral. The villages have been established for between 5 and 30 years. Four villages are owned by Australian Unity RLS and the other four are managed by Australian Unity RLS under contract with the owners. Four sites offer both independent living units and serviced apartments but it is expected that most RVCP clients will be sourced from independent living units.

Community profiles differ considerably across the villages. Willandra Village and Willandra Bungalows at Cromer comprise a mix of very new single-level units in a resort-style environment and older, multi-storey townhouse-style accommodation. Their location on the northern beaches of Sydney places these villages at the high end of the retirement village market. Unit prices at Cromer range from approximately $450,000 to $700,000. However, many of the units at Cromer are 30 years old and Cromer accommodates a large number of much older residents who settled in the village many years ago. Mt Eymard at Bowral has been operating as a retirement village for around 12 years and also provides high-end accommodation due to relatively high land values. Lakefront Village at Toukley, and Kiah Lodge, Karagi Court and Elderslee Village at Bateau Bay are in a more affordable range. For example, the three villages at Bateau Bay are owned by charitable institutions; units are rarely priced for sale at over $285,000. Greglea Village at Penshurst is priced somewhere between these two extremes. Willandra Village at Cromer and Elderslee Village at Bateau Bay, the oldest villages, are generating the highest demand for RVCP services.

Australian Unity's stated objective in applying for RVCP funding is to deliver a range of professionally delivered flexible care service options to existing clients. It facilitates the use of existing physical infrastructure to aid in care service delivery, especially 24-hour emergency assistance and continual monitoring of clients in need of assistance through liaison with village staff. The project places an emphasis on promoting socialisation in the

local community for clients with dementia and providing support and assistance to clients whose partners are suffering from dementia.

Specific local unmet needs to be addressed by the RVCP project were said to include a shortage of CACP and EACH packages on the Central Coast, Southern Highlands and in the northern and southern suburbs of Sydney. The project reported waiting periods for mainstream packages in these areas that run to between 6 and 8 months. Village residents have reported being unable to access community services in these areas.

Australian Unity RLS clients are self-care residents who tend to be new to service delivery. A proportion of clients had been purchasing domestic assistance from organisations or individuals in the wider community under private arrangement. Some clients have retained these services, while the needs of other clients are being met solely through the project.

The evaluation team visited the project in July 2004, just three months after the initial client intake. At that time, eight places were filled and the project coordinator remarked that the evaluation was possibly taking place too early in the project life cycle. Initially, uptake of places was slow and a number of early referrals did not realise into eligible clients following ACAT assessment. Like other projects that rely on salaried staff, the Australian Unity RLS project experienced staffing difficulties in the early days when the number of clients was too small to engage new staff for a roster with capacity to meet new demand. This situation arose mainly because existing staff in the villages were unable to provide effective service to the project under their contracts as was initially envisaged and take-up of RVCP places was slower than anticipated.

At the time of the site visit, the project was staffed by nine salaried employees (three full-time equivalent staff). One case manager (0.5 full-time equivalent) and five care workers (1.5 full- time equivalent) were caring for clients. The project aims to maintain a caseload of one care manager per 8 clients and a primary and secondary care worker for every client. Secondary care workers ensure familiarity and consistency of care should the primary worker become unavailable. Nursing and allied health care will be brokered on an as-needed basis.

Project establishment involved recruitment of a coordinator and care workers and the development of care management systems. Relationships were forged between the project, ancillary health care providers and local ACAT. Strong working partnerships have been formed with ACAT located in Bowral, on the Central Coast, and in the southern and northern beachside suburbs of Sydney.

Target group issues

People must be aged 55 years or over to enter the villages and it was observed that age at entry has been increasing over recent years. Across the participating villages, an estimated 30% of residents live alone and 70% live with a partner.

A slower than anticipated uptake of packages may not truly reflect the level of need for services in the retirement communities. Cost is believed to have been a deterrent for some residents thought to benefit from the project. Fees for the project are capped at the standard CACP client contribution rate and at $50 per week for clients on higher incomes. Client contributions are on top of retirement village fees and general expenses, and collectively this can consume a large portion of fixed income.

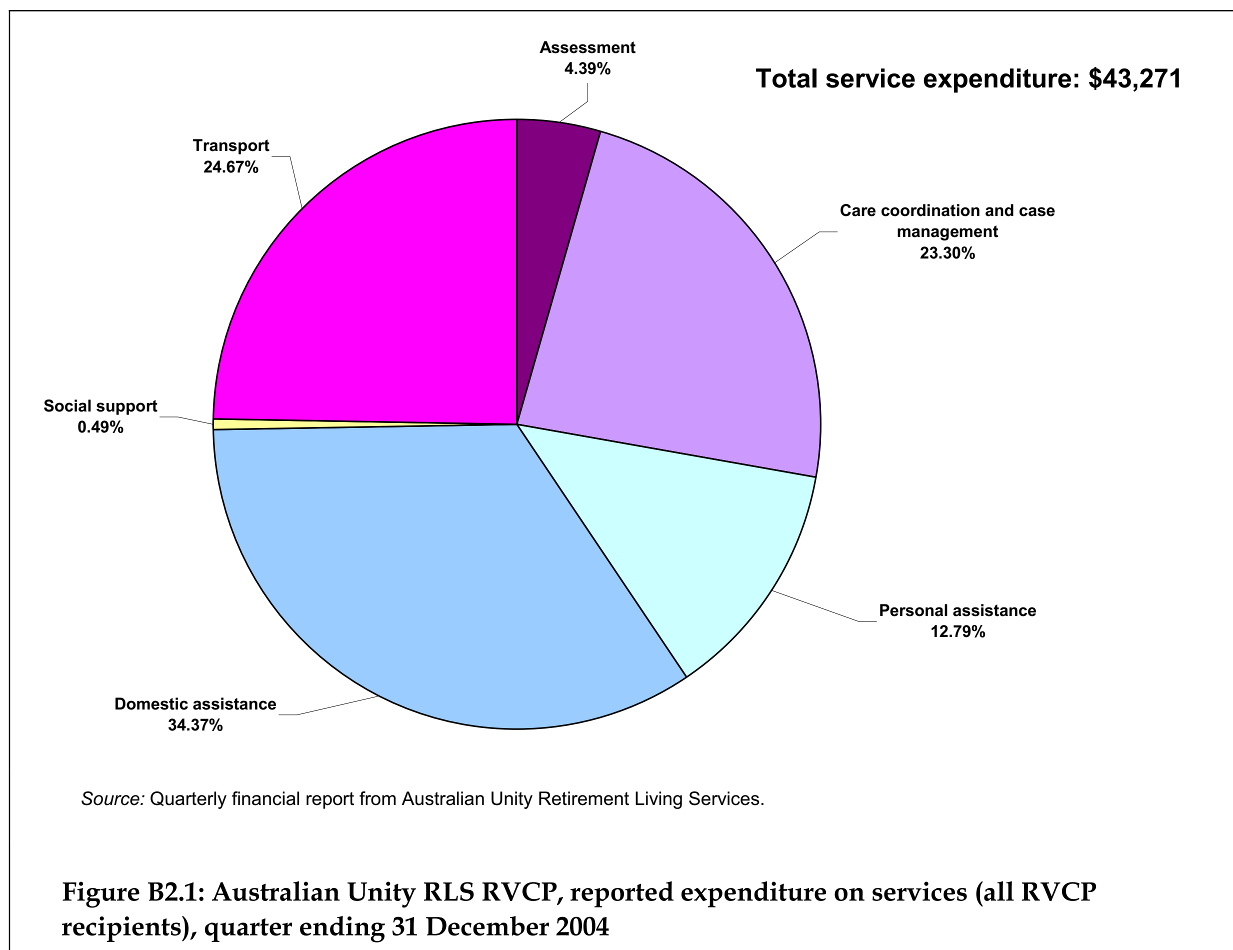
People often enter retirement villages with an expectation that higher levels of service will automatically be available as their needs change with age. Most retirement village units are,

in fact, self-care. Cost and physical access barriers can impact on the provision of adequate levels of care for people in retirement communities. In addition, in New South Wales, village residents are required to approve the village's operating budget each financial year and difficulties can arise in obtaining consensus among residents of all ages for devoting resources and energy to innovative programs for assisting higher-needs residents to remain at home.

Profile of services expenditure

Australian Unity RLS reported services expenditure falling primarily into the areas of personal assistance, domestic assistance, transport and care coordination (Figure B2.1). Client level data for the project do not include transport services for individual care recipients. Either service activity of the evaluation group is not completely representative of the wider Australian Unity RLS project, or the project has recorded expenditure on transport by the project coordinator and staff as services expenditure. A relatively high level of staff transport expense would be expected in this project because of the distribution of care recipients across multiple villages at different geographic locations.

This project did not report the range of service types seen in some other projects. Notably, no Australian Unity RVCP packages delivered nursing care or allied health care. During the reporting period Australian Unity delivered a very basic level of service and a limited range of services. The evaluation coincided with the early project establishment phase and this is the only RVCP project established by an organisation new to both care package delivery and residential aged care services. It is concluded that more time is needed to assess whether the project expands on the range of services offered to clients as it becomes more established and develops a service network.



Source: Quarterly financial report from Australian Unity Retirement Living Services.

Figure B2.1: Australian Unity RLS RVCP, reported expenditure on services (all RVCP recipients), quarter ending 31 December 2004

2.2 Client profiles

Australian Unity RLS provided data on 21 clients for the evaluation (19 females and 2 males), representing approximately 73.3% of clients who were active during the September and December quarters of 2004.

Age and sex

At the time of the evaluation Australian Unity RLS RVCP clients averaged 83 years of age. Ages ranged from 59 to 94 years and nine clients were aged 85 years or over (Table B2.1).

Table B2.1: Australian Unity RLS RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
Less than 65	—	1	1
65–74	1	3	4
75–84	1	6	7
85+	—	9	9
Total	**2**	**19**	**21**
		(per cent)	
Less than 65	—	4.8	4.8
65–74	4.8	14.3	19.0
75–84	4.8	28.6	33.3
85+	—	42.9	42.9
Total	**9.5**	**90.5**	**100.0**

— Nil.

Language and communication

All clients were able to communicate effectively in spoken language and all but one was proficient in spoken English.

Accommodation and living arrangement

Most Australian Unity RLS clients were living alone in an independent living (self-care) unit within a retirement village. Two clients were living in an assisted living unit (Table B2.2). All 20 clients were in their usual place of residence at time of referral.

Table B2.2: Australian Unity RLS RVCP, number of clients by usual accommodation setting, usual living arrangement and accommodation setting at time of referral to RVCP

	Usual living arrangement			
Accommodation setting	Alone	With family	Total usual accommodation	Accommodation at referral
Retirement village—independent living	17	2	19	19
Retirement village—assisted living	2	—	2	2
Total	**19**	**2**	**21**	**21**

— Nil.

Years at usual place of residence ranged from less than one year to 20 years, with a mean of 7.8 years. Six clients had been living in the same village for 10 or more years.

Carer availability

Fifteen clients had a carer—all non-resident carers. Most carers were a daughter or son (Table B2.3). Carers' ages ranged from 45 to 68 years, averaging 55 years (Table B2.4).

Table B2.3: Australian Unity RLS RVCP, number of clients by carer availability, carer sex, carer relationship to client and co-residency status

	Carer lives with client	Carer does not live with client	Total
Relationship of carer to client			
Daughter or daughter-in-law	—	10	10
Other female relative	—	2	2
Son or son-in-law	—	2	2
Other male relative	—	1	1
Total	—	*15*	*15*
Clients without a carer	. .	. .	6
Total clients			**21**
Per cent of clients with a carer			71

— Nil.

. . Not applicable.

Table B2.4: Australian Unity RLS RVCP, number of carers by age group and sex

Age (years)	Males	Females	Persons
45–54	—	8	8
55–64	2	3	5
65–74	1	1	2
Total	**3**	**12**	**15**

— Nil.

Income and concession status

Government pensions were the primary source of cash income for the majority of clients in the evaluation (Table B2.5). Twelve clients held a health care concession card. Due to financial hardship, two clients received a discounted weekly contribution rate for the RVCP.

Table B2.5: Australian Unity RLS RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

Principal source of cash income	Number of clients	Per cent
Age Pension	10	47.6
DVA pension	5	23.8
Superannuation	3	14.3
Disability pension	1	4.8
Other source of income	1	4.8
Not stated	1	4.8
Total	**21**	**100.0**
Health care concession card holder	12	57.1
RVCP concession status	2	9.5

Previous use of government support programs

Most clients were not receiving assistance from government community care programs before the RVCP (Table B2.6). Home and Community Care had been providing assistance to one client. Most carers said they had not needed respite care in the 12 months prior to their care recipient entering the project.

Table B2.6: Australian Unity RLS RVCP, number of clients by use of government support programs prior to RVCP

Previous use of government support programs	Number of clients	Per cent
Program support prior to RVCP		
Home and Community Care	1	4.8
Total clients with known previous program support	*1*	*4.8*
No previous government program support	17	81.0
Previous support not stated or unknown	3	14.3
Total	**21**	**100.0**
Use of respite care in the 12 months prior to RVCP (clients with a carer)		
Respite care not needed	13	86.7
Not stated	2	13.3
Total	**15**	**100.0**

Three clients were on a waiting list for residential aged care.

Referral and assessment

Clients enter the project mostly as a result of self-referral, or through the involvement and awareness of family members (Table B2.7). This referral pattern reflects promotion of the

RVCP service throughout the villages in the early days of the project, which coincided with the evaluation period. The project experienced some difficulty in obtaining prompt ACAT response to referrals, which appears to have been related to a lack of awareness of the project in its early days. Australian Unity RLS fully briefed all ACATs in the catchment area to resolve the problem and maintains regular contact with ACATs.

Table B2.7: Australian Unity RLS RVCP, number of clients by source of referral

Referral source	Number of clients
Self-referral	10
Family	7
Aged Care Assessment Team	3
Hospital	1
Total	**21**

All clients had completed an ACAT within one year prior to service commencement (Table B2.8).

Table B2.8: Australian Unity RLS RVCP, number of clients by days between completion of ACAT assessment and commencement of services

Completion date of ACAT assessment	Number of clients
Before service commencement	
0–20 days	10
21–30 days	3
31–90 days	5
91–180 days	2
181–365 days	1
Total	**21**

Health conditions and health status on entry

The number of health conditions recorded for Australian Unity RLS clients ranged from one to nine. Seventeen of the 20 clients had three or more health conditions when they entered the RVCP. Table B2.9 shows the primary health conditions recorded on the Aged Care Client Records for Australian Unity RLS clients.

Table B2.9: Australian Unity RLS RVCP, number of clients by primary health condition at entry

Primary health condition	Number of clients
Rheumatoid arthritis, other arthritis and related disorders	4
Heart disease or hypertension	4
Dementia (includes dementia in Alzheimer's disease and vascular dementia)	3
Cerebrovascular disease or TIA	2
Chronic lower respiratory disease	2
Other specified diseases and disorders	6
Total	**21**

Four of the 21 clients were both hearing and vision impaired and nine clients were assessed as being at risk of falls due to impaired gait or balance (Table B2.10).

Clients were taking between two and 10 different types of medication when they entered the RVCP. Ten clients were taking five or more different types of medication. The modal number of medication types was seven.

Table B2.10: Australian Unity RLS RVCP, number of clients by presence of selected health conditions at entry to RVCP

Health condition	Number of clients
Vision impairment	10
Hearing impairment	6
Both hearing and vision impairment	4
Impaired gait or balance—at risk of falls	9
Total or partial paralysis	1
Diagnosis of depression	7
Disorientation/confusion	4

Clients rated their health status at the baseline assessment as excellent (one client), good (eight clients), fair (three clients) or poor (eightclients). One client did not report.

Level of core activity limitation

Three Australian Unity RLS clients were assessed as having at least one severe or profound core activity limitation—two with mobility restriction and one with communication restriction—when they entered the RVCP. This is a higher prevalence of severe or profound core activity limitation than is suggested by baseline measures of functioning in ADL using the Modified Barthel Index (MBI). The MBI does not measure communication restriction and includes a greater number of self-care compared with mobility items. Scores for mobility items on the Barthel scale appear inconsistent with the levels of mobility limitation recorded for two clients.

The majority of core activity limitations exhibited by clients on entry to the project fall into the mild and moderate range (Table B2.11).

Table B2.11: Australian Unity RLS RVCP, number of clients by level of core activity limitation at entry to RVCP

	Level of activity limitation				
Core activity	No limitation	Mild	Moderate	Severe or profound	Total
Self-care	7	9	5	—	**21**
Mobility	4	9	6	2	**21**
Communication	15	3	2	1	**21**

— Nil.

Use of medical and hospital services prior to entry

Baseline profiles contain information about a client's use of medical and hospital services in the 6 months prior to entering the RVCP—the 'pre-entry period'. These data are available for 19 clients, however they are incomplete for one client.

Nineteen clients consulted a medical practitioner at least once in the pre-entry period. The number of visits varies from one to 20 per client. Four clients recorded six visits in the pre-entry period (the modal number). Cumulatively, 19 clients recorded 133 visits to a medical practitioner outside of a hospital setting over an estimated 3,420 person days.

Nine clients contributed to an aggregate total of 10 hospital admissions in the pre-entry period. The remaining seven clients with one or more hospital admissions recorded solely unplanned or urgent admissions. Five of these clients collectively accumulated 118 patient days over approximately 900 person days. Individually, they recorded between 15 and 42 days in hospital for unplanned admissions.

Conditions recorded as occasioning admissions to hospital for Australian Unity RLS clients in the pre-entry period include:

- type 2 diabetes mellitus
- heart disease
- transient cerebral ischaemic attacks
- fracture of the ribs, sternum and thoracic spine
- breathing difficulties
- amnesia.

Four clients had a fall with injury in the 12 months prior to entering the project. One of these clients was rendered immobile and without assistance for more than 30 minutes. The other three clients who had had a fall with injury had all presented to the emergency department and had unplanned hospital admissions. Two clients had also had a serious medical emergency in the 12 months prior to entry.

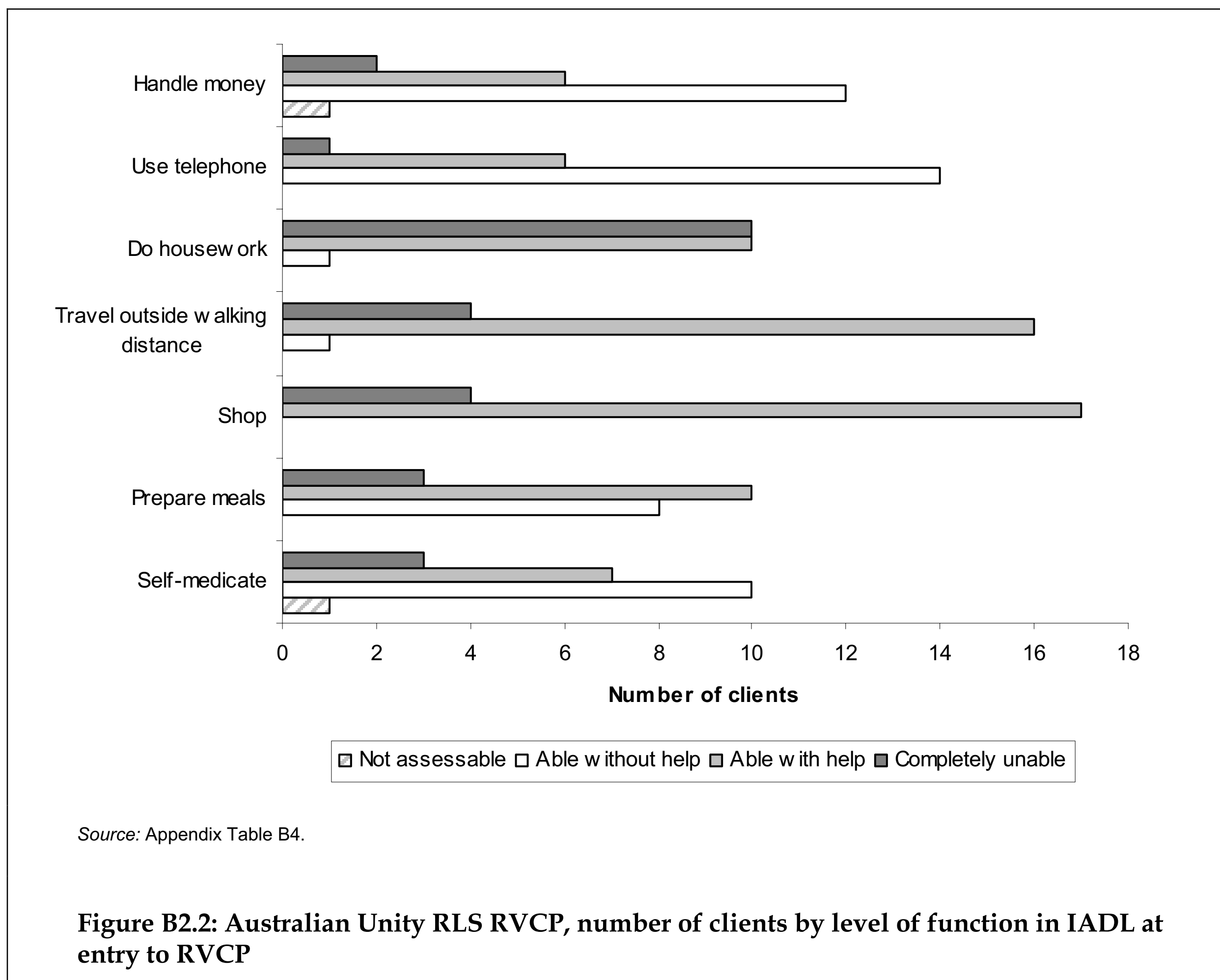
2.3 Client assessment results

Activities of daily living

On entry to the project, most Australian Unity RLS clients were independent in most of the activities of daily living (ADL), apart from grooming and negotiating stairs for which one-third or more clients needed assistance (Appendix Table B3). Baseline Modified Barthel Index (MBI) scores ranged from 11 to 20 out of a total 20 points. The mean score was 17.7 points with a standard deviation of 2.2 (median 18 points).

According to a classification scheme for the Barthel Index (Shah et al. 1989), one client exhibited severe dependency in ADL on entry to the RVCP; 12 clients were moderately dependent; four clients were slightly dependent and four clients were independent in ADL. The mean baseline score indicates that the middle of the MBI distribution for Australian Unity RLS lies in the range of moderate dependency in ADL.

Most Australian Unity RVCP clients were in need of help with IADL tasks at the baseline assessment (Figure B2.2). On average, clients were completely dependent in one out of seven IADL and were at least partially dependent in between one and three IADL. One client was completely dependent in all seven IADL. All but one client was unable to perform household chores independently and all clients needed help to shop for food and clothing or were unable to shop. Over half of the clients needed assistance to safely administer medication.



Source: Appendix Table B4.

Figure B2.2: Australian Unity RLS RVCP, number of clients by level of function in IADL at entry to RVCP

The median baseline score on the OARS IADL scale for IADL was 9 points, with scores ranging from 5 to 12 out of a possible maximum of 14 points. Baseline results indicate that all Australian Unity RLS RVCP clients had lost some IADL function by the time they entered the project and that there is considerable variation in the extent of functional loss among clients.

Final assessments were conducted on average 19.2 weeks after entry.

Changes in the MBI between baseline and final assessments range from –3 (a 3-point decline in ADL function) to 5 points (a 5-point improvement in ADL function). The median change was zero (Table B2.12), indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments. Of the clients who recorded a non-zero change score, most registered a change in level of dependency by one category (independent, mild or moderate).

The median IADL change between baseline and final assessments was zero, with variation within the range of –3 to 3 points (Table B2.12). Twenty-five per cent of clients registered a deterioration in IADL function between baseline and final assessments and 25% registered an improvement.

Table B2.12: Australian Unity RLS RVCP, summary measures for MBI and OARS IADL scores at baseline and paired change scores between baseline and final assessments[(a)]

	Count	Median	Mean	Standard deviation
ADL				
Baseline MBI	16	18	17.8	2.3
Change in MBI	16	0	0.1	1.7
IADL				
Baseline IADL	16	9	8.4	2.1
Change in IADL	16	0	0.3	1.7

(a) Score at final assessment minus score at baseline for an individual client.

2.4 Carer assessment results

Fifteen carers completed the CSI at baseline assessment to generate a mean score of 8.6 points (median 9 points) with a standard deviation of 2.9 points. Baseline scores range from 3 to 12 points. Twelve carers recorded scores on or above the threshold for carer strain of 7 points. Baseline carer strain scores for carers participating in the Australian Unity RLS project are high compared to scores recorded for carers in other projects.

Fifteen carers rated their own health status at baseline assessment. Four carers reported that they were in very good or excellent health, seven reported good health and four carers reported fair health.

2.5 Accommodation outcomes

Five of the 30 clients active in the September and December 2004 quarters were discharged from the Australian Unity RLS RVCP.

Discharge and ongoing support outcomes for evaluation clients were reported on 9 June 2005 (Table B2.13). On this date, 12 of the 21 clients were still with the project. An additional two clients had been discharged because they no longer needed formal services and remained at home. Six clients had entered residential care (five high care).

Table B2.13: Australian Unity RLS RVCP, number of clients by discharge outcome, June 2005

	Number of clients	Per cent
At home		
With RVCP	12	57.1
With HACC	—	—
Without formal services	2	9.5
Total at home	*14*	*66.7*
Institutional care		
Hospital	—	—
Residential aged care total	6	28.6
Low care	1	4.8
High care	5	23.8
Total in care	*6*	*28.6*
Deceased	1	4.8
Total	**21**	**100.0**

— Nil.

3 Morshead Home

3.1 Project description

Morshead Home RVCP is a project of 25 flexible care places available to residents at six retirement village sites located in the suburbs of Canberra. The project is a consortium of the management of four retirement village complexes: Morshead Home for Veterans and Aged Persons Incorporated (approved provider); Goodwin Villages, operated by Goodwin Aged Care Services Incorporated; Canberra Masonic Homes; and Villaggio Sant' Antonio. Morshead Home RVCP began delivering services to clients in December 2003.

Resident population age profiles are thought to be similar across the sites. Goodwin Homes at Farrer and Monash are described as particularly well educated and articulate communities with a relatively high proportion of self-funded retirees.

Morshead Home comprises a retirement village (15 rented and 40 private units) co-located with a 56-bed low care and 23 high care residential aged care facility. War veterans living in the village receive priority access to low and high care beds at Morshead Home. All retirement village units are self-care and RVCP care recipients at all locations live in self-care units. Morshead Home appears to routinely offer a considerable amount of support to residents on request. For example, village residents are often assisted with shopping and appointments. Morshead Home operates on a 'wellness model' following the principles and practices of healthy ageing. Residents are encouraged to stay active and keep fit. A visiting sports physiologist and registered nurse perform scheduled resident assessments and the physiologist runs three exercise classes per week. These services are available to RVCP clients.

Goodwin Homes operates three retirement villages in the Australian Capital Territory, two of which participate in the project. The villages are co-located with low care residential facilities. Goodwin Aged Care Services is an approved CACP provider; half of the evaluation clients at Goodwin have transferred from a CACP. Goodwin RVCP care workers are part of the Goodwin CACP team. Goodwin's CACP social coordinator provides extra service to RVCP clients that would not be available were it not for parallel CACP service delivery.

Canberra Masonic Homes (CMH) operates two retirement villages in the Canberra area which are pilot sites. Evaluation clients were all residents at the CMH retirement village at Holt, which is located adjacent to a CMH residential low-care facility. CMH is an approved provider for residential aged care, Home and Community Care and Veterans' Home Care.

Villaggio Sant' Antonio has 60 self-care units co-located with a 63-bed residential aged care facility (low and high care). Villaggio does not deliver community care packages. Village (self-care) residents would not ordinarily receive direct care from Villaggio staff. Residents tend to approach management and staff when a need for assistance emerges and Villaggio assists them to access appropriate community services. Villaggio staff commented that residents are often not aware of the types of help that are available or how to access formal services.

The proposal for RVCP funding was developed to address an increasing level of need among residents in ageing retirement village communities in the Australian Capital Territory. Awareness of the level of unmet need prompted Morshead Home to apply over a number of

years to become an approved CACP provider. During this period, Morshead Home introduced private packages for residents to purchase at approximately the CACP recipient co-payment rate to meet short-term—up to 8 weeks—intensive care needs. Eight such packages could run simultaneously. These packages have been principally used to support residents returning to a self-care unit after hospitalisation. Instances of inappropriate hospital discharge practice had meant that Morshead Home had no option but to provide unfunded, intensive post-acute care when the need arose. The Morshead RVCP coordinator highlighted an urgent need for improved post-acute care for elderly people in the region. In addition, staff at Morshead Home identified an increasing number of residents with dementia. Thus, a need for packages of ongoing care within ageing retirement communities has been highlighted, particularly to support residents in self-care units with dementia or physical frailty who live alone and couples where one partner has dementia. Management at Villaggio concurred that this form of ongoing care is an area of increasing demand among residents in its community.

The RVCP coordinator at Morshead Home performs initial needs assessment for clients at both Morshead and Canberra Masonic Homes villages. Once a client at Canberra Masonic Homes is accepted into the project, their care is managed by the Masonic Homes coordinator. Goodwin and Villaggio have their own RVCP coordinators who are responsible for initial needs assessment and care management in liaison with the Morshead coordinator.

Services delivered to clients comprise mainly personal assistance, medication prompts, accompanied shopping and bill paying, and personal transport for medical, dental and allied health care. Shopping and accompaniment to provide general assistance in the wider community is the area of highest demand among RVCP clients.

RVCP packages are viewed as very similar to a CACP, but allow for more rapid response and the flexibility to pay short, frequent visits to a client each day. It was noted that less flexibility comes from having the small number of RVCP places assigned to specific villages within the consortium. This has, on occasion, resulted in staffing difficulty and inefficiency, since RVCP client care is delivered by salaried staff in each village. Low numbers and dedicated allocations reduce the potential to average funding across a larger group of clients with varying levels of need. Notwithstanding this, the RVCP has provided a welcome opportunity to be able to meet the needs of residents in the participating villages promptly and efficiently, using existing infrastructure. Staff involved in the project remarked on the efficiencies and economies of scale, especially in relation to travel time, that come from servicing co-located clients.

These efficiencies are illustrated in a journal of the project care assistant at Morshead Home whose week is dedicated to the seven clients in the Morshead Home village by interleaving brief visits to different clients during each day (Box 3.1). The journal entries refer to care assistant activities for multiple clients. By removing travel time from the service delivery model, an on-site care assistant is able to divide time between clients to suit the task and time requirements of each client. This avoids the need for each client to book long blocks of time that compress care services into specific days of the week and times of day, which is the characteristic pattern of many mainstream community aged care service models. It can be seen from the journal entries that a client with a need for frequent short monitoring visits is easily accommodated. Each client receives a brief 'check-in' at the end of every day. The project coordinator emphasised the social support and accompaniment aspects of the service.

Box 3.1: Morshead RVCP care assistant journal for three selected days of a typical week

Monday

7.30: Personal assistance; tidy kitchen and living areas.
8.15: Check on condition; personal assistance; socialise.
8.45: Check on status (at risk of falls); hang out washing.

9.30: Personal assistance (shower and dress), adjust oxygen line; tidy unit.

10.15: Shopping.

11.45: Coordination meeting; take client to doctor.

12.30: Deliver lunches.

13.45: Full unit clean.

15.00: Skin integrity/wound care; domestic assistance.

15:30: Equipment check.

15:40: Check on status of all clients.

Wednesday

7.30: Personal assistance (shower and dress); tidy unit; socialise.

8.15: Check condition; personal assistance; socialise.

8.45: Check condition; personal assistance; assist with general duties; socialise.

9.30: Personal assistance (shower and dress); tidy unit; socialise.

10.15: Full unit clean; socialise.

11.15: Assist with client medical and other appointments.

12.15: Equipment check.

12.30: Deliver lunches.

13.00: Full unit clean and laundry; skin integrity/wound care.

14.45: Assist with client medical/other appointments. Check on status of all clients.

Friday

7.30: Personal assistance (shower, dress, attend to risk of falls as per care notes); tidy unit; socialise.

8.15: Check on condition; personal assistance; socialise.

9.15: Check on condition; assist with general duties; socialise.

9.45: Personal assistance (shower and dress); tidy unit; socialise.

10.30: Full unit clean.

12.00: Coordination meeting.

12.30: Deliver lunches.

13.00: Full unit clean and laundry; change beds; attend to client requests.

14.30: Skin integrity/wound care; domestic assistance.

14.45: Check on status of all clients.

Social support is dovetailed with instrumental support and the spaced timing of instrumental support means that a client receives socialisation at various times on most days of the week. The Morshead RVCP care assistant spends 2 to 3 hours each week accompanying clients to medical and other appointments.

Based on the care assistant journal, clients at Morshead Home receive an average of around 5.5 hours of direct care per week. It appears that this number of hours would be insufficient to deliver multiple visits per day each day of the week unless clients are co-located. A care assistant whose time is dedicated to the RVCP recipients at Morshead Home has been a major factor in maximising service efficiency and effectiveness for clients.

Risk factors for continuing care

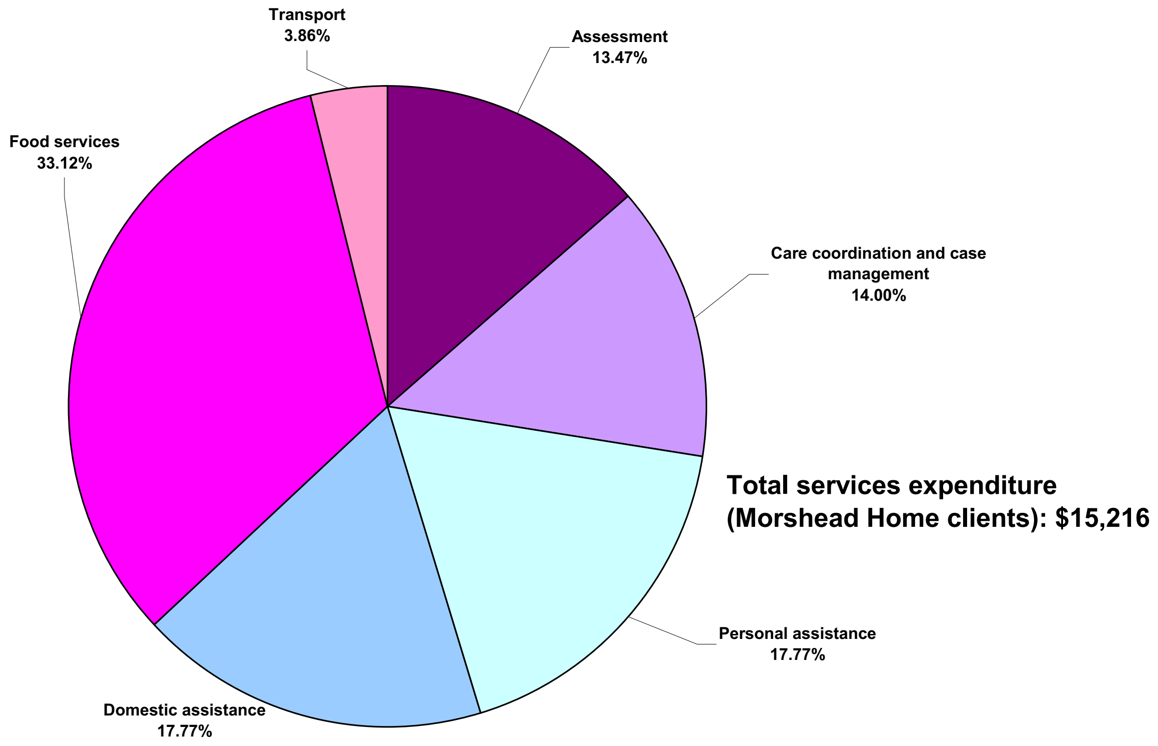
Severe mobility impairment combined with a lack of suitable mobility aids and occupational health and safety issues associated with client behaviour such as aggression or wandering are the main factors that could preclude a client from receiving RVCP services. The project is able to support clients with mobility problems provided that the appropriate equipment can be sourced and safely accommodated in the client's unit. This type of equipment can be difficult to obtain, particularly the larger items such as hoists.

Clients' reasons for leaving the project have included: escalation of need above that which can be supported with available funding; onset of an acute health condition or behavioural symptoms which require 24-hour supervision; and take-up of a place in a residential facility.

Profile of services expenditure

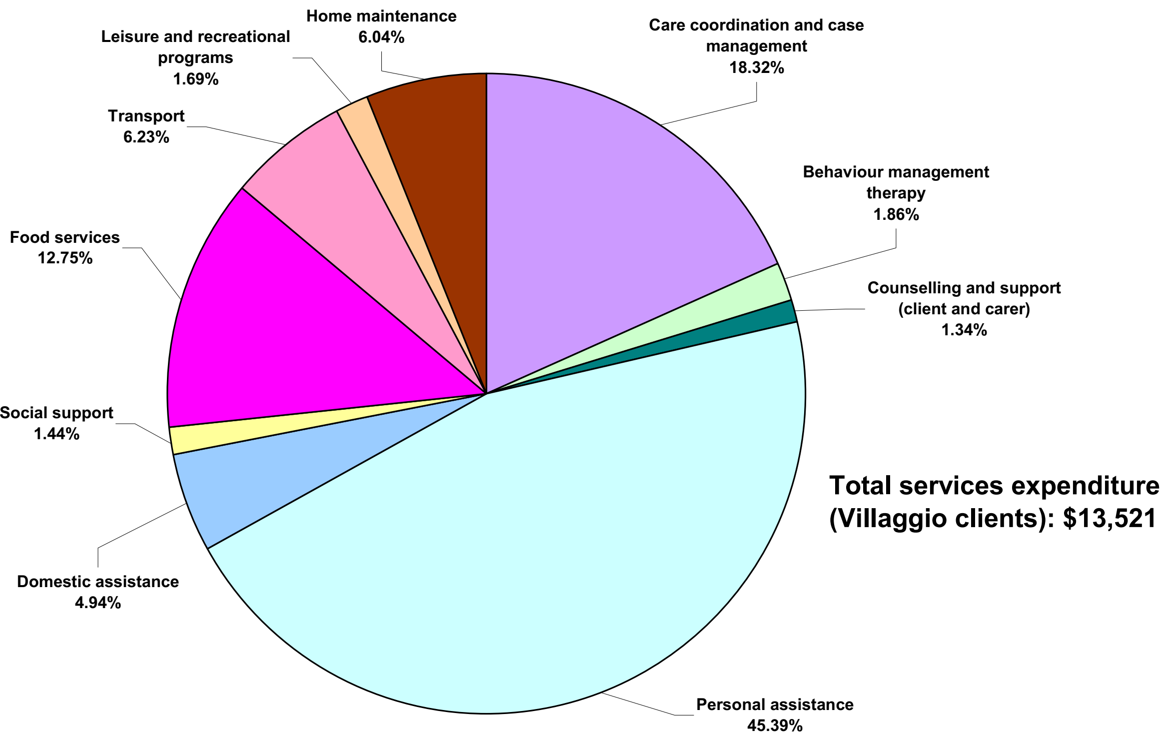
Morshead Home provided a breakdown of expenditure on direct care services for the quarter ending 31 March 2005. Villiaggio San' Antonio did the same for the quarter ending 31 December 2004. Goodwin Aged Care Services did not report expenditure in the requested timeframe and Canberra Masonic Homes did not report expenditure by service category using the standard template. Morshead Home and Villaggio results are presented separately in Figures B3.1 and B3.2. These results are based on very small numbers of packages (seven and five respectively).

There was considerable variation in the expenditure profiles of consortium members. At Morshead Home, service delivery focuses mainly on food service, domestic and personal assistance. Villaggio reported a more diverse range of services with a high personal assistance profile. Notably, this arm of the project reported expenditure on behaviour management therapy and counselling/carer support.



Source: Morshead Home financial report.

Figure B3.1: Morshead Home RVCP expenditure on services (RVCP recipients located at Morshead Home), quarter ending 31 March 2005



Source: Villaggio Sant' Antonio financial report.

Figure B3.2: Villaggio Sant' Antonio RVCP expenditure on services, quarter ending 31 December 2004

3.2 Case study reports

Morshead Home provided the following two case study reports.

Case study 1

'The first case study is of a lady who lived by herself in the retirement village and joined the Retirement Village Care Pilot in August 2003 until she was admitted to high care residential facility in July 2005. She had limited family and social supports. She was assessed as high care and received a high care RVCP package. She had multiple medical problems which affected her sight, hearing (with Meniere's—dizziness), mobility, continence and depression and suffered pain.

The client received personal care, home help, assistance with transport, and three meals a day on 7 days a week through the RVCP.

She had several admissions to hospital during this time but had refused offers of admission to residential aged care.

Early in 2005 the client visited a GP and an emergency department for pain in the lumbar region and hip. This was diagnosed as pain due to her hip replacement which was performed some 15 years before.

On return home her pain increased and the RVCP care worker noticed while showering the client that there was a patchy red area on the lower back which tracked down to her hip. The care worker called the registered nurse RVCP coordinator as it was suspected that the client was suffering from shingles. The coordinator contacted the GP who saw the client straight away, confirmed shingles, and sent her home with strong pain relief medication.

RVCP staff were concerned that the medication would affect the client's balance which was chronically impaired. Indeed it did—she could not get out of bed. The project arranged for a respite bed for 2 weeks. At the end of this period the client did not want to return home but there was no available bed in the residential aged care facility.

Several days after returning home the client was admitted to hospital with a urinary tract infection. During this hospitalisation, a high care bed became available and the client did not return to her unit.

It is a tribute to the services provided by the Retirement Villages Care Pilot program that this client was able to remain in her own home for nearly 2 years. The intimate knowledge gained by the care worker and the close relationship that developed between staff and client enabled the client to become comfortable and to have confidence in staff advice. The continuity of the care and level of service provision was a major factor in this favourable situation.'

Case study 2

'This client, a delightful 87-year-old lady, had lived in the retirement village independently and had previously utilised the services of the RVCP 15 months earlier for a period of 1 month. She terminated RVCP services at that time, stating that she "doesn't require assistance". Her family expressed concern about their mother's eating problems at the time (the client was not eating well and consequently losing weight). Arrangements were made to deliver one meal per day.

Fifteen months later a Retirement Villages Care Pilot package became available. Around that time concerns had been expressed to the project coordinator regarding the client's welfare. Neighbours and friends reported that she was misplacing her keys, locking herself out, not taking her medication, losing more weight, starting to wander and generally not coping well. The gardener also expressed great concern about her.

The coordinator's initial impression was that the client was coping well: her house was clean and tidy, she was quite well dressed and she spoke very well. Unfortunately, this was all superficial. On further questioning and assessment the client displayed extremely poor short-term and long-term memory but hid the deficits very well by changing the subject and stating (with a beautiful smile) "I am 87 and a half, dear". She weighed just 35 kilograms.

The client's ACAT approval had by this time expired. It was going to be up to 2 months before a reassessment would be performed. The project coordinator decided to provide assistance (unofficially) with meals, medication prompt and whatever else was required until the assessment was completed.

The client was extremely difficult to manage as she would always say "I'm all right, dear" and "I don't need that done, dear". She continued to lose weight, not eat and not take medications (including Warfarin) despite 7 days a week assistance. She did not appear to be attending to her personal hygiene. The daily contact before and during the activation of the package allowed staff to recognise that the client's ability to live independently was extremely limited. It was decided to offer her respite care as an introduction to residential low care living. With a little bit of encouragement she decided to accept the offer.

The client gained 2 kilograms in one week. She did not return to her home and remained in residential low care; 6 months she had later gained about 7 kilograms in weight, partially regained her memory and was participating in every social event that is available to the residents.

Due to the proximity and familiarity of the coordinator of the RVCP with residents and staff of the retirement village as well as the easy accessibility to her expert nursing assessment and advice, the RVCP program at Morshead Home helped to recognise problems and provide the client with a safety net which prevented her experiencing a critical medical event which could have been life threatening or resulted in hospitalisation.'

'It has been our experience at Morshead Home that the Pilot has provided a service which promotes continuity of care as none of our services are outsourced and the personal care, home help etc. is all provided by the one care worker who becomes very familiar with, not only the residents on the program, but also other residents in the village.'

3.3 Client profiles

Morshead Home RVCP received an allocation of 25 flexible care places. During the September and December quarters of 2004, 33 care recipients were active in the project. The project supplied data on 19 clients for the evaluation (five males and 14 females), sourced from five of the six participating sites. This group represents approximately 61% of active care recipients during the evaluation period.

Age and sex

Participants in the evaluation had a mean age of 83 years. Ages ranged from 59 years to 103 years and nine clients in the group were aged 85 years or over (Table B3.1).

Table B3.1: Morshead Home RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
Less than 65	1	—	1
65–74	—	2	2
75–84	1	6	7
85+	3	6	9
Total	**5**	**14**	**19**
		(per cent)	
Less than 65	5.3	—	5.3
65–74	—	10.5	10.5
75–84	5.3	31.6	36.8
85+	15.8	31.6	47.4
Total	**26.3**	**73.7**	**100.0**

— Nil.

Language and communication

One client had little or no effective means of communication. Two national languages are represented in the evaluation group (Table B3.2).

Table B3.2: Morshead Home RVCP, number of clients by language spoken at home and proficiency in spoken English

	How well does client communicate in English?		
Language spoken at home	Very well or well	Not well	Total
English	17	1	18
Finnish	—	1	1
Total	**17**	**2**	**19**

— Nil.

Accommodation and living arrangement

All participants in the evaluation were living in independent living units at one of the participating villages (Table B3.3). Three clients were living in a private residence when referred to the project.

Table B3.3: Morshead Home RVCP, number of clients by usual accommodation setting, living arrangement and accommodation setting at time of referral to RVCP

	Usual living arrangement			
Accommodation setting	**Alone**	**With family**	**Total usual accommodation**	**Accommodation at referral**
Private residence	—	—	—	2
Retirement village—independent living	17	2	19	16
Boarding or rooming house/private hotel	—	—	—	1
Total	**17**	**2**	**19**	**19**

— Nil.

Years at the current place of residence ranged from less than one to 20, with a mean of 6.6 years. Five clients had been living in their retirement village for 10 or more years.

Carer availability

Fourteen clients had a carer; 11 carers were not living with the RVCP recipient (Table B3.4). Carers' ages ranged from 45 to 83 years, averaging 60 years. Two carers were aged 75 years or over (Table B3.5).

Table B3.4: Morshead Home RVCP, number of clients by carer availability, carer relationship to client and co-residency status

Carer relationship to client	Carer lives with client	Carer does not live with client	Total
Spouse or partner	2	—	2
Son or daughter	1	8	9
Son- or daughter-in-law	—	1	1
Other relative	—	1	1
Not stated	—	1	1
Total clients with a carer	*3*	*11*	*14*
Clients without a carer	. .	. .	5
Total clients			**19**
Per cent of clients with a carer			74

— Nil.

. . Not applicable.

Table B3.5: Morshead Home RVCP, number of carers by age group and sex

Age (years)	Males	Females	Not stated	Persons
45–54	1	4	—	5
55–64	2	3	—	5
65–74	1	1	—	2
75–84	—	1	1	2
85+	—	—	—	—
Total	**4**	**9**	**1**	**14**

— Nil.

Income and concession status

Government pensions were the primary source of cash income for 17 clients (Table B3.6). All clients held a health care concession card.

Table B3.6: Morshead Home RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number of clients	Per cent
Principal source of cash income		
Age Pension	12	63.2
DVA pension	3	15.8
Disability Pension	2	10.51
Superannuation or annuities	2	10.5
Total	**19**	**100.0**
Health care concession card holder	19	100.0
RVCP concession status	—	—

— Nil.

Previous use of government support programs

More than half of the clients were receiving assistance from government community care programs before the RVCP (Table B3.7). Home and Community Care had been providing assistance to eight clients. Morshead RVCP is among the four RVCP projects with at least 60% of clients who were in receipt of government-funded community care before joining the RVCP.

Respite care was used by four carers in the 12 months prior to entry; the remaining ten carers reported that they had not needed respite.

Table B3.7: Morshead Home RVCP, number of clients by use of government support programs prior to RVCP

Previous use of government support program?	Number of clients	Per cent
Program support prior to RVCP		
Home and Community Care	8	42.1
Community Aged Care Packages	3	15.8
Veterans' Home Care	1	5.3
Total clients with previous government program support	*12*	*63.2*
No previous government program support	7	36.8
Total	**19**	**100.0**
Use of respite care in the 12 months prior to Morshead (clients with a carer)		
Respite care not needed	10	71.4
Respite care used	4	28.6
Total	**14**	**100.0**

Seven clients are reported to have been on a waiting list for aged care placement. The project reported anecdotally that residents are proactively planning for their future and often seek out ACAT assessment and residential aged care waitlisting as a precautionary measure.

Referral and assessment

Morshead Home conducted an initial survey of residents in the Morshead village and promoted the RVCP during December 2003. This process identified a number of potential clients who were subsequently assessed for eligibility. Later referrals came from family members contacting staff in participating villages to express concern for the welfare of their relative and from ACAT (Table B3.8). RVCP coordinators arrange for ACAT assessments of clients who self-refer or who are identified by staff as needing assistance. RVCP staff at the participating villages reported differing experiences in accessing ACAT service, with some evidently receiving an acceptable response time and others indicating that persistent attempts were often required to achieve a response from ACAT. Staff often advised families to contact ACAT directly, since it is thought that this results in a faster response.

Table B3.8 Morshead Home RVCP, number of clients by source of referral

Referral source	Number of clients
Aged Care Assessment Team	5
Retirement village staff	5
Family	5
Self-referral	2
Other community service	2
Total	**19**

Two clients had been assessed by an ACAT twice in the twelve months prior to entering the project, and the remaining 17 clients had had one ACAT assessment.

ACAT assessment was completed for 15 clients before services commenced (Table B3.9).

Initial needs assessment by an RVCP coordinator is modelled on the Goodwin Homes model of assessment for CACP. Each village maintains the care plan for its own clients.

Client care managers for the Morshead RVCP include nurse managers and welfare and community workers (Table B3.10).

Table B3.9: Morshead Home RVCP, number of clients by days between completion of ACAT assessment and service commencement

Completion date of ACAT assessment	Number of clients
Before service commencement	
0–20 days	3
21–30 days	1
31–90 days	3
91–180 days	8
181–365 days	—
Total	*15*
After service commencement	
Between 6 and 18 days after service commencement	4
Total	**19**

— Nil.

Table B3.10: Morshead Home RVCP, number of clients by care manager profession

Care manager profession	Number of clients
Nurse Manager	10
Welfare and community worker	6
Other profession	3
Total	**19**

Health conditions and health status on entry

Data on health conditions and health status at entry to the RVCP were reported for 18 of the 19 Morshead RVCP clients. The number of health conditions ranges from one to six per client. Thirteen clients had three or more health conditions at entry. Respiratory infections, dementia and musculoskeletal disorders are among the more common primary health conditions (Table B3.11).

Table B3.11: Morshead Home RVC, number of clients by primary health condition at entry

Primary health condition	Number of clients
Chronic and acute respiratory infections	4
Dementia (includes Alzheimer's disease and vascular dementia)	3
Rheumatoid and other arthritis and related disorders	2
Diseases of the nervous system (including Parkinson's disease)	3
Cerebrovascular disease	2
Osteoporosis	1
Other specified conditions	3
Total	**18**[(a)]

(a) Primary health condition missing for one client.

Four clients were both hearing and vision impaired at time of entry; 13 clients were at risk of falls due to impaired gait or balance (Table B3.12).

Table B3.12: Morshead Home RVCP, number of clients by presence of selected health conditions at entry to RVCP

Health condition	Number of clients
Impaired gait or balance—at risk of falls	13
Vision impairment	9
Hearing impairment	9
Both hearing and vision impairment	4
Total or partial paralysis	2
Diagnosis of depression	2
Disorientation/confusion	—

— Nil.

Morshead RVCP clients were taking between two and 12 different types of medication at entry. Fourteen clients were taking four or more different types of medication.

Level of core activity limitation

Four clients were assessed as having a severe or profound core activity limitation. One of these clients had dual severe or profound limitation in self-care and mobility. Most cases of moderate to profound activity limitation among Morshead RVCP clients were in the areas of self-care and mobility (Table B3.13).

Table B3.13: Morshead Home RVCP, number of clients by type and level of core activity limitation at entry to RVCP

	Level of activity limitation					
Core activity	No limitation	Mild	Moderate	Severe or profound	Not stated	Total
Self-care	2	7	8	1	1	**19**
Mobility	1	6	8	3	1	**19**
Communication	12	5	—	1	1	**19**

— Nil.

Use of medical and hospital services prior to entry

Medical and hospital service utilisation data suggest that the level of risk associated with poor mobility, impaired gait and balance, and, possibly, sensory impairment may have contributed to relatively high health system utilisation in the period immediately prior to entering the RVCP for a number of clients.

Baseline profiles contain information about a client's use of medical and hospital services in the 6 months prior to entering the RVCP—the 'pre-entry period'. These data are recorded for 19 clients. All had visited a medical practitioner at least once in the pre-entry period. The reported number of visits to a medical practitioner varies from two to 24 per client, with a mode of six visits recorded by five clients. Two clients recorded more than 20 consultations with a medical practitioner outside of a hospital setting. One of these clients had suffered a fall with injury during the pre-entry period; the timing of the event in relation to the number of medical consultations is not captured in the data. Both of these clients had also spent time in hospital for unplanned admissions. Cumulatively, clients recorded 168 visits to a medical practitioner outside of a hospital setting over an estimated 3,420 person days.

Ten clients contributed to an aggregate total of 26 hospital admissions in the pre-entry period. Nine clients with one or more hospital admissions recorded either solely unplanned/urgent admissions, or both unplanned/urgent and planned admissions. These clients collectively accumulated 78 unplanned hospital bed days over approximately 1,620 person days. Individually, they recorded between one and 20 days in hospital for unplanned admissions.

Conditions recorded as occasioning admissions to hospital in the pre-entry period include:

- injuries, poisoning or consequences of external causes
- dementia
- chronic lower respiratory diseases
- cerebrovascular disease
- diseases of the nervous system
- heart disease
- anaemia
- thyroid disease
- influenza and pneumonia.

In total, five clients suffered a fall-related injury in the pre-entry period. Two of these clients had been rendered immobile and without assistance for more than 30 minutes.

3.4 Client assessment results

Activities of daily living

Assessments were completed for 15 clients. Modified Barthel Index (MBI) scores at entry ranged from 9 to 19 out of a total 20 points (mean 15.7 points, standard deviation 3.0).

According to a classification for the Barthel Index (Shah et al. 1989), on entry to the RVCP three clients were severely dependent in ADL, 10 clients were moderately dependent and two clients showed slight dependency. No client was assessed as independent in ADL (self-care and mobility). The mean MBI score at baseline indicates that the middle of the MBI distribution for Morshead RVCP clients lies in the range of moderate dependency in ADL (Table B3.14).

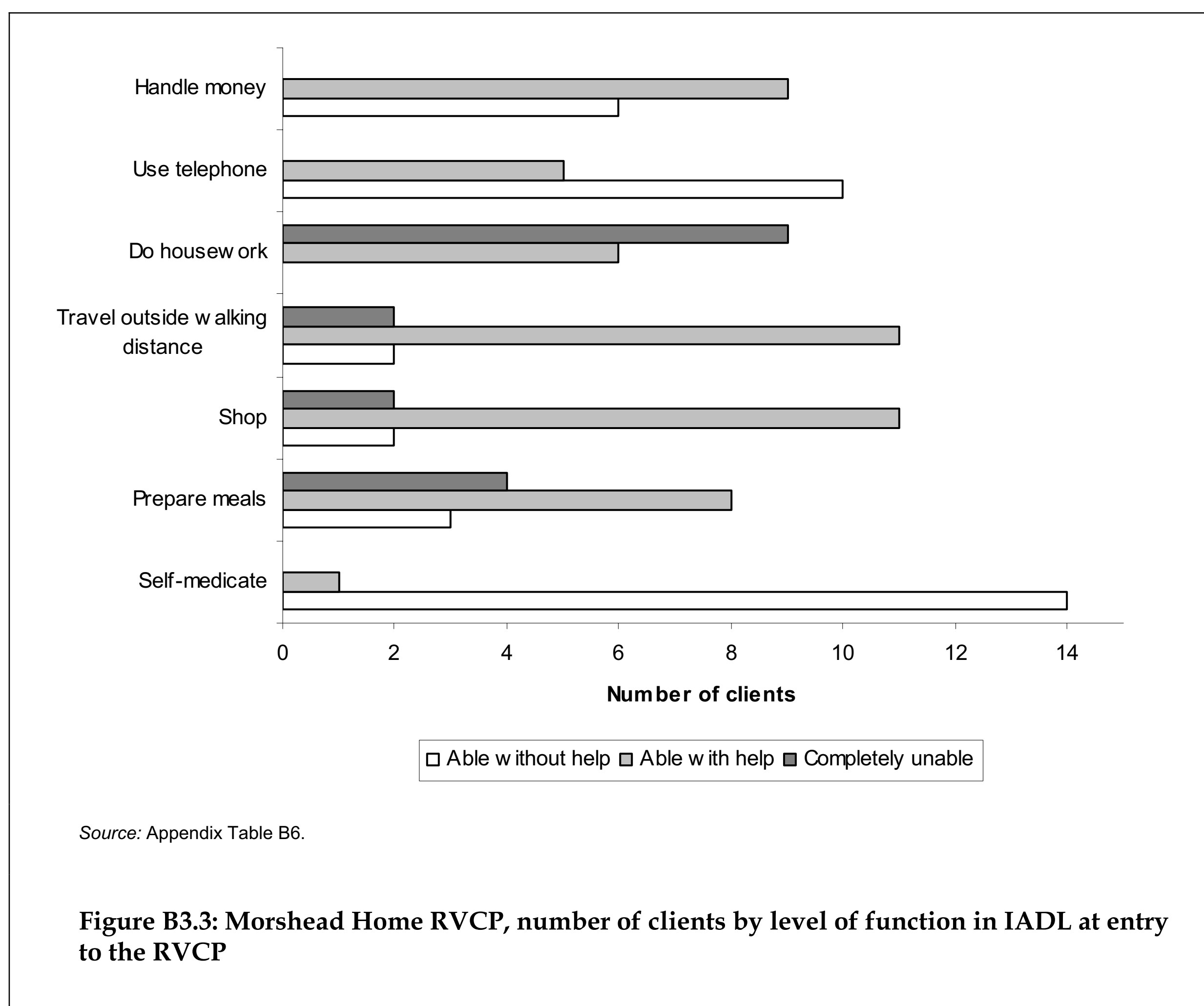
Nine clients were unable to bathe or shower without assistance. All but two clients needed help to negotiate stairs (Appendix Table B5).

At entry to the project, most Morshead RVCP clients either needed help or were completely unable to complete IADL tasks (Figure B3.3). In the area of housework all clients needed assistance. A typical Morshead RVCP client was completely dependent in one out of seven types of IADL and partially dependent in three IADL when they entered the project.

The median baseline score on the OARS IADL scale for IADL is 8 points, with scores ranging from 5 to 13 out of a possible maximum of 14 points. Baseline results indicate that all Morsehead clients had lost some IADL function and that there was considerable variation in the extent of functional loss among clients entering the project.

Changes in the MBI between baseline and final assessments ranged from –7 (a 7-point decline in ADL function) to 11 points (11-point improvement in ADL function). The median change was zero (Table B3.14), indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments.

The median change in IADL score between baseline and final assessments was zero, with change scores falling in the range of –4 to 8 points (Table B3.14).



Source: Appendix Table B6.

Figure B3.3: Morshead Home RVCP, number of clients by level of function in IADL at entry to the RVCP

Table B3.14: Morshead Home RVCP, summary measures for baseline and change scores on the ADL and IADL scales(a)

	Count	Min.	Median	Max.	Mean	Standard dev.
ADL						
Baseline MBI	14	9	16	19	15.5	3.1
Change in MBI	14	–7	0	11	0.6	3.7
IADL						
Baseline IADL	13	5	8	13	8.0	2.1
Change in IADL	13	–4	0	8	0.4	2.6

(a) Change score = score at final assessment minus score at baseline assessment.

3.5 Carer assessment results

Twelve carers in the Morshead Home evaluation completed the Caregiver Strain Index (Robinson 1983) at the start of the evaluation to generate a mean score of 3.9 points (median

4 points) with a standard deviation of 2.7 points. Scores ranged from 1 to 10 points. Two carers recorded scores above the case threshold for carer strain of 7 points and another carer scored just below the threshold. These carers likely needed a considerable level of support from the RVCP to sustain them in their caring role.

Twelve carers reported that they were in very good or good health at baseline assessment. Two carers reported excellent health.

3.6 Accommodation outcomes

Morshead Home RVCP consortium members completed a follow-up of evaluation clients in August 2005. By that time, three clients had entered a low care facility and 10 of the original group were still with the project (Table B3.15).

Table B3.15: Morshead Home RVCP, number of clients by accommodation setting and program support at follow-up, August 2005

	Number of clients	Per cent
At home		
With RVCP	10	52.6
With HACC	1	5.3
Without formal services	—	—
Total at home	*11*	*57.9*
In care		
Hospital	2	10.5
Residential aged care total	3	15.8
Low care	3	15.8
High care	—	—
Total in care	*5*	*26.3*
Deceased	3	15.8
Total	**19**	**100.0**

— Nil.

4 Forest Place Retirement Village

4.1 Project description

Forest Place Group Limited operates an RVCP project of 27 places (funding for seven high care places) at the Forest Place Retirement Village in Durack, western Brisbane. Forest Place Group is a provider and manager of retirement village care and accommodation in Brisbane. In addition to Durack, Forest Place villages are located in the suburbs of Taringa, Albany Creek, Cleveland and Clayfield, providing accommodation for over 1,100 residents. Forest Place Group is an approved service provider for the Department of Veterans' Affairs.

Forest Place Retirement Village is the largest and oldest of the Forest Place Group retirement communities. Around 500 residents live in independent living units and 100 residents live in serviced apartments. A serviced apartment contract typically provides for 2 to 3 hours of paid housework per week. Residents in serviced apartments tend to be frailer and have greater difficulty with mobility than residents in independent living units. There is some movement between the independent living units and serviced apartments in the village in addition to residents entering serviced apartments directly from private residences.

The village has an on-site medical centre and pharmacy that open five days a week. These operate on a fee-for-service basis just as they would in the wider community. However, Forest Place residents receive additional, unpaid assistance from the manager of the medical centre, who also happens to be coordinating the RVCP project. The manager estimated that around a quarter of her time is spent coordinating aged care assessments and services for residents. Various allied health services including podiatry, audiology and optometry visit at least once a month and there are regular pathology (weekly) and nursing services (24 hours, 7 days a week) for village residents to use on a fee-for-service basis. All residents are provided with the Vital Call emergency alarm system as standard issue, and a community centre in the village offers a range of social activities.

Four respite rooms are available for post-acute care and residential respite. These rooms are available to Village residents and non-residents on a fee-for-service basis (the Department of Veterans' Affairs may pay a subsidy for eligible veterans). Older people in the wider community who need post-hospitalisation care are often referred to these facilities directly from hospital. The facility caters for stays from a few days to several months. The Forest Place site includes a 25-bed nursing home.

Management at Forest Place reported that the age of serviced apartment residents ranges from around 80 to102 years, although two residents are in their sixties. In the wider village, residents are all over 60 years of age, with an estimated average age of between 75 and 80 years. The average age of residents is thought to be increasing. Many residents have been in the village for 15 years or more but the age of new entrants to the village has also been rising steadily. In the 12 months to mid-2004, the youngest new entrants were in the 75–80 years age group. Correspondingly, the prevalence of dementia among residents in the village is increasing as the resident population ages. It is estimated that more than a quarter of the residents in serviced apartments (over 25 people) have dementia and there are indications that a sizeable proportion of residents in the wider village community have dementia.

The RVCP coordinator reported that a large number of Forest Place residents receive Australian Government community aged care services—through Community Aged Care Packages, Home and Community Care and Veterans' Home Care. Some residents also access care at private expense from Forest Place Medical Centre, community nursing agencies and/or paid carers. For example, residents can pay $3 for a house call by staff from the Forest Place Medical Centre to administer medication. There are two providers of Community Aged Care Packages in the local area. Both operate a small number of packages and both operated a waiting list in July 2004. One waiting list contained 15 names. The second agency operates Community Options packages and fills vacated Community Aged Care Packages places exclusively from the Community Options list. At the time of the site visit there were no Extended Aged Care at Home packages in the area.

Forest Place applied for RVCP funding to fill a gap the village had identified for serviced apartment residents, namely the need for holistic care, additional services and case management. As such, RVCP packages at Forest Place are targeted specifically at residents in serviced apartments. The Pilot is seen as particularly important for residents who cannot afford to 'top up' a basic level of service from private finances. The project was also designed to assist residents to remain linked into their existing social networks and activities within the village.

RVCP services to clients commenced in October 2003 and all but one of the 27 places were filled at the time of the site visit in July 2004. The project coordinator estimated that a client on a low care package received 5 to 10 hours of care per week and a high care client 13 or more hours per week.

Forest Place RVCP relies on existing infrastructure and services, most importantly, the medical centre and nursing staff. The coordinator identified 24-hour access to nursing care through the on-site medical centre and the ability for staff familiar to and with residents (and their medical histories) to supply effective case management as major differences between RVCP packaged and Community Aged Care Packages.

Brisbane South Aged Care Assessment Team provided information on approvals and care outcomes for clients living in Forest Place Retirement Village serviced apartments who were referred to the ACAT during two 6-month periods, before and after the establishment of the RVCP project. This reveals that a number of Forest Place RVCP clients had high care needs for an extended period before they entered the project.

Risk factors for continuing care

The project has identified 24-hour supervision for either mobility problems—high risk of falls or frequent falling—or for behavioural problems associated with dementia as the main factors that might prevent a client from participating in the project or lead to early discharge. Clients with high care needs including poor mobility can be accommodated by the project, but not if they require 24-hour supervision.

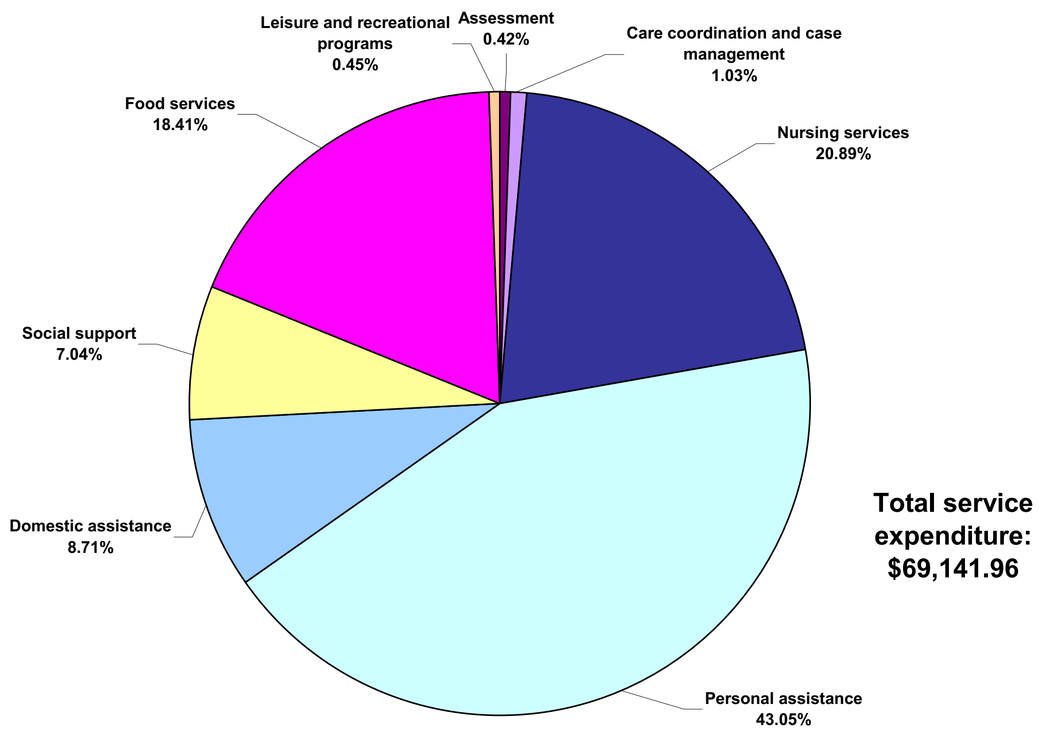
Clients are initially identified and screened by Forest Place staff. The on-site medical centre is an asset in terms of identifying residents who may need assistance. A potential client is referred to the ACAT for assessment. ACAT approves for residential care any client who is recommended for a high care package. Low care clients are approved for a flexible care package only. The ACAT has been recommending to clients approved for high care that they also put their name on waiting lists for residential aged care because care hours available through the Pilot have an upper limit and the needs of a high care client can quickly escalate beyond what the Pilot can deliver. However, the RVCP coordinator reported that most

people who have been put onto a package since October 2003 are still being cared for in the village. ACAT views this as a positive outcome for the project, since these are people who were clearly on their way to residential aged care when they were assessed. The ACAT also reported that noticeably fewer residential and residential respite approvals had been required for village residents since the project began.

Six clients exited the project between October 2003 and the start of the evaluation period. Four transferred to residential aged care facilities, one client moved back to an independent living unit at Forest Place, and one client died.

Profile of services expenditure

Forest Place Retirement Village reported services expenditure falling mainly into the categories of personal assistance, nursing care, food services, domestic assistance and social support. This project has reported higher than average proportional expenditure on personal assistance and nursing care, reflecting the higher than average support needs profile of the client group (see section 4.3). Domestic assistance comprises a lower than average proportion of total expenditure on services to care recipients, which is partly due to the fact that clients in the Forest Place project already receive a basic level of domestic assistance through the serviced apartment arrangement. Transport services do not feature in the expenditure profile, which is most likely due to the on-site medical centre and pharmacy and access to private and public transport at the Durack site.



Source: Quarterly financial report from Forest Place Retirement Village.

Figure B4.1: Forest Place RVCP, expenditure on services (all RVCP recipients), quarter ending 31 December 2004

4.2 Client profiles

Thirty-three care recipients were active in the project during the September and December 2004 quarters.

The project provided data on 28 clients for the evaluation including 10 males and 18 females. This number represents approximately 85% of care recipients who were active during the latter half of 2004. Seven evaluation clients had ACAT approval for high care at the time of the evaluation.

Age and sex

Forest Place RVCP clients averaged 86 years of age at the time of the evaluation. Ages ranged from 73 to 97 years. Nineteen clients were aged 85 years or over (Table B4.1).

Table B4.1: Forest Place RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
Less than 65	—	—	—
65–74	1	1	2
75–84	3	4	7
85+	6	13	19
Total	**10**	**18**	**28**
		(per cent)	
Less than 65	—	—	—
65–74	3.6	3.6	7.1
75–84	10.7	14.3	25.0
85+	21.4	46.4	67.8
Total	**35.7**	**64.3**	**100.0**

— Nil.

Language and communication

All clients were able to communicate effectively in spoken Engligh. Two national languages, English and Italian, were represented in the group (Table B4.2).

Table B4.2: Forest Place RVCP, number of clients by language spoken at home and proficiency in spoken English

	How well does client communicate in English?			
Language spoken at home	Very well or well	Not well	Not at all	Total
English	27	—	—	27
Italian	1	—	—	1
Total	**28**	**—**	**—**	**28**

— Nil.

Accommodation and living arrangement

All Forest Place clients were living in supported accommodation (serviced apartments) within the Forest Place Retirement Village in Durack, a suburb of Brisbane, Queensland. One client was in hospital at the time of referral (Table B4.3).

Table B4.3: Forest Place RVCP, number of clients by usual accommodation setting, living arrangement and accommodation setting at time of referral to RVCP

	Usual living arrangement			
Accommodation setting	Alone	With family	Total usual accommodation	Accommodation at referral
Retirement village—supported accommodation	19	9	28	27
Hospital	—	—	—	1
Total	**19**	**9**	**28**	**28**

— Nil.

Years at Forest Place Retirement Village ranged from less than one to 6 years, with an average of around 2 years. Twelve of the 28 clients had been living in their serviced apartment for less than one year when they entered the RVCP. To a large extent, this shorter tenure, compared with other RVCP projects, reflects the targeting of Forest Place RVCP places to residents of serviced apartments. Clients may have lived in independent living units at Forest Place Retirement Village prior to moving into a serviced apartment, however this cannot be ascertained from the data.

Carer availability

Five Forest Place clients had a carer during the evaluation and in each case the carer was living with the RVCP client (Table B4.4). This project does not have the same representation of younger carers caring for a parent that is observed in most of the other RVCP carer groups.

Carer ages ranged from 83 to 90 years, averaging approximately 87 years. Three carers were aged 85 years or older (Table B4.5).

Table B4.4: Forest Place RVCP, number of clients by carer availability, carer relationship to client and co-residency status

Relationship of carer to client	Carer lives with client	Carer does not live with client	Total
Spouse or partner	5	—	5
Son or daughter	—	—	—
Son- or daughter-in-law	—	—	—
Total clients with a carer	*5*	—	*5*
Clients without a carer	. .	. .	23
Total clients			**28**
Per cent of clients with a carer			18

— Nil.

. . Not applicable.

Table B4.5: Forest Place RVCP, number of carers by age group and sex

Age (years)	Males	Females	Persons
75–84	2	—	2
85+	2	1	3
Total	**4**	**1**	**5**

— Nil.

Income and concession status

Superannuation or annuities was the primary source of cash income for 14 clients (Table B4.6). Fifteen clients held a health care concession card. Forest Place RVCP has a higher proportion of self-funded retirees than other RVCP projects. Staff remarked that residents in serviced apartments can encounter access barriers to community services as a result of certain prevailing attitudes towards the financial circumstances of people who live in serviced apartments. It is felt, within Forest Place, that such judgments are generally ill-informed and unjustified since many self-funded retirees have very little disposable income remaining after covering full-price living expenses. Staff at Forest Place argue that people in serviced apartments who have taken personal responsibility to meet some of their own needs from the range of services that are available within the village should not be disadvantaged in accessing additional community services for which they are eligible.

Forest Place charges a variable co-payment rate based on a client's financial capacity. Recorded daily client co-payment amounts range from a discounted rate of $2 per day to the standard $5 per day for pensioners and $24 per day for most self-funded retirees. The mean co-payment amount calculated over all evaluation clients is $10.93 per day.

Table B4.6: Forest Place RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number of clients	Per cent
Principal source of cash income		
Superannuation or annuities	14	50.0
Age Pension	10	35.7
DVA pension	3	10.7
Other income	1	3.6
Total	**28**	**100.0**
Health care concession card holder	15	53.6
Project concession status	1	3.6

Previous use of government-funded community care programs

More than two-thirds of clients were not receiving assistance from government community care programs before the RVCP (Table B4.7). Two carers reported that, despite having had a need for respite care in the 12 months prior to joining the project, they had not used a respite care service. The remaining two carers said they had not needed respite care.

Table B4.7: Forest Place RVCP, number of clients by use of government support programs prior to RVCP

Previous government support program	Total	Per cent
Program not stated or not known	3	10.7
'Other' program[(a)]	1	3.6
Total clients with previous government support	*4*	*14.3*
No previous use of government support	24	85.7
Total	**28**	**100.0**

(a) Program other than HACC, CACP, EACH, Day Therapy Centre, Veterans' Home Care and National Respite for Carers Program.

Five Forest Place RVCP clients were on a waiting list for residential aged care during the evaluation.

Referral and assessment

Client referrals are sourced mainly through awareness of RVCP packages within the Forest Place community and among family members of residents, plus contact between local hospitals and Forest Place Retirement Village (Table B4.8). Among the evaluation clients, no referral had been made directly by an ACAT.

Seven clients had ACAT approval for high care. In April and May 2005 two clients with low care approvals were reassessed by ACAT and approved for high care.

All clients had completed ACAT assessments before or soon after service commencement (Table B4.9).

Table B4.8: Forest Place RVCP, number of clients by source of referral

Referral source	Number of clients
Family member	9
Self-referral	8
Hospital	6
Forest Place staff	4
Friend	1
Total	**28**

Table B4.9: Forest Place RVCP, number of clients by days between completion of ACAT assessment and commencement of services

Completion date of ACAT assessment	Number of clients
Before RVCP service commencement	
0–20 days	19
21–30 days	—
31–90 days	5
91–180 days	1
181–365 days	2
Over 1 year	—
Total	*27*
After service commencement	
8 days after services commenced	1
Total	**28**

— Nil.

Forest Place RVCP clients are under the supervision of a nurse manager who is on staff at the on-site medical centre.

Health conditions and health status on entry

The number of health conditions recorded for Forest Place RVCP clients as at entry to the RVCP ranges from two to 10, with a mode of four conditions recorded by 11 clients. Twenty-three clients had four or more health conditions on entry. Table B4.10 lists the primary health conditions recorded for Forest Place clients.

Table B4.10: Forest Place RVCP, number of clients by primary health condition at entry

Primary health condition	Number of clients
Cerebrovascular disease	5
Transient ischaemic attacks	3
Dementia in Alzheimer's disease	3
Arthritis and related disorders	3
Parkinson's disease	3
Malignancy	2
Blindness/poor eyesight	2
Other specified diseases and disorders[(a)]	7
Total	**28**

(a) Includes hypertension, psychoses and depression/mood affective disorder, chronic lower respiratory disease, liver disease, back problems and osteoporosis.

Two clients were both hearing and vision impaired at time of entry to the project and 20 clients were assessed as being at risk of falls due to impaired gait or balance. Around one-third of clients had diagnosed depression (Table B4.11).

Table B4.11: Forest Place RVCP, number of clients by selected health conditions at entry

Health condition	Number of clients
Impaired gait or balance—at risk of falls	20
Hearing impairment	9
Vision impairment	4
Hearing and vision impairment	2
Total or partial paralysis	3
Missing or non-functional limb/s	2
Diagnosis of depression	8
Disorientation/confusion	1

Clients were taking between one and 16 different types of medication at the time of entry to the project. Twenty-four clients were taking four or more different types of medication.

Level of core activity limitation

Three Forest Place clients experienced severe or profound core activity limitation on entry to the project. Most clients experienced mild to moderate core activity limitations (Table B4.12).

Table B4.12: Forest Place RVCP, number of clients by level of core activity limitation at entry

	Level of activity limitation				
Core activity	**No limitation**	**Mild**	**Moderate**	**Severe or profound**	**Total**
Self-care	1	15	11	1	**28**
Mobility	1	14	10	3	**28**
Communication	19	8	1	—	**28**

— Nil.

Use of medical and hospital services prior to entry

Baseline profiles contain information about a client's use of medical and hospital services in the 6 months prior to entering a project—the 'pre-entry period'. All but four Forest Place clients had consulted a medical practitioner at least once in the pre-entry period. The reported number of consultations varies from zero to 10 per client. Cumulatively, 24 clients recorded 100 visits to a medical practitioner outside of a hospital setting over an estimated 4,320 person days.

Sixteen clients contributed to a total of 26 hospital admissions in pre-entry periods. One client had planned admissions only. The remaining 15 clients with one or more hospital admissions recorded either solely unplanned/urgent admissions, or both unplanned/urgent and planned admissions. These 15 clients collectively accumulated 364 urgent/unplanned patient days over approximately 2,700 person days.

Individually, they recorded between two and 59 days in hospital for unplanned admissions. The client with the highest number of unplanned bed-days recorded five unplanned admissions, five visits to a hospital emergency department, and four consultations with a medical practitioner outside of hospital.

Conditions recorded as occasioning admissions to hospital for Forest Place clients in the pre-entry period include:

- falls (frequent with unknown aetiology)
- injuries to leg/knee/foot/ankle/hip
- other injury, poisoning or other effect of an external cause
- fracture of femur, lumbar spine or pelvis
- arthritis and related disorders
- back problems (dorsopathies)
- transient cerebral ischaemic attack
- cerebrovascular disease
- intestinal disease
- abnormalities of gait
- symptoms and signs concerning food and fluid intake
- diseases of the genitourinary system not elsewhere classified.

This list includes conditions that are commonly associated with severe mobility restriction and lack of supervision or assistance when performing mobility-related tasks in addition to problems related to nutrition management.

Thirteen clients had experienced a serious medical emergency during the 12 months prior to entering the project. Six clients suffered a fall with injury, and seven clients were rendered immobile and without assistance for more than 30 minutes in the same period.

4.3 Client assessment results

Activities of daily living

On entry to the project, most Forest Place clients were independently mobile but needed help with stairs and around one-third needed help with transfers (Appendix Table B7). Significant numbers of clients needed assistance with bathing and continence management. This client group recorded a higher prevalence of incontinence than other RVCP projects. All but four clients needed help to bathe or shower and at least half of the clients also needed help with dressing and grooming.

Modified Barthel Index (MBI) scores at entry range from 5 to 20 out of a total 20 points. The mean score was 13.8 points with a standard deviation of 3.3 (median 14). Five clients scored below 12 points on the MBI, which is a threshold for severe dependency in ADL according to a classification scheme for the Barthel Index (Shah et al. 1989).

There is also a relatively high-scoring group of clients: four clients scored 18 points or higher on the MBI, including one client with a perfect score in ADL whose need for assistance related to more IADL. Thus, the Forest Place RVCP project during the evaluation period comprised a diverse range of clients in terms of need for assistance.

The mean MBI score at baseline indicates that the middle of the MBI distribution for Forest Place RVCP clients was in the range of moderate dependency in ADL (Table B4.13).

Most Forest Place RVCP clients were moderately or highly dependent in IADL when they entered the RVCP (Figure B4.2). On average, Forest Place RVCP clients were completely dependent in three out of seven IADL. This is a relatively high level of need compared with other RVCP projects in which clients tend to average around one IADL with complete dependency.

On entry to the project, no client was able to prepare meals or perform household chores without assistance.[2] Twenty-one clients needed assistance with medications. One client was able to go places outside of walking distance without assistance (assuming that transport was available). All other clients required assistance or were completely unable to travel away from home. Although all clients registered as being able to walk or use a wheelchair independently on the MBI, the mobility item on the IADL scale reveals that for all but one client, independent mobility was limited to the home environment.

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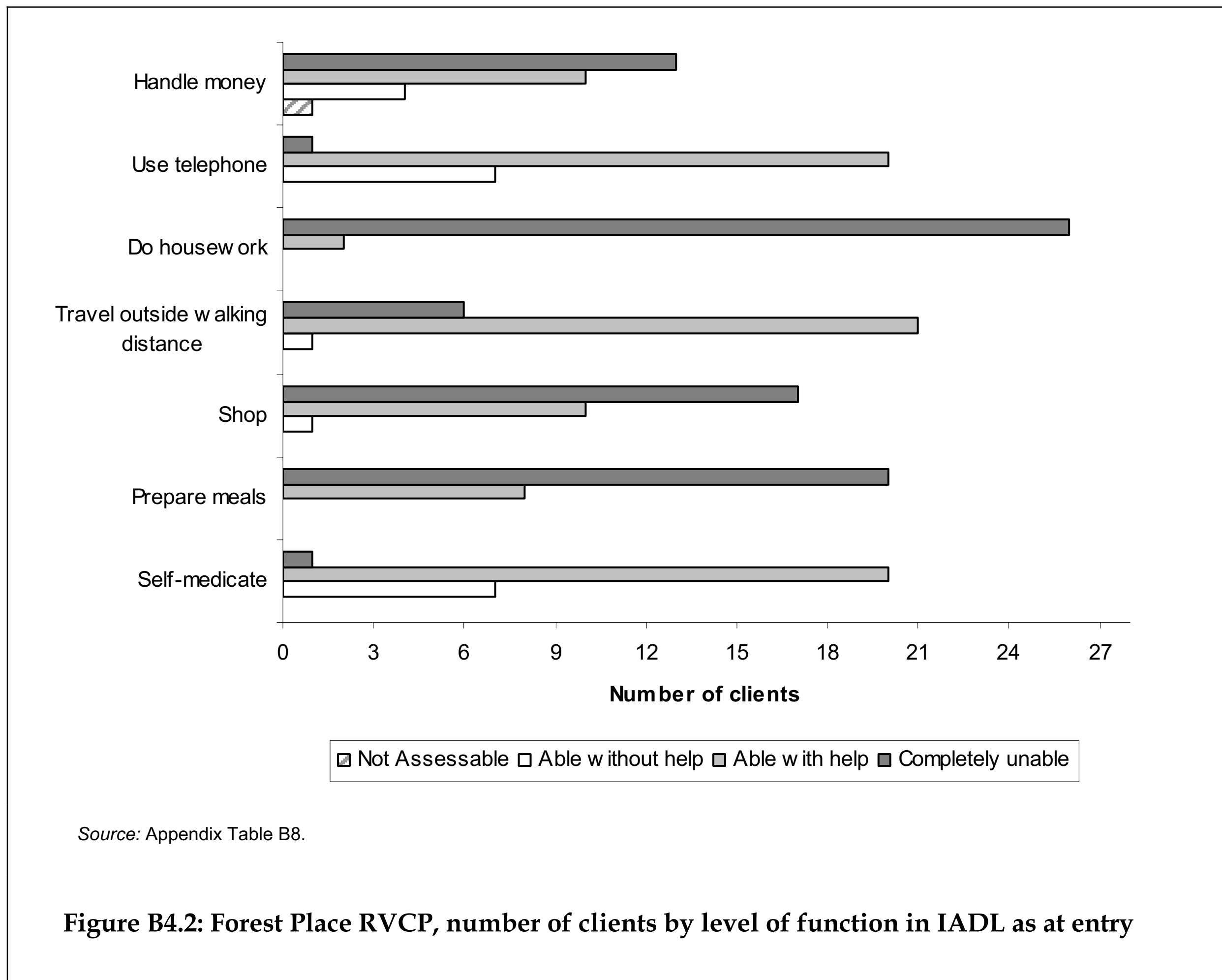
2 All Forest Place RVCP care recipients continue to receive basic meals and cleaning services as part of their usual accommodation arrangement (serviced apartment contract).



Source: Appendix Table B8.

Figure B4.2: Forest Place RVCP, number of clients by level of function in IADL as at entry

Final assessments were conducted on average 34.6 weeks after entry.

Changes in the MBI between baseline and final assessments range from –3 (a 3-point decline in ADL function) to 8 points (an 8-point improvement in ADL function). The median change of one point indicates that, on average, level of functioning in ADL as measured by the MBI improved only slightly between the baseline and final assessments (Table B4.13). Clients who recorded a non-zero change score mostly moved from a severe to moderate level of dependency.

The median baseline score on the OARS IADL scale was 4 points, with scores ranging from 2 to 9 out of a possible maximum of 14 points. Baseline results indicate that all Forest Place RVCP clients had lost some IADL function and that there was considerable variation in the extent of functional loss among clients entering the project. Change scores for IADL function (between baseline and final assessments) ranged from –1 to 5 points, with a median of zero (Table B4.13). Forty per cent of clients registered an improvement in IADL function between baseline and final assessments.

Table B4.13: Forest Place RVCP, summary measures for ADL and IADL baseline and change scores[(a)]

	Count	Median	Mean	Standard deviation
ADL				
Baseline MBI	25	14	14.0	2.9
Change in MBI	25	1	1.2	2.1
IADL				
Baseline IADL	24	4	4.8	2.2
Change in IADL	24	0	0.6	1.2

(a) Score at final assessment minus score at baseline for an individual client.

4.4 Carer assessment results

Three carers agreed to take part in carer assessments. All three carers scored 9 points, which is above the case threshold for carer strain of 7 points. These carers most likely needed a considerable amount of support from the project to sustain their caring roles.

4.5 Accommodation outcomes

Six of the 33 clients active in the September and December 2004 quarters were discharged from the Forest Place RVCP.

By completion of follow-up (9 June 2005), 18 of the 28 clients (64%) remained in the project. Four clients had entered an aged care facility (Table B4.14)

Table B4.14: Forest Place RVCP, number and per cent of clients by discharge outcome, June 2005

	Number of clients	Per cent
At home		
With RVCP	18	64.3
With HACC	—	—
Without formal services	—	—
Total at home	*18*	*64.3*
Institutional care		
Hospital	2	7.1
Residential aged care total	4	14.3
Low care	—	—
High care	4	14.3
Total in care	*6*	*21.4*
Deceased	4	14.3
Total	**28**	**100.0**

— Nil.

5 Southern Cross Care (Victoria)

5.1 Project description

Southern Cross Care (Victoria) is a community organisation that delivers community aged care including HACC services and CACP and EACH packages, retirement village accommodation and both high and low level residential aged care. The Southern Cross Care RVCP project operates 25 flexible care places (including three high care) to deliver services to eligible residents in four retirement villages. Three villages are owned and managed by Southern Cross Care and the fourth, Rice Village, is owned by Mercy Health:

- Rice Village, in the Barwon region, near Geelong, includes both independent living units and serviced apartments, and has a co-located hostel and nursing home.
- JJ Waldron Court, also in the Barwon region, has no attached facilities.
- Macleod Village, in northern metropolitan Melbourne, has independent living units adjacent to a residential facility and Day Therapy Centre. The retirement village has no permanent staff.
- Michael Chamberlain Court, in eastern metropolitan Melbourne, caters for financially disadvantaged people and most residents enter because they are at risk of homelessness.

Services offered in the serviced apartments include basic domestic assistance such as laundry, cleaning and meals. Personal assistance is not covered in the contracts for these apartments but domestic assistants occasionally provide support for short periods of time as required.

Retirement village residents are able to access community aged care services in the same way as members of the wider community. However, Southern Cross Care finds that they tend to be less knowledgeable about services than most members of the general community and often do not know how to access mainstream programs. There is a mistaken belief among some residents, families and even some hospital staff that retirement villages should and will provide an appropriate level of support to residents who need assistance. There is also an erroneous perception among residents that they have preferential access to co-located hostel and nursing home beds. Residents in some villages are hesitant to ask for help because they are afraid of being pressured into moving out of the village if it is perceived that they are not coping.

Southern Cross Care identified a service delivery gap for serviced apartment residents who require higher care. People often live in serviced apartments for many years. Their needs increase over time so that the basic services they receive become inadequate. For example, people begin to need medication management and help to manage disabilities. For residents in serviced apartments who are accepted into the project, RVCP-funded services are provided in addition to existing services.

The three RVCP care managers work across other Southern Cross Care programs such as CACP and EACH. Two care managers are involved with each client to provide a back-up in the event of staff illness or other leave of absence. RVCP services are delivered by a combination of salaried and brokered staff. Allied health services are generally acquired

through private channels, as it is faster and easier to use the private system than the public system.

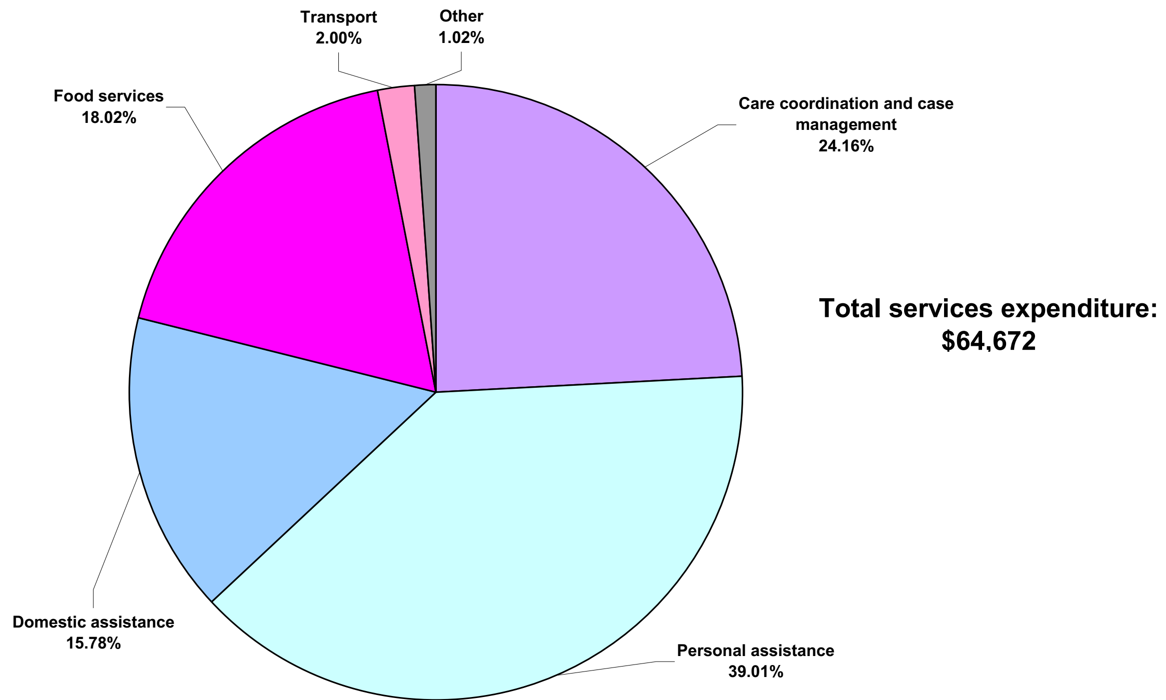
The project coordinator summarised a number of benefits and advantages of the RVCP. First, RVCP packages allow for more flexible service delivery than mainstream packages. The case management component is highly valued by staff and clients as it allows for time to help clients understand the service system. Economies of scale are realised when services are delivered within small communities as travel costs and time are greatly reduced. Other benefits for the retirement village communities accrue. Having staff in the immediate vicinity makes it easier for residents to approach them for assistance if needed. Residents have become more aware of the assistance available to them and RVCP clients display more trust in service providers. Finally, the burden is reduced for residents who are acting as carers for neighbours and friends within the villages.

Risk factors for continuing care

Clients are generally not accepted into the project if they require 24-hour supervision, for example, for problem wandering or intrusive behaviour; if mobility equipment is required but cannot be obtained or accommodated in the home; or if there are significant occupational health and safety issues in providing care. A strong desire on the part of the client's family for the client to be placed in residential care may also preclude a client from taking up or staying on a package.

Profile of expenditure on services to care recipients

Southern Cross Care RVCP delivered a limited range of services to clients during the reporting period, focusing on personal assistance, domestic assistance and food service (Figure B5.1).



Source: Quarterly financial report from Southern Cross Care (Victoria).

Figure B5.1: Southern Cross Care RVCP, expenditure on services, quarter ending 31 December 2004

5.2 Case study report

The project provided a case study report on the impact of the RVCP for residents and staff:

> 'One client with Parkinson's disease receives five visits daily for medication management. If medications are not administered when due the client is at high risk of fall-related injury. Care workers have been educated about the importance of keeping to a strict timetable and the client copes well with activities in and around home as long as the medication regime is well managed. The project coordinator remarked that the client's care needs would quickly escalate if it were not for frequent brief daily visits.
>
> Another client has advanced dementia and exhibits wandering and intrusive behaviour. The client receives close monitoring from RVCP care workers for nutrition and medication management, which involves three visits per day. A set care plan is essential because the client does not react well to change. Through the package, the client is attended by the same care workers and mutual familiarity is a key to successful management of the client at home. Wandering behaviour has continued but it has been possible to monitor the client's activity in a safe and familiar environment. Reassessment by ACAT is highly likely for this client and there are indications that the client will eventually enter residential aged care, particularly because of an increasing care load due to incontinence. However, the client's general practitioner has been surprised that the client has been maintained for as long in the village through RVCP services as it had been expected that the client would enter residential care at least 12 months earlier than is likely to be the case.
>
> More generally, village management and project staff have noted a number of positive flow-on effects. There has been a quietening of concerns among RVCP care recipients. While care services are not part of the standard residence contract, residents with increasing needs for assistance typically approach management with an expectation that assistance will be forthcoming. It is felt that calls on village management have reduced significantly since the introduction of RVCP care packages. It was also remarked that the introduction of packages has led to an increased sense of security among the wider communities, through the visibility of care workers entering villages multiple times per day.
>
> An unanticipated benefit of the Pilot has been the increased capacity to respond to the needs of residents on return home from hospital. In some ways the project has functioned as a form of slow-stream rehabilitation for people after an acute episode. Clients are accompanied on walks around the village, for example, to and from the dining room, and are encouraged to keep active by their care workers. Mobility assistance in the days following hospitalisation, and the encouragement and confidence building engendered by RVCP staff, help to relieve clients' feelings of vulnerability. The project is able to make available a high level of support immediately after a client is discharged from hospital and then taper the hours off as the client's condition improves. Often it does not take much in terms of accompaniment and monitoring to have a profound effect on a client's confidence. It is thought that the existence of supports within the villages assists clients to avoid premature placement that might occur as a result of physical frailty and loss of confidence following an acute episode.
>
> Some residents in need of assistance are initially reluctant to take up a package because they perceive this to be giving up their independence. Services can be introduced gradually and it has been observed that care recipients soon realise that by accepting assistance they actually gain independence through being able to increase their participation in life activities. '

5.3 Client profiles

There were 30 active care recipients in the September and December quarters of 2004. The project provided data on 18 clients for the evaluation (13 females and five males), representing 63.3% of clients who were active during the evaluation period.

All evaluation clients were approved by ACAT for low care.

Age and sex

The majority of Southern Cross Care RVCP clients who participated in the evaluation were aged 75 years or over (Table B5.1). The mean age was 84 years (the range was 73–92 years) and seven clients were aged 85 years or over.

Table B5.1: Southern Cross Care RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
65–74	—	1	1
75–84	2	8	10
85+	3	4	7
Total	**5**	**13**	**18**
		(per cent)	
65–74	—	5.6	5.6
75–84	11.1	44.4	55.6
85+	16.7	22.2	38.9
Total	**27.8**	**72.2**	**100.0**

— Nil.

Language and communication

One client had little or no effective means of communication. All other clients communicated effectively in English.

Accommodation and living arrangement

All clients were living in independent living units and were in their usual place of residence at time of referral to the project (Table B5.2). Eleven clients lived alone.

Table B5.2: Southern Cross Care RVCP, number of clients by usual accommodation setting, living arrangement and accommodation setting at time of referral to RVCP

Accommodation setting	Usual living arrangement: Alone	With family	With others	Total usual accommodation	Accommodation at referral
Retirement village—independent living	11	5	2	18	17
Other accommodation	—	—	—	—	1
Total	**11**	**5**	**2**	**18**	**18**

— Nil.

Years at usual accommodation ranged from one to 16. Three clients had been living in their retirement village for over 10 years.

Carer availability

Six clients had a carer at entry to the project, three of whom were co-resident spouses. Four carers are female—one wife and three daughters (Table B5.3).

The mean age of carers was 72 years, however the presence of two daughters means that the average age of female carers was considerably lower (67 years) than that of the male spouse (82 years). Two carers were aged 85 years or over (Table B5.4).

Table B5.3: Southern Cross Care RVCP, number of clients by carer availability, carer relationship to client and co-residency status

Relationship of carer to client	Carer lives with client	Carer does not live with client	Total
Spouse or partner	3	—	3
Son or daughter	—	3	3
Total clients with a carer	*3*	*3*	*6*
Clients without a carer	. .	. .	12
Total clients			**18**
Per cent of clients with a carer			33

— Nil.

. . Not applicable.

Table B5.4: Southern Cross Care RVCP, number of carers by age group and sex

Age (years)	Males	Females	Persons
25–44	—	1	1
45–54	—	—	—
55–64	—	1	1
65–74	—	—	—
75–84	1	1	2
85+	1	1	2
Total	**2**	**4**	**6**

— Nil.

Income and concession status

Government pensions were the primary source of cash income for 15 clients (Table B5.5). All but four clients held a health care concession card. Six clients receive a discounted rate of co-payment for RVCP services.

Table B5.5: Southern Cross Care RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number	Per cent
Principal source of cash income		
Age Pension	11	61.1
DVA pension	3	16.7
Superannuation	2	11.1
Disability Pension	1	5.6
Other source of income	1	5.6
Total	**18**	**100.0**
Health care concession card holder	14	77.8
RVCP concession status	6	33.3

Previous use of government-funded community care programs

Eleven clients had been receiving assistance through government community care programs prior to joining the project, most commonly Home and Community Care (Table B5.6). Southern Cross Care RVCP is one of the four projects to record 60% or more clients as having previously received assistance from government-funded care services.

Table B5.6: Southern Cross Care RVCP, number of clients by use of government support programs prior to RVCP by carer availability

	Has a carer	No carer	Total	Per cent
Previous government support program				
Home and Community Care	4	5	9	50.0
Community Aged Care Packages	1	—	1	5.6
Veterans' Home Care	—	1	1	5.6
Total	*5*	*6*	*11*	*61.1*
No previous government program support	—	7	7	38.9
Total	**5**	**13**	**18**	**100.0**

— Nil.

One client was on a waiting list for residential aged care.

Previous use of respite care was recorded for five of the six clients with a carer. One client had used mainly residential respite care. The other clients had not used it because their carers said they had not needed respite (three clients), or they had not used respite care even though respite was needed (one client).

Referral and assessment

Most referrals to the project are made by staff at Southern Cross Care and ACAT (Table B5.7). Many clients would have been known to Southern Cross Care because the organization is an approved HACC, CACP and Veterans' Home Care provider.

Table B5.7: Southern Cross Care RVCP, number of clients by source of referral

Referral source	Number of clients
Southern Cross Care	10
Aged Care Assessment Team	5
Other person	2
Self-referral	1
Total	**18**

Most commonly, clients make the initial contact or are referred by family or retirement village staff. Retirement village staff liaise with the RVCP project for an initial interview before the client is referred to an ACAT. Once the ACAT assessment is completed and eligibility established, the project coordinator and case manager contact the client and family to arrange a more in-depth needs assessment. A care plan is developed and a formal service agreement negotiated. Sometimes there is an adjustment period before the care plan becomes established as some clients and families are reticent to accept help.

All clients had ACAT approval for low care and in each case ACAT assessment had been completed before RVCP services commenced (Table B5.8). The project coordinator indicated that by June 2005, two clients were likely to be referred to an ACAT for reassessment and that each would likely be approved for high care.

Table B5.8: Southern Cross Care RVCP, number of clients by days between completion of ACAT assessment and commencement of services

Completion date of ACAT assessment	Number of clients
Before service commencement	
0–20 days	4
21–30 days	3
31–90 days	2
91–180 days	4
181–365 days	5
Total	**18**

The client care managers for the project included a registered nurse, a welfare and community worker and a nurse manager.

Health conditions and health status on entry

The number of health conditions per client as at entry to the project varies from two to nine with a mode of four conditions recorded for seven clients. Four or more health conditions were recorded for 14 of the 18 clients. Table B5.9 lists the primary health conditions recorded.

Table B5.9: Southern Cross Care RVCP, number of clients by primary health condition at entry

Primary health condition	Number of clients
Blindness or poor vision	4
Dementia (Alzheimer's disease and other dementias)	4
Psychoses and depression	2
Parkinson's disease	2
Arthritis and related disorders	2
Heart disease and other circulatory system diseases	2
Other specified diseases and disorders[a]	2
Total	**18**

(a) Skin cancer and genitourinary system disease.

Nine clients were assessed to be at risk of falls due to impaired gait and/or balance at the time of entry to the project. Vision or hearing impairment was present in seven and six clients respectively (Table B5.10).

Table B5.10: Southern Cross Care RVCP, number of clients by presence of selected health conditions at entry to RVCP

Health condition	Number of clients
Vision impairment	7
Hearing impairment	6
Both hearing and vision impairment	4
Impaired gait or balance—at risk of falls	9
Diagnosis of depression	3
Disorientation/confusion	1

The number of different types of medication recorded at baseline varies from zero to 14. Eleven clients were taking at least four different medications.

At the start of the evaluation clients reported their health status and change in health status over the past 12 months against a 5-point Likert scale. Eleven clients said that they were in very good or good health; four reported fair health and two said that they were in poor health. One client did not report. On change in health status, 14 clients said that they were in better, or about the same, health as 12 months earlier. Three clients felt that they were in somewhat worse health and one client did not report.

Clients reported on significant health events in the 12 months before entering RVCP. One client had sustained a fall causing fracture or other significant injury and another client had been rendered immobile and unable to summon assistance through an accident.

Level of core activity limitation

Two clients were assessed as having a severe or profound level of core activity limitation. Most instances of core activity limitation among Southern Cross Care clients are of a mild nature (Table B5.11). Compared to most other RVCP client groups, Southern Cross Care had a higher proportion of clients with no core activity limitation.

Table B5.11: Southern Cross Care RVCP, number of clients by level of core activity limitation at entry to RVCP

	Level of activity limitation				
Core activity	No limitation	Mild	Moderate	Severe or profound	Total
Self-care	6	8	3	1	**18**
Mobility	5	10	3	—	**18**
Communication	12	3	1	2	**18**

— Nil.

Use of medical and hospital services prior to entry

Baseline profiles contain information about a client's use of medical and hospital services in the 6 months prior to entering the RVCP—the 'pre-entry period'. All 18 clients had visited a medical practitioner at least once in the pre-entry period. The reported number of visits varies from two to 12 per client, with a mode of six visits. Three clients recorded 12 medical consultations outside of hospital during the pre-entry period.

Cumulatively, the 18 clients recorded 117 visits to a medical practitioner outside of a hospital setting over an estimated 3,240 person days.

Data on hospital admissions are missing for two clients. Among clients with non-missing data, four had been admitted to hospital in the pre-entry period, one of whom had three urgent/unplanned admissions in the 6-month period.

5.4 Client assessment results

Activities of daily living

At entry to the RVCP, most Southern Cross Care evaluation clients needed help to negotiate stairs but were independent in the other activities of daily living. Modified Barthel Index (MBI) scores at entry range from 12 to 20 out of a total 20 points. The mean baseline score was 17.9 points with a standard deviation of 2.2 points (median 19).

According to a classification scheme for the Barthel Index (Shah et al. 1989), the baseline results indicate that one client exhibited severe dependency in ADL at time of entry to the project; five clients were moderately dependent, and 10 clients were slightly dependent. Two clients were independent in all ADL at time of entry.

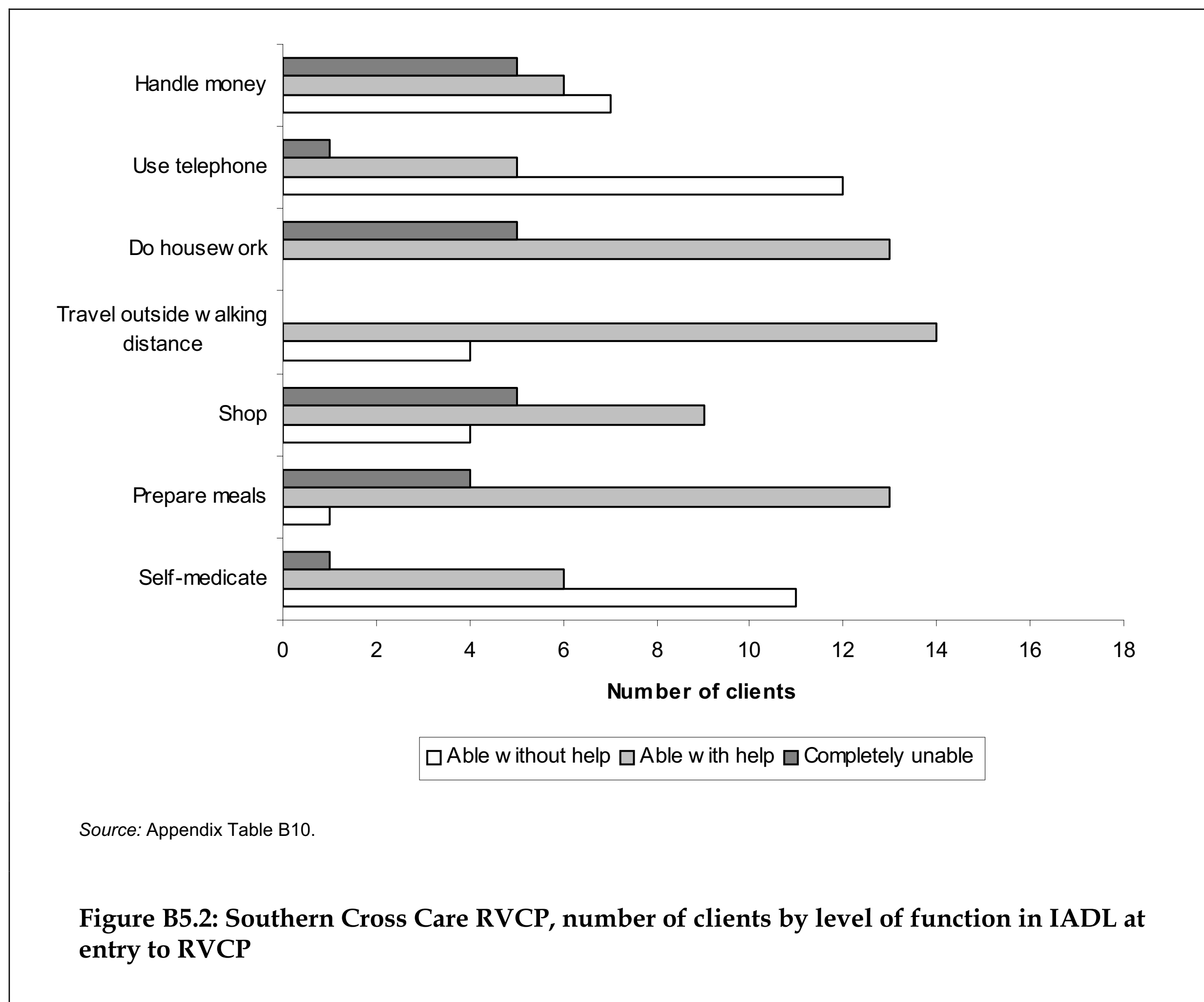
The mean MBI score at baseline indicates that the middle of the MBI distribution for Southern Cross Care RVCP clients was in the range of slight dependency in ADL (Table B5.12).

Apart from medication management, most clients needed assistance in IADL when they entered the project (Figure B5.2). Most notably, all clients were completely unable to do housework and all but one client needed assistance to prepare meals. Only four clients could travel outside of walking distance and shop for food or clothes without assistance. The median baseline score on the IADL scale is 9 points, with scores ranging from 2 to 12 out of a possible maximum of 14 points. These results indicate that all clients had lost some IADL function and that there is considerable variation in the extent of functional loss among clients entering the project.

Final assessments were conducted on average 19.6 weeks after entry.

Changes in the MBI between baseline and final assessments range from –3 (a 3-point decline) to zero. The median change score was zero (Table B5.12), indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments. Of the clients who recorded a non-zero change score, the most common pattern was a decline from slight to moderate dependency in ADL.

The median IADL change score (between baseline and final assessments) is zero, with variation in the range of –1 to 1 point (Table B5.12). Eighteen per cent of clients registered a change in IADL function between baseline and final assessments.



Source: Appendix Table B10.

Figure B5.2: Southern Cross Care RVCP, number of clients by level of function in IADL at entry to RVCP

Table B5.12: Southern Cross Care RVCP, summary measures for ADL and IADL baseline and change scores[(a)]

	Number of clients	Median	Mean	Standard dev.
ADL				
Baseline MBI	17	19	18.1	2.2
Change in MBI	17	0	–0.1	0.9
IADL				
Baseline IADL	17	9	8.4	2.7
Change in IADL	17	0	0	0.5

(a) Score at final assessment minus score at baseline for an individual client.

5.5 Carer assessment results

Five carers reported self-assessed health status. The reports range from poor to excellent health.

Caregiver Strain Index scores were recorded for two carers; neither was above the case threshold for carer strain.

5.6 Accommodation outcomes

By completion of follow-up (16 June 2005), 15 of the 18 clients were still with the project. Two clients had entered an aged care facility (Table B5.13).

Table B5.13: Southern Cross Care RVCP, number of clients by discharge outcome, June 2005

	Number of clients	Per cent
At home		
With RVCP	15	83.3
With HACC	—	—
Without formal services	—	—
Not stated	1	5.6
Total at home	*16*	*88.9*
Institutional care		
Hospital	—	
Residential aged care total	2	11.1
Low care	1	5.6
High care	1	5.6
Total in care	*2*	*11.1*
Deceased	—	—
Total	**18**	**100.0**

— Nil.

6 Kingston City Council

6.1 Project description

Kingston City Council, an established provider of community aged care services through the HACC and CACP programs, received an allocation of 22 flexible care places under the RVCP (including two high care). The project covers four retirement villages in the Council's local government area that are owned and operated by other organisations: Patterson Village in Carrum, RSL Village in Cheltenham, Greenwood Village Mews in Dingley and Illawong Residential Club at Patterson Lakes.

The project was established in December 2003 and operates from the council's Aged and Disability Services Department, which is co-located with the ACAT and Community Health Service. As a result, the project has strong links to the Council's HACC service and other existing service networks. Council auspice provides for a range of complementary information and services such as information technology and financial and human resource management expertise, in addition to a considerable level of 'in-kind' assistance.

The primary aim of the RVCP project is to expand an existing council client base and to increase options available to clients in retirement villages who are assessed by ACAT as having complex care needs. A strong preventive focus is intended to assist eligible residents before they reach a crisis point. This requires active participation of retirement village management and staff. None of the villages delivers direct care to residents. Ordinarily, management in three of the four villages provide an informal monitoring service. An exception is Greenwood Mews. Run by a body corporate, Greenwood Mews has no manager to provide ongoing monitoring or to help arrange ACAT assessment and other services. All self-referrals to the RVCP project have come from Greenwood Mews.

The project has developed strong links between project staff, management and residents in the four villages and this has raised awareness of the range of services that is available to help maintain people at home. These links help to build confidence in the system of community care.

The project coordinator reported that people are entering retirement villages at older ages than in the past, often with established age-related frailty. When a person buys into an independent living unit, they typically expect to stay there forever. As frailty increases with age, residents generally move into residential aged care because the required level of support has not traditionally fit with the independent living unit concept. Family members sometimes expect that a resident will receive the necessary support from within the retirement village, which is not necessarily the case. It is Kingston City Council's experience that many retirement village residents are, or believe that they will be, encouraged to leave their home when their level of need exceeds what village management is comfortable with. Thus, even gardening and home maintenance can be important services to clients who worry that an untidy garden will create an impression of an inability to manage alone.

Retirement village residents can access community aged care services in the same way as the general community, however there are widespread shortages of supply in community care in general. In addition, retirement village residents are often unaware of services or how to access them, particularly if the village they live in does not have an active manager.

The Victoria Government Community Linkages program provides packages of around 12 to 15 hours per week, which can be too low to maintain a very high needs client at home, in the view of Kingston City Council. There are 55 such packages in the municipality, but the demand is so high that the program maintains a closed waiting list of approximately 20 names. Whenever the list opens it fills within hours. HACC services are delivered in conjunction with Linkages, and usually contribute around 6 hours at the HACC subsidised rate of the total hours that clients receive.

There are 30 EACH packages in the municipality; EACH places are difficult to access. Kingston City Council believes that EACH is a good program, but that the money may have been better spent expanding the value of existing packages. Currently, EACH delivers more hours to clients than CACP or Linkages.

All residents in the RVCP project are living in independent living units, though two of the villages also provide serviced apartments. Residents of serviced apartments are eligible for the project, though only one such client has been referred so far. The RVCP provides services in addition to those received through the serviced apartment contract, which typically include basic housework twice a week, meals and access to group activities in the retirement village. Clients are charged a co-payment of up to $39 per week according to capacity to pay.

RVCP client services

Specific areas of unmet need that the Kingston City Council project is designed to meet include high level case management and service coordination, home-based allied health services and personal accompaniment.

- The outreach case management component facilitates regular personal contact between care manager and client in the care recipient's familiar home environment. Existing case management programs have long waiting lists. The RVCP care model provides efficiencies as a number of care recipients can be visited on the same day. It also provides continuity and the ability for village managers and care managers to establish strong working relationships.
- Vulnerable older people find the service system complex and daunting. The RVCP care manager is able to coordinate client-focused flexible care arrangements and advocate for individual clients. All care recipients who have commenced with the project have required and gained access to one or more services that they were not previously receiving.
- Home-based allied health care can be hard to access through mainstream programs and long delays are often encountered. The RVCP project has the capacity to purchase these services in a timely manner, which allows care recipients to achieve and maintain an optimum level of functioning.
- Older people are able to use half-price taxi fares and similar transport services to attend medical and personal appointments. While this is suitable for some, others require accompaniment on outings to assist with transfers and provide general guidance. This type of assistance can be hard to obtain. When accompaniment is required the RVCP covers that cost and the care recipient continues to cover the transport cost. This offers a greater sense of safety and security to RVCP care recipients.

Kingston City Council employs staff for in-home respite care for RVCP care recipients. Residential respite is arranged through private placements as needed. Allied health care is accessed through the community health centre co-located with Kingston City Council. The

project can supply aids, smaller pieces of equipment and home modifications such as hand rails in addition to assisting clients to borrow from a pool of larger items such as commode chairs. By arrangement with the Royal District Nursing Service, RVCP recipients are able to receive nursing care at a small cost to the project. Personal care assessments, clinical assessments and ongoing training of personal care staff is provided through Kingston City Council nursing staff. Existing Department of Veterans' Affairs Royal District Nursing Service contracts remain in place but the project assumes responsibility for providing other services and case management for veteran clients.

The coordinator reports that the project has benefits for the wider community in each participating retirement village. Residents are more comfortable asking for help, and are aware of more service options, particularly for transport and social activities for previously housebound residents. An increase in the amount of social activity within the villages has been observed and attributed at least in part to the project. In addition, the project has reduced the burden of caring for neighbours and friends within villages, and intrusive behaviours that once impacted on other residents are better managed.

The project has strengthened an already strong relationship between Kingston City Council and the ACAT. The ACAT views RVCP packages as similar to CACP packages and Community Linkages, but preferentially refers clients who need more than HACC-level service for an RVCP package because of their immediate availability. RVCP provides a flexible service with good case management, which the ACAT believes is important for clients and at the same time relieves some of the burden on ACAT staff. The ACAT expressed a desire for any future mainstream service to retain the flexibility that is available through RVCP packages.

The RVCP coordinator also remarked on the flexibility afforded by the RVCP that is not possible with most mainstream program care packages. The grant funding model and lack of restriction on hours makes true case management and flexible, responsive care viable.

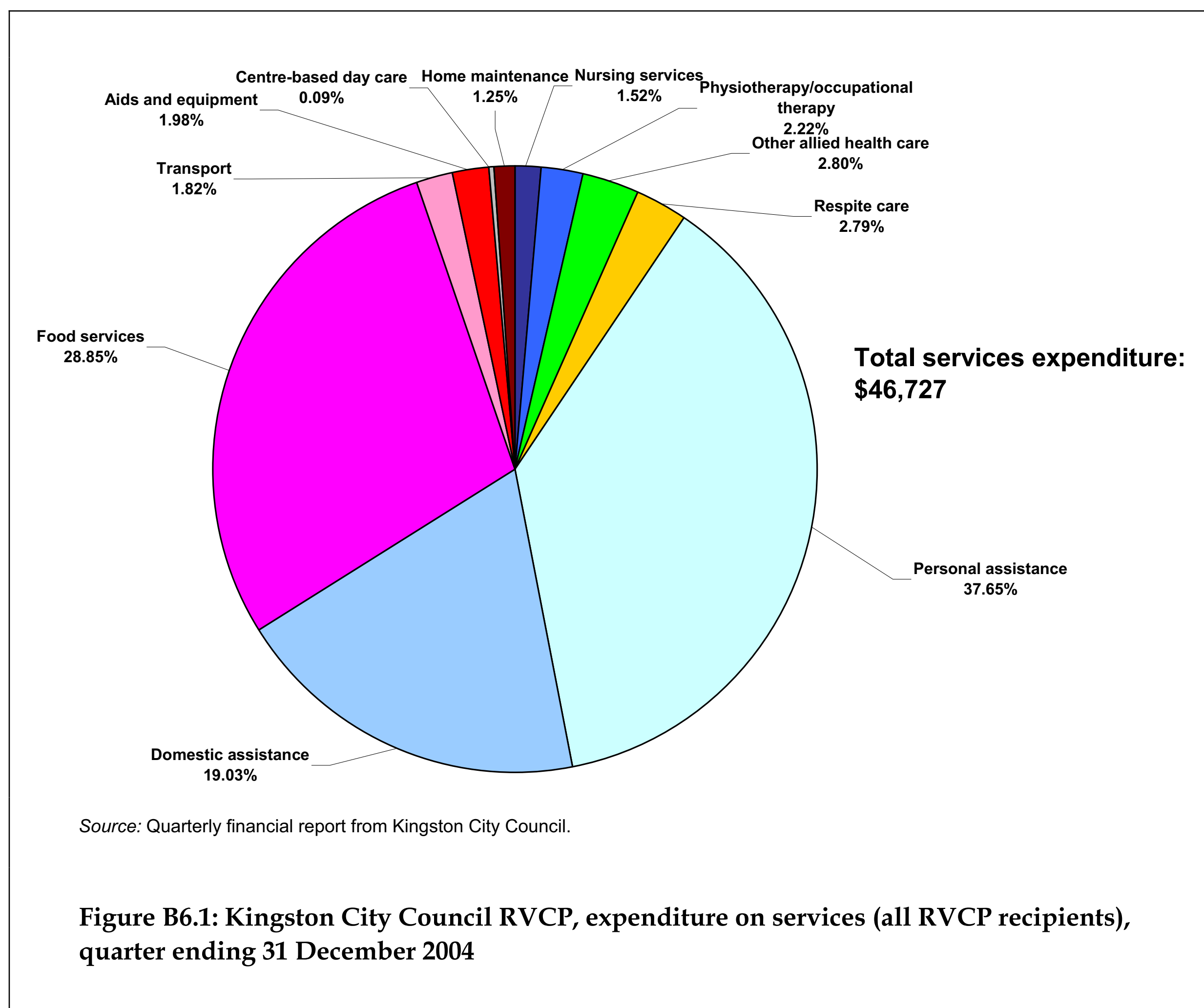
Risks factors for continuing care

Care recipients are at risk of having to leave the project if they require 24-hour supervision, for example, because of frequent falls or wandering. The project can cater for people who need hoists for transfers, provided that the carer (if there is one) can manage, the nurse or occupational therapist assesses that transfers are safe for care workers to perform, and appropriate equipment can be accommodated within the person's unit. Nurses are available to train care workers and carers in manual handling and transfers for a particular care recipient.

Some RVCP recipients have left the project because their needs have lessened—such as when the initial need for assistance related to a health condition that subsequently improves.

Profile of expenditure on services to care recipients

A breakdown of expenditure on direct care services for the Kingston City Council project reveals project activity in the reporting period was concentrated on personal assistance, domestic assistance and food services. However, the project recorded expenditure against a diverse range of service types, including nursing care, allied health care and respite care (in-home and day centre respite).



Source: Quarterly financial report from Kingston City Council.

Figure B6.1: Kingston City Council RVCP, expenditure on services (all RVCP recipients), quarter ending 31 December 2004

6.2 Case studies

Kingston City Council supplied the following case study reports.

Case study 1

'Mr and Mrs W were referred to the RVCP in February 2004. They had been assessed by ACAT in early February 2004 due to an increase in their needs. Mrs W had been receiving services through Linkages, however her needs were becoming more complex and could not be covered under this package. Given that both Mr and Mrs W both needed support services, the flexible care available through the RVCP was felt to be a better option for them.

Mr and Mrs W were both very determined to stay living at the retirement village in their unit and were both very supportive of each other. They considered that they were each other's carer. Both clients were in their mid-90s, Mrs W was legally blind and both were frail with increasingly complex health issues at the time. The family were very supportive: two daughters with their own families live close to the village and would come to see their parents to help as often as possible. Both daughters are aged in their 60s and work part-time

and were finding it difficult to cover the needs of their parents. They were very grateful when both their parents were accepted onto the RVCP.

In September 2004, due to a rapid deterioration in Mr W's health, both clients were re-assessed by ACAT for probable entry into residential care. ACAT indicated that the family needed to actively look for a facility which had both low and high level care as it was expected that Mr W would need high care in the very near future. From this time onwards, the role of carer went more to one of the daughters who needed to be there with her parents more often to take her father to medical appointments. She also liaised with the RVCP case manager in relation to increased care needs for both parents.

The RVCP was able to support Mr and Mrs W with services including personal care for showering daily, meal preparation of a small snack in the evenings, a delivered hot meal at lunch time daily, domestic care weekly, carers to take Mrs W for recreational outings to give Mr W respite weekly and podiatry six-weekly. This level of support was in place for approximately 9 months until Mr W's health deteriorated dramatically. Royal District Nursing Service had also been seeing Mr W three times weekly to dress wounds (independently of the RVCP) for approximately 8 months. The RVCP level of supports needed to increase to cover his medical and hospital visits, including carers to stay with Mrs W while her daughter took Mr W to these appointments due to her blindness and because she was very anxious. Throughout the month prior to Mr W passing away, there was the need for overnight care on several occasions, alternating with family to stay with the couple. Permanent residential care placements had been organised by the family, however this was not available for another 3 to 4 weeks.

Unfortunately, Mr W had to be taken into palliative care where he remained for two weeks until he passed away. Mrs W was placed in an emergency respite bed for this time until a permanent placement became available. During this time also, carers were used to transport Mrs W (alternating with family) to visit her husband until his death, after which Mrs W was discharged from RVCP'

Case study 2

'Mrs X, aged in her mid-80s, has multiple complex medical conditions. These illnesses caused Mrs X to become confined to her retirement village unit, which contributed to symptoms of depression and anxiety. Mrs X had always enjoyed a very active life, participating in the local dances and many other community activities which she was now unable to attend. Mrs X is not able to walk without a "wheelie walker" and even then only a very short distance. She has always had a very good appetite but was losing weight because she was unable to cook or prepare adequate meals for herself anymore.

Mrs X felt that she was not able to cope anymore without support but did not want to leave the retirement village where all her friends lived.

The RVCP flexible care was able to address the changing needs of Mrs X by putting in personal care for showering three times weekly, personal care in the morning and evening daily to fit and remove medical support stockings. Weekly domestic care was introduced, meals are delivered hot at midday and a snack in the evening. Carers take Mrs X to her numerous medical appointments as required. Mrs X occasionally needs to go shopping for

personal items, which is made possible with an RVCP carer. Continence products are provided.

The capacity for Mrs X to socialise and feel a little more independent was still limited by her multiple health problems. However, over 2 months these difficulties stabilised and the RVCP was able to provide access to a motorised scooter and attendance at an adult day program once a week. Having access to the scooter changed Mrs X's outlook on life as she is now able to get out of her unit to go to see her friends in the village. It also allows here to travel to nearby shops occasionally, with a friend who also has a scooter.

Mrs X has relied heavily on the case management and services provided by the RVCP since the beginning of 2004. On a visit to see Mrs X, the project coordinator saw her riding her scooter to the community centre at the village, with her hand in the air saying "I'm off to bingo, yahoo !!" with a big smile. She has not been able to do this for the past 2½ years, but now has a quality of life that she thought she would never regain.

Mrs X is observed to be a different person and her mental attitude to life is reported to have improved dramatically. '

Case study 3

'Mr Y has been a client of the RVCP since early 2004 and lives alone in his retirement village unit. He suffers from a degenerative disease which causes muscles to gradually become weaker. This has resulted in Mr Y becoming more dependent on his extremely supportive daughter and RVCP services to remain in his unit. Mr Y has several other medical conditions which contribute to his complex care needs. His daughter works shifts and comes to see him every Tuesday and Thursday and stays with him on the weekends.

Prior to coming onto the RVCP, Mr Y was receiving domestic assistance fortnightly and personal care three times a week for showering from City of Kingston HACC services. This client was also having the Royal District Nursing Service visit three times a week for wound dressing. Meals on Wheels was delivering meals three times weekly, which Mr Y reheated in the evening as his main meal. RVCP increased the domestic assistance to weekly and changed the meal service to a daily frozen delivery, thus providing a main meal every night. The RVCP case manager organised a home visiting podiatrist for Mr Y. Personal assistance for showers has continued, as have the nursing service visits with the cost being covered by the RVCP.

As time has passed, Mr Y's health has deteriorated and his care needs have become more complex, which was to be expected. The project coordinator was able to change his care plan accordingly and supply equipment to enable Mr Y to have a reasonable quality of life. Mr Y now has great difficulty walking and does not have the strength to pull himself up out of his lounge chair—he sits most of the time. RVCP has been able to hire a lift chair which has helped enormously. Mr Y is not able to prepare/heat his meals anymore as he no longer has the muscle control to hold a plate. RVCP now has a carer go in to do this every weekday evening. His daughter does this on the weekends when she is there.

Mr Y has been an avid model boat builder for many years. He has done this in his garage, but due to his illness he is not able to do much any longer. His daughter helps him do some

as she too is an enthusiast. Having the services and support of the RVCP has enabled Mr Y to remain in the retirement village, which is set around a small lake where he and his daughter are able to sail his model boats.'

Case study 4

'Mrs Z is "young" lady in her late 90s who lives alone in her retirement village unit. Mrs Z is very mentally alert and has been involved in community activities at the village for many years. She was referred to RVCP in mid-2004 after having a fall and breaking her hip. Mrs Z spent 2 months in hospital and rehabilitation and her daughters did not expect her to be able to return to independent living at the village. As both daughters live a distance away, they had started looking for a low care residential placement so that their mother could be closer to them.

Mrs Z had different ideas when she heard about the supports that the RVCP would be able to offer if she were able to go home to her unit. Although physically frail, Mrs Z felt that she would be able to cope in the village with a case manager and services for support. Mrs Z was previously receiving personal care for showers twice weekly, domestic assistance fortnightly and Meals on Wheels four times per week.

Mrs Z receives personal care three times weekly, domestic assistance weekly and Meals on Wheels daily with a small 'snack' meal delivered from the village dining room every evening. She also has regular home visits from a physiotherapist who works on walking and arm strength. Mrs Z works on these exercises regularly and is now able to go for walks around the village with her walker.

Mrs Z attends an adult day activity group once a week, accompanied by a carer. She enjoys the company and the outing very much.

Mrs Z became the 'public face' for the RVCP in the Kingston area when she agreed to have her photo and story in the local *Kingston Your City* newspaper with an article promoting the Retirement Village Care Pilot. She feels that without the supports and the case management of the RVCP, she would not be able to stay in her home. Her daughters are astounded at her success and are very happy for her. They feel relieved knowing their mother is being looked after and supported in what she wants to do.

The following remarks, extracted from a letter to the project coordinator, were written by a daughter of a client:

> [We] relied so very much on you and your program's team of carers for support and assistance to allow them to remain living in the comfort of their own home with the peace of mind that all was organised for that to work successfully.
>
> The program gave [us] the safety net we needed. The confidence and trust allowed us to go about our everyday lives knowing our parents' needs were taken care of. You assured us that whatever happened the program was flexible enough that it allowed change to meet their needs and you did and we will be forever grateful.'

6.3 Client profiles

There were 26 care recipients active in the project during the September and December 2004 quarters. The project provided data on 23 care recipients for the evaluation (18 females and five males), representing 88.5% of package recipients who were active during the evaluation period.

Age and sex

The mean age of clients in the Kingston City Council evaluation group was 85 years at the time. Ages ranged from 76 to 97 years. Nine clients were aged 85 years or over (Table B6.1).

Table B6.1: Kingston City Council RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
75–84	4	10	14
85+	1	8	9
Total	**5**	**18**	**23**
		(per cent)	
75–84	17.5	43.5	60.9
85+	4.3	34.8	39.1
Total	**21.7**	**78.3**	**100.0**

Language and communication

All clients could communicate effectively in spoken language and English was the main language spoken at home by all clients.

Accommodation and living arrangement

All clients were living in independent living units at the time of referral to the project (Table B6.2). Most clients lived alone.

Table B6.2: Kingston City Council RVCP, number of clients by usual accommodation setting, living arrangement and accommodation setting at time of referral to RVCP

Accommodation setting	Usual living arrangement			Total usual accommodation	Accommodation at referral
	Alone	With family	With others		
Retirement village—independent living	18	2	3	23	23
Total	**18**	**2**	**3**	**23**	**23**

Years at usual place of residence ranged from 2 to 24 years. Fourteen clients had been living in their retirement village for over 10 years; four of these clients had been in their retirement village for over 20 years.

Carer availability

Of the 23 clients, 15 had a carer during the evaluation and four carers lived with the RVCP client. Eleven of the 15 carers were female, with a relatively high representation (six carers) of non co-resident daughters (Table B6.3). Carers' ages ranged from 45 to 96 years, averaging 65 years. Carers of Kingston City Council RVCP clients were either in the 45–54 year age group, or were aged 75 years or over (Table B6.4), with one exception. Two carers were aged 85 years or over.

Table B6.3: Kingston City Council RVCP, number of clients by carer availability, carer relationship to client and co-residency status

Relationship of carer to client	Carer lives with client	Carer does not live with client	Total
Spouse or partner	4	1	5
Son or daughter	—	8	8
Other relative	—	1	1
Friend or neighbour	—	1	1
Total clients with a carer	*4*	*11*	*15*
Clients without a carer	. .	. .	8
Total clients			**23**
Per cent of clients with a carer			71

— Nil.

. . Not applicable.

Table B6.4: Kingston City Council RVCP, number of carers by age group and sex

Age (years)	Males	Females	Persons
45–54	2	6	8
55–64	—	—	—
65–74	—	1	1
75–84	1	2	3
85+	1	2	3
Total	**4**	**11**	**15**

— Nil.

Income and concession status

Government pensions were the primary source of cash income for all clients (Table B6.5). Most clients held a health care concession card and one-third of the group were allowed a discount on the RVCP client co-payment.

Table B6.5: Kingston City Council RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number of clients	Per cent
Principal source of cash income		
Age Pension	14	60.9
DVA pension	9	39.1
Total	**23**	**10.0**
Health care concession card holder	20	87.0
RVCP concession	7	30.4

Previous use of government-funded community care programs

The proportion of clients who had previously received assistance through government community care programs distinguishes Kingston City Council RVCP from other projects. All but two clients had been receiving assistance through government programs before they entered the RVCP (Table B6.6). Seven clients had been receiving assistance through more than one program: Home and Community Care and Veterans' Home Care were delivering services concurrently in each case.

Table B6.6: Kingston City Council RVCP, number of clients by use of government support programs prior to RVCP

Previous use of government support programs	Has a carer	No carer	Total	Per cent
Government support program				
Home and Community Care (HACC)	5	6	11	47.8
Multiple programs (HACC & VHC)	6	1	7	30.4
Veterans' Home Care (VHC)	2	—	2	8.7
Other program	—	1	1	4.3
Total clients with previous government support program	*13*	*8*	*21*	*91.3*
Clients without previous government program support	2	—	2	8.7
Total	**15**	**8**	**23**	**100.0**

— Nil.

Referral and assessment

Client referrals were received from a variety of sources. Retirement village managers make referrals, in which case the manager and RVCP coordinator discuss the client's history, needs and family support. If the referred person appears eligible and suitable, the retirement village manager arranges an ACAT assessment. The RVCP coordinator does not formally screen these potential clients. Residents who self-refer or who are referred by a family member undergo an initial needs and screening assessment by the RVCP coordinator before being referred to an ACAT. Other sources of referral include HACC agency staff, who may

refer directly to ACAT or to the RVCP coordinator and ACAT staff. ACAT involvement in ongoing care planning and management is minimal once assessment is completed.

The project coordinator writes a care plan for each client, and a council nurse completes a personal care plan. RVCP care workers complete observation sheets if they suspect a client needs a subsequent nursing assessment or any other type of assessment, which is then arranged by the coordinator.

During the evaluation, nine clients were referred to the Kingston City Council RVCP by staff at their retirement village and nine clients were referred by a person other than a relative or friend (Table B6.7). 'Other person' can, for example, be a retirement village neighbour.

Table B6.7: Kingston City Council RVCP, number of clients by source of referral

Referral source	Number of clients
Participating retirement villages	9
Other person	9
Self-referral	2
Aged Care Assessment Team	1
Other community service agency	1
Friend	1
Total	**23**

The two villages with on-site managers and nursing staff have provided the most ready access to eligible residents. Direct referrals from the nursing staff to ACAT along with staff recommendations for the RVCP has led to more referrals to the project from these villages. The other two villages, one operated by a body corporate and the other by an off-site manager, have been more difficult to access. RVCP project staff attended resident and body corporate meetings in these villages to maintain awareness of the project. Many residents in these villages were not aware that they were eligible for ACAT assessment, or even what an ACAT assessment entails.

All clients had completed an ACAT assessment prior to or shortly after commencement of services (Table B6.8).

The care of Kingston City Council RVCP clients is managed by a counsellor/psychologist.

Table B6.8: Kingston City Council RVCP, number of clients by days between completion of ACAT assessment and commencement of services

Completion of ACAT assessment	Number of clients
Before service commencement	
0–20 days	14
21–30 days	1
31–90 days	4
91–180 days	1
181 days to 365 days	2
Total	*22*
After service commencement	
16 days after services commenced	1
Total	**23**

— Nil.

Health conditions and health status on entry

A range of primary health conditions were represented among clients participating in the evaluation, including dementia, arthritis, heart disease and other circulatory system disorders (Table B6.9). Three or more health conditions were recorded for 18 clients, and the number of health conditions recorded per client ranges from one to 10.

Table B6.9: Kingston City Council RVCP, number of clients by primary health condition at entry

Primary health condition	Number of clients
Heart disease and diseases of the circulatory system	5
Dementia in Alzheimer's disease	4
Arthritis and other diseases of the musculoskeletal system and connective tissue	3
Parkinson's disease	2
Fracture of femur	2
Falls and abnormalities of gait and mobility	2
Malignancy	2
Chronic lower respiratory disease	1
Epilepsy	1
Muscular dystrophy	1
Total	**23**

Among the selected health conditions surveyed, restricted mobility and risk of falls appears to be the greatest risk factor for most Kingston City Council RVCP clients. Nineteen clients were assessed to be at risk of falls due to impaired gait and/or balance. Vision or hearing

impairment, depression and disorientation were reported for between one and three of the 23 clients (Table B6.10).

Table B6.10: Kingston City Council RVCP, number of clients by presence of selected health conditions at entry

Health condition	Number of clients
Impaired gait or balance—at risk of falls	19
Vision impairment	2
Hearing impairment	3
Both hearing and vision impairment	—
Diagnosis of depression	2
Disorientation/confusion	1

— Nil.

A high proportion of clients are recorded as being on a number of different types of medication. Per client numbers of medications vary from zero to 12. Nineteen of the 23 clients were taking at least four different types of medication.

Clients were asked to rate their health status and change in health status over the past 12 months using a five-point Likert scale. Five clients said that they were in good health; 12 reported fair health and six clients said they were in poor health. On change in health status relative to 12 months earlier, 13 clients reported that their health was somewhat worse and five clients said that their health was much worse. Four clients indicated that their present state of health was about the same as one year earlier and one client reported that their health was much better.

Selected significant health events in the 12 months before entering the RVCP were also recorded. Five clients had sustained a fracture or other significant injury as a result of a fall. Three clients had been rendered immobile by a fall or accident and left unable to summon assistance for 30 minutes or more. Five clients reported a life-threatening medical event that resulted in severe decline in health status in the 12 months prior to entry.

On the basis of these data, Kingston City Council RVCP clients realised a relatively high rate of risk compared with other groups. Mobility restriction as a result of musculoskeletal disease and disorders and fall-related injuries is particularly prevalent.

Level of core activity limitation

Assessments of Kingston City Council RVCP clients as at entry to the RVCP indicate that only one client had a severe or profound level of core activity limitation in mobility and self-care. This result may indicate under-reporting of severe or profound core activity limitation since baseline client assessment results indicate that four clients showed severe dependency in self-care and/or mobility.

Most instances of core activity limitation seen in Kingston City Council clients at baseline were of a mild to moderate level (Table B6.11). As in other RVCP client groups, communication limitation is less common than self-care or mobility limitation.

Table B6.11: Kingston City Council RVCP, number of clients by level of core activity limitation by type of limitation, at entry

	Level of activity limitation				
Core activity	No limitation	Mild	Moderate	Severe or profound	Total
Self-care	2	8	12	1	**23**
Mobility	1	10	11	1	**23**
Communication	22	1	0	0	**23**

Use of medical and hospital services prior to entry

Baseline profiles contain information about a client's use of medical and hospital services in the 6 months prior to entering the RVCP—the 'pre-entry period'. All 23 Kingston City Council RVCP clients had consulted a medical practitioner at least once in the pre-entry period. The reported number of visits varies from one to 24 per client, with a mode of six visits recorded by 10 clients. Four clients recorded 24 medical consultations outside of hospital during the pre-entry period.

Cumulatively, the 23 clients recorded 220 visits to a medical practitioner outside of a hospital setting over an estimated 4,140 person days. This level of medical service utilisation in the pre-entry period is high relative to other RVCP client groups.

Data on hospital admissions in the 6 months prior to entry were also collected. Fifteen clients accumulated a total of 31 hospital admissions in their pre-entry periods, of which 18 were urgent or unplanned admissions. Six clients had planned admissions only. The remaining clients had had at least one urgent /unplanned admission. Three clients had each had three urgent admissions to hospital in the 6 months prior to entering the RVCP and one client had had four urgent/unplanned admissions. Clients with hospital admissions averaged two admissions in the 6 months before joining RVCP. Time spent in hospital for urgent admissions during the pre-entry period averaged 17 days per client.[3] Urgent hospital admissions accounted for 215 hospital bed days over an estimated 1,620 person days for this group of clients. Length of stay in hospital for each urgent admission varied from 10 to 60 days.

Six clients had visited a hospital emergency department in the pre-entry period, including two who reported three visits each and one client who reported four visits. In addition, seven clients had been registered with a rehabilitation facility for 14 days, one client had spent 60 days in rehabilitation and one client had spent 69 days in rehabilitation in the 6 months before entering the RVCP.

3 Five clients with planned admissions only had hospital days recorded for unplanned hospital days. The coordinator has confirmed that these were planned hospital days.

6.4 Client assessment results

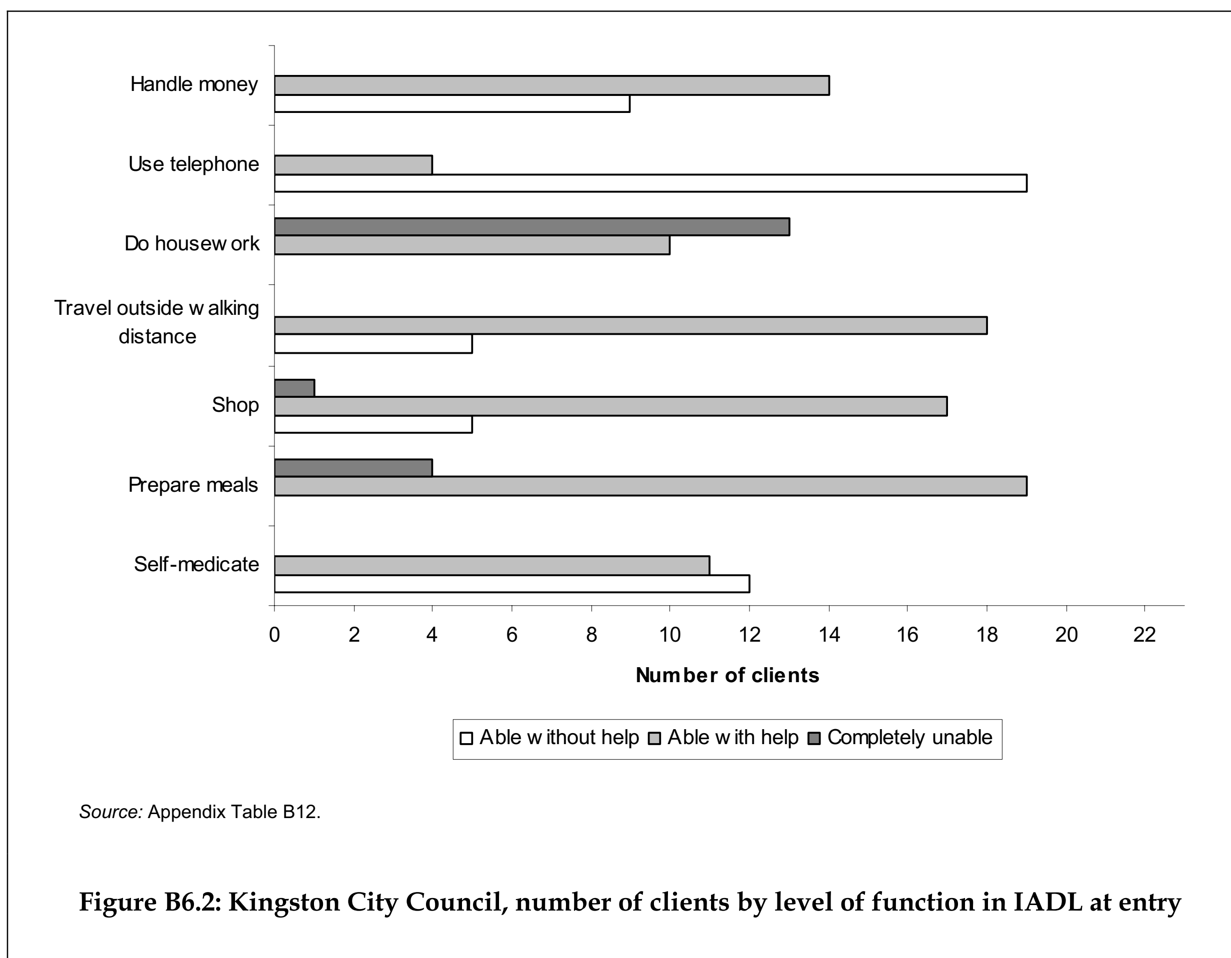
Activities of daily living

At entry to the project, around half of Kingston City Council evaluation clients needed assistance to bathe or shower and with transfers (Appendix Table B11). Baseline Modified Barthel Index (MBI) scores range from 8 to 20 out of a total 20 points. The mean score at baseline was 15.5 points with a standard deviation of 3.3 (median 16.0), indicating that the middle of the MBI distribution for Kingston City Council RVCP clients was within the range of moderate dependency in ADL (Table B6.13).

According to a method of classifying Barthel Index scores (Shah et al. 1989), five clients fell into the category of severe dependency in ADL at the time of entry to the project. The remaining clients were either moderately dependent (15 clients) or independent (three clients) in ADL.

Baseline results for IADL indicate that all Kingston City Council RVCP clients had lost some IADL function and that there was considerable variation in the extent of functional loss among clients entering the project. The median baseline score on the IADL scale for IADL was 9 points, with scores ranging from 5 to 12 out of a possible maximum of 14 points. Apart from telephone use, a high proportion of clients needed assistance in each type of IADL when they entered the RVCP (Figure B6.2). Most notably, all clients either needed assistance or were completely unable to prepare meals and do housework. Only five clients could shop for food or clothes without assistance. Twelve and nine clients respectively needed assistance to take medications and manage their finances.

At baseline, the average Kingston City Council RVCP client was completely dependent in one out of seven IADL when they commenced RVCP services, which is comparable to the average level of IADL function in other projects.



Source: Appendix Table B12.

Figure B6.2: Kingston City Council, number of clients by level of function in IADL at entry

Final assessments were conducted on average 34.6 weeks after entry.

Changes in the MBI between baseline and final assessments ranged from –1 (a 1-point decline in ADL function) to 8 points (an 8-point improvement). The median change score was zero
(Table B6.12), indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments. Of the clients who recorded a non-zero change score, most improved from baseline to final assessment by changing dependency category (independent, mild, moderate or severe).

The median change score on the IADL scale (between baseline and final assessments) was zero, with variation within the range of –9 to 3 points (Table B6.12). Thirty per cent of clients registered a decline in IADL function between baseline and final assessments.

Table B6.12: Kingston City Council RVCP, summary measures for ADL and IADL baseline and change scores[(a)]

	Number of clients	Median	Mean	Standard deviation
ADL				
Baseline MBI	23	16	15.5	3.0
Change in MBI	23	0	0.5	3.8
IADL				
Baseline IADL	23	9	8.4	2.1
Change in IADL	23	0	–0.7	2.8

(a) Score at final assessment minus score at baseline for an individual client.

6.5 Carer assessment results

Thirteen of the 15 carers reported that they were in good to excellent health at the time that their care recipient entered the RVCP. One carer reported fair health and one carer reported poor health.

Caregiver Strain Index (Robinson 1983) scores for carers at baseline range from zero to 10 points (mean 5.5). Eight carers scored on or over the case threshold for carer strain of 7 points, suggesting that they required substantial support to sustain them in the caring role.

6.6 Accommodation outcomes

Six of the 26 care recipients who were active during the September and December 2004 quarters were discharged from the RVCP during that period.

Kingston City Council provided preferred discharge destinations for clients who remained in the project at the end of the evaluation period. These destinations reflect how the project coordinator believes clients would best be supported if the RVCP were not available. These are:

- for six clients, Home and Community Care services
- for one client, a combination of a Community Aged Care Package and Home and Community Care services
- for 10 clients, a combination of HACC and Veterans' Home Care.

By completion of follow-up (9 June 2005), 15 clients remained in the project and six clients had entered an aged care facility (Table B6.13).

Table B6.13: Kingston City Council RVCP, number of clients by discharge outcome, June 2005

	Number of clients	Per cent
At home		
With RVCP	15	65.2
With HACC	—	—
Without formal services	—	—
Not stated	1	4.3
Total at home	*16*	*69.6*
In care		
Hospital	—	—
Residential aged care total	*6*	*26.1*
Low care	5	21.7
High care	1	4.3
Total in care	*6*	*26.1*
Deceased	1	4.3
Total	**23**	**100.0**

— Nil.

7 ECH Incorporated

7.1 Project description

ECH Incorporated operates an RVCP project funded for 35 flexible care places (including five high care) to deliver a package service to eligible residents in eight retirement villages owned by ECH and all located in close proximity in Adelaide's western suburbs. The project commenced in January 2004.

ECH is a charitable organisation which operates over 1,650 retirement village units in various locations throughout metropolitan Adelaide, including Victor Harbour, Nairne and Ardrossan. In addition to the RVCP project, ECH operates high and low level residential aged care facilities (including residential respite care), CACP services, Day Therapy Centre services, HACC services and a rehabilitation pilot under the auspice of other organisations. ECH is also running a dementia care pilot program funded by the Aged Care Innovative Pool initiative of the Australian Government.

All villages are comprised solely of independent living units. A Vital Call emergency alarm service is an optional service for residents. No other service is available through the retirement villages even if residents are willing and able to pay. Residents who need care services must make private arrangements. Residents have access to some case management through the ECH Support Coordination Service, which is designed to assist residents to maintain their independence. Support Coordination Service coordinators located in ECH head office provide assistance in coordinating community services. Should a resident become unable to manage at home, a coordinator will liaise with the resident, family, medical practitioners and an ACAT to seek permanent accommodation in a residential aged care facility or to access support through Community Aged Care Packages.

The RVCP coordinators reported that the age of residents in participating villages ranges from 56 to 102 years, with most residents aged between 80 and 85 years. Two-thirds of residents live alone, and women comprise around two-thirds of the resident populations. A steady increase in the age of people entering the villages has been observed, with most new residents aged in their late seventies to early eighties. Older residents generally have higher levels of need for assistance, and there appears to be a misconception among residents, families and the community at large that services will automatically be available within the retirement village when a need arises. Some families are very active in providing care to their loved one, acting as non-resident carers. Apart from a small number of people with privately paid house cleaning services, most RVCP care recipients are new to formal services through government community aged care programs.

Meeting unmet need for high care in the community and the ability to arrange packages of lower level care in a timely manner are the primary objectives of the ECH RVCP project. Prior to commencement of the RVCP, there was no high care available in the community in the locations covered by the pilot. For eligible people wishing to access CACP- and HACC-funded services, there were significant waiting lists, with few or no interim services available. The project reported an ongoing difficulty of delay in accessing ACAT services for assessment and approval of residents who appear to be eligible for RVCP services. ECH has

provided RVCP type services unfunded to some residents in independent living units while waiting for ACAT assessment.

Retirement village residents are able to access community aged care services as can members of the general community. However, in the project's catchment area, there were approximately 280 people on the waiting list for a CACP in mid-2004. HACC services are available to retirement village residents, but the range of HACC-funded services is very limited and provides little scope for client-focused care. For example, people require transport to do shopping or assistance to hang out the laundry but neither of these needs is catered to by HACC services in the area. In addition, ECH sometimes encounters an attitude among staff in community service agencies that residents in retirement villages are the sole responsibility of ECH because ECH is also a provider of community aged care.

Key features of the project include the level of case management that it is possible to deliver with flexible funding arrangements and the ability to provide clients with the services they want to receive versus merely provision of services that are easy to source. These aspects of care can be difficult to achieve with mainstream packages. The project is able to vary levels of service to meet short-term changes in need. For example, hours can be increased when a client returns home from hospital and then dropped back following recovery. The project aims to address the social isolation that results from mobility restriction, and is seeing good flow-on effects from relatively low levels of assistance in a number of cases.

Care workers employed by ECH for the project generally work across all ECH programs. The ECH Community Care Program had an existing pool of approximately 75 home support workers, with systems in place for after-hours services, training and support, leave coverage, performance management, occupational health and safety provisions, etc. The implementation of the RVCP has required an expansion of the pool. Staff working with RVCP clients have had specific coaching around confidentiality and the need to maintain the privacy of clients who live in close proximity to each other.

ECH operates occupational therapy and nursing services. ECH brokers to other providers for podiatry and other allied health services if and when needed by RVCP clients.

Case management for RVCP clients is the responsibility of two experienced CACP coordinators who are regional senior coordinators within ECH. Each of the two coordinators works approximately 0.5 full-time equivalent on the RVCP and provides case management for 17–18 RVCP clients as well has their other client and management responsibilities in the Community Care Program. An additional coordinator has been employed for the duration of the pilot, to cover part of the CACP case load of each of the RVCP coordinators.

An important element of the ECH RVCP program is the collaboration between ECH colleagues from the Support Coordination Service and the Community Care Program. The Support Coordination Service provides a unique service to residents of ECH independent living units—support coordination, advocacy, health and lifestyle information, monitoring and support when the time comes that the resident needs to consider moving on to residential care. On the sites where the RVCP is operating, residents now have an additional option to remain in their unit longer with support. Support Coordination Service staff know the sites well and have a detailed understanding of residents' situations, as well as often having an accumulated history of a resident's changing circumstances covering several years of documented interaction.

ECH reports low staff turnover and rarely experiences staff recruitment difficulties. ECH does not insist that care workers have a Certificate III, but instead provides a week-long induction program. All new staff receive dementia-specific training. Currently, ECH employs three male care workers and always has some males responding to advertisements

for new staff. Two half-time coordinators manage the project and 31 home support workers deliver client care services. Project administration involves the equivalent of 0.4 full-time staff. The project itself has not experienced staffing difficulties.

Continuity of care is seen as important, and consistent staffing is a priority. However, some high care clients who are having up to 21 visits from a carer worker per week might see up to 10 workers. In general, at least two workers are assigned to each client to provide a back-up in the case of leave or illness.

Access to allied health care has not been problematic. ECH has some in-house providers and enters into contracts for other service types. There is also a local Day Therapy Centre which can be accessed. In-home services are more difficult to obtain, but the level of funding for RVCP allows services to be purchased on a case-by-case basis. Nursing services are brokered as needed.

ECH believes that the RVCP project is able to reduce hospital admissions and help residents to avoid or delay entry into residential aged care. ECH cited anecdotes from hospital discharge planners that the project facilitates safe early discharge from hospital.

The project includes input from allied health professionals to deliver individualised services in the form of:

(a) assessment for equipment

(b) assessment and delivery of treatment

(c) advice on the outcomes of allied health assessment to project coordinators for incorporation in the way services are delivered.

Services under (a) and (b) are funded by the project. This level of access to allied health assessment helps to encourage client independence and recovery of lost competencies.

The coordinators report that the project has had benefits for village residents who are not actively participating as RVCP recipients. Residents become familiar with the care workers and have grown more aware of services that are available by talking about the project. The mere existence and awareness of the project within communities has encouraged residents to ask for help when a need first arises. Residents have reported reduced anxiety from just knowing that the project is operating 'if I need it'. The project has also reduced care issues for neighbours and an overall increased availability of services has reduced jealousy associated with a widespread difficulty in accessing mainstream services, described by some residents as 'exclusive' and not fairly distributed.

The coordinator sees several advantages in the RVCP over mainstream programs. High care RVCP packages provide a level of care appropriate for people with high needs (EACH was not available in the area during the reporting period), and low care places enable people who would not ordinarily receive a package through ACAT assessment (because of limited availability) to access services. Flexible funding enables ECH to tailor packages to meet short-term changes in need. In-home allied health care can be purchased privately due to the level of funding for RVCP, whereas publicly funded in-home allied health services are difficult to access.

A co-located client population makes service delivery cheaper and easier, and provides more scope for flexibility around the timing and duration of each service episode. This might be possible to replicate in a mainstream program such as CACP, but ECH suggests it would be necessary to guarantee that one provider operated all the packages within a site in order to achieve the same efficiencies. ECH does not believe that the demand for RVCP places will exceed the number allocated, and hopes to be able to extend the project to retirement

accommodation at another 85 ECH sites within metropolitan Adelaide. A plan exists to carry 10 unfunded places within the current RVCP budget and to date one client has received an unfunded care package, made possible through the accumulation of surplus funds due to higher numbers of people with relatively lower levels of support needs in the early stages of the new program. ECH indicated that unfunded packages are not sustainable in a more mature program as the needs of established clients increase.

The time-limited nature of the Pilot has been explained to care recipients and the coordinator noted that this has not been a deterrent. Some clients have transferred from other programs such as Veterans' Home Care, in which case ECH has negotiated a guaranteed return if and when necessary and provided a client's needs are within the criteria of the program.

ECH sees a mainstreamed RVCP as enabling the Support Coordination Service to steer residents in independent living units whose care needs increase towards a care package instead of to residential care. Premature entry to residential care is frequently an outcome of a lack of appropriate options for care in the community. As a dedicated service, the RVCP eliminates this as a reason for avoidable admission to aged care facilities.

A June 2004 project progress report indicated that the project was carrying 27 funded clients and one unfunded client. Clients at one site were initially targeted for the Pilot when the submission was being prepared. However, by the time the project was established, demand in that village had decreased: residents no longer required services, had entered residential care (nine residents) or had died (two residents). As a result, the intention was to expand the project into other villages with identified need. To June 2004, one client had been discharged due to improved health status and independence.

The project delivers the following types of service:

- personal care—dressing, grooming, bathing, fitting of aids, medication prompts
- domestic assistance—house cleaning, dish washing, laundry and ironing, shopping and bill paying
- social support—letter writing, escorting and accompaniment
- meal preparation
- light gardening work
- transport for appointments, shopping and social activities
- case management
- allied health care—podiatry and occupational therapist assessment
- provision of aids and equipment.

During the first 6 months of operation, the number of staff visits to an RVCP care recipient home averaged around four per week, each visit lasting for just over an hour. Around 35 after-hours visits were taking place each week (all care recipients).

Risk factors for continuing care

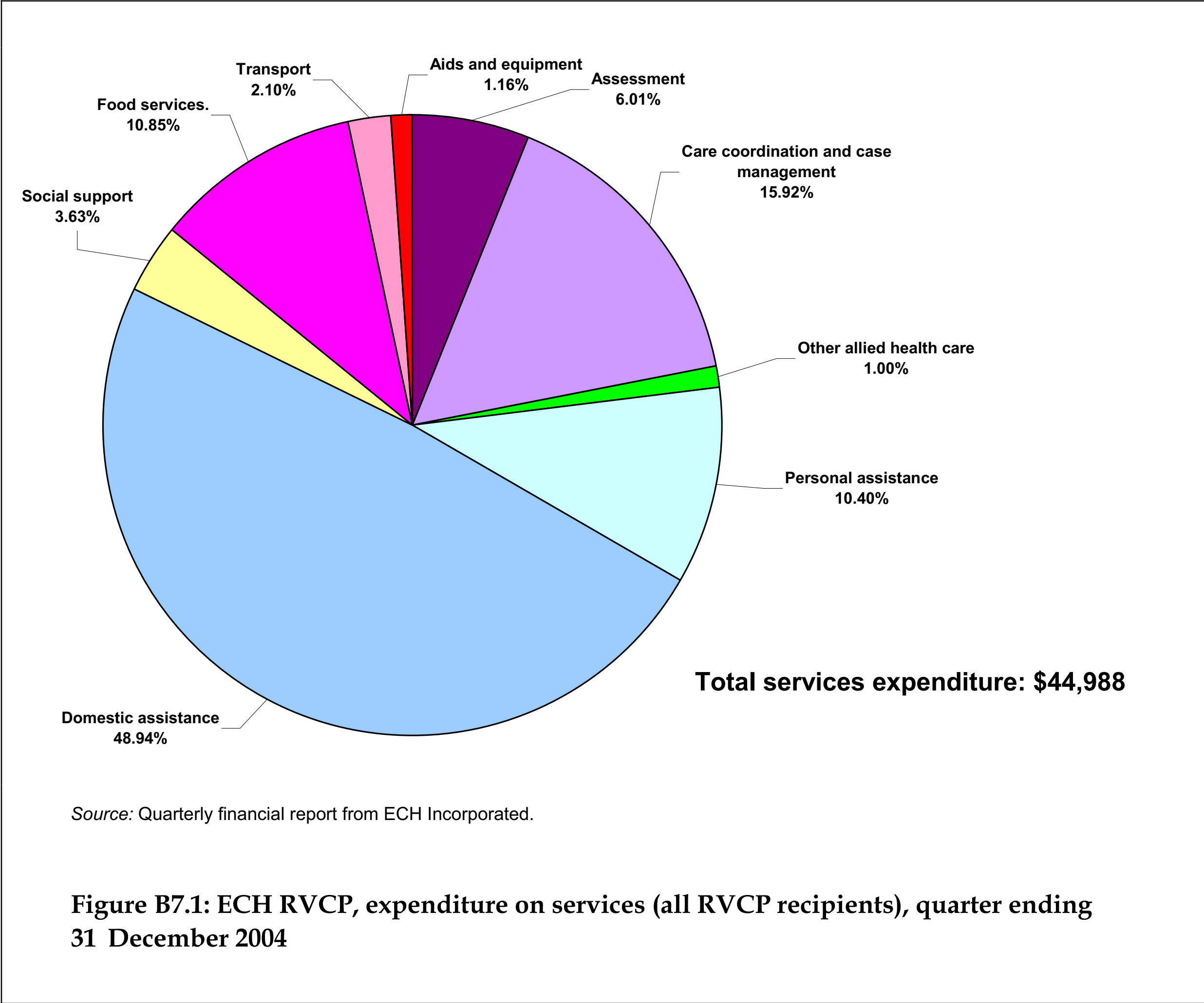
Factors that increase residents' risk of transfer to an aged care facility include mobility restriction, poor physical fitness, family pressure, high and complex health care needs, mental health problems, and inability to access community services due to lack of availability.

The RVCP project can support a client who needs the help of one or two people for safe transfer, but does not easily accommodate clients who require large items of equipment such

as hoists. Clients may also not be suitable for the project if they refuse to accept services that are deemed necessary for health and safety reasons, for example, medication management or assistance with personal hygiene, for example, or if they wander or exhibit other behaviour that requires constant supervision (particularly behaviours that endanger the client or staff or impact adversely on neighbours).

Profile of expenditure on services for care recipients

The ECH project reported expenditure across a range of service types, with a high proportion of services expenditure on domestic assistance relative to most other projects (Figure B7.1).



Source: Quarterly financial report from ECH Incorporated.

Figure B7.1: ECH RVCP, expenditure on services (all RVCP recipients), quarter ending 31 December 2004

7.2 Client profiles

In total, 42 care recipients were active in the project during the September and December 2004 quarters. ECH provided data on 38 clients for the evaluation (31 females and seven males), representing approximately 90.5% of active recipients during the reporting period.

This section reports on the characteristics of ECH evaluation clients during the 2004 reporting period.

Age and sex

The mean age of ECH evaluation clients was 85.4 years. Client ages ranged from 76 to 95 years. Twenty-one clients were aged 85 years or over (Table B7.1).

Table B7.1: ECH RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
75–84	2	15	17
85+	5	16	21
Total	**7**	**31**	**38**
		(per cent)	
75–84	5.3	39.5	44.7
85+	13.2	42.1	55.3
Total	**18.4**	**81.6**	**100.0**

Language and communication

All clients communicated effectively in spoken English.

Accommodation and living arrangement

All clients were living in an independent living unit at a participating ECH retirement village. Thirty-two of the 38 clients lived alone and six clients lived with spouses.

Years at usual place of residence ranged from one to 31 years, with an average of 13.6 years. Nine clients had lived in their retirement village for 20 or more years.

Carer availability

Sixteen clients had a carer, four of whom lived with the client (Table B7.2). There is a relatively high representation of non-resident sons and daughters caring for a parent. Age was recorded for 10 carers, ranging from 41 to 92 years, with a mean of 66.5 years. Two carers were aged 85 years or over (Table B7.3).

Table B7.2: ECH RVCP, number of clients by carer availability, carer relationship to client and co-residency status

Relationship of carer to client	Carer lives with client	Carer does not live with client	Total
Spouse or partner	2	—	2
Son or daughter	1	10	11
Other relative	1	2	3
Total clients with a carer	*4*	*12*	*16*
Clients without a carer	. .	. .	22
Total clients			**38**
Per cent of clients with a carer			42

— Nil.

. . Not applicable.

Table B7.3: ECH RVCP, number of carers by age group and sex

Age (years)	Males	Females	Persons
25–44	—	1	1
45–54	2	1	3
55–74	1	1	2
75–84	—	2	2
85+	1	1	2
Not stated	1	5	6
Total	**5**	**11**	**16**

— Nil.

Income and concession status

Government pensions were the primary source of cash income for the majority of ECH RVCP clients (Table B7.4). Twenty-seven clients held a health care concession card and 28 clients received a discounted rate of co-payment for RVCP.

Table B7.4: ECH RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number of clients	Per cent
Principal source of cash income		
Age Pension	28	73.7
DVA pension	8	21.1
Superannuation or annuities	2	5.3
Total	**38**	**100.0**
Health care concession card holder	35	92.1
RVCP concession status	36	94.7

Previous use of government-funded community care programs

Around three-quarters of the clients were not receiving assistance through government community care programs before the RVCP (Table B7.5). Three clients reported having accessed residential respite care in the 12 months prior to entering the project. All other clients indicated that they had no need for respite services in this period.

Clients often transfer from another package to the RVCP in order to receive assistance from the one set of care workers attending a village.

Table B7.5: ECH RVCP, number of clients by use of government support programs prior to RVCP

Previous use of government support programs:	Has a carer	No carer	Total	Per cent
Government support program				
Home and Community Care	4	—	4	10.5
Veterans' Home Care	1	1	2	5.3
Other program	2	1	3	7.9
Community Aged Care Packages	—	1	1	2.6
Day Therapy Centre	1	—	1	2.6
Total clients previously in receipt of government support	*8*	*3*	*11*	*28.9*
No previous government support	9	18	27	71.1
Total	**17**	**21**	**38**	**100.0**

— Nil.

Four clients were on a waiting list for residential aged care.

Assessment and referral

Most clients were referred to the project by staff at ECH retirement villages (Table B7.6). Initially, clients were identified from the ECH waiting list for Community Aged Care Packages. The RVCP is promoted within the villages; some clients make the first contact, while others are referred by friends and neighbours. Potential clients are also identified by the ECH Support Coordination Service worker in the course of normal monitoring of

residents, or through Support Coordination Service assessments, which are usually initiated by family or hospital staff.

Once a person is identified as potentially being able to benefit from an RVCP package, one of the coordinators conducts an initial needs assessment in conjunction with the relevant Support Coordination Service worker. Initial needs assessment was completed within 21 days of referral for 31 of the 38 evaluation clients. Delays between referral and assessment by a project coordinator can occur for many reasons including a reluctance of a client to formally pursue a care package, planned leave, family reasons, and acute illness.

Many older ECH village residents already have a valid ACAT approval through standard ECH monitoring processes that are designed to keep assessments up-to-date for residents who may require services. Eleven evaluation clients had completed an ACAT assessment prior to referral to the project. Clients without a valid ACAT approval are referred for ACAT assessment after the initial needs assessment by ECH. Two different ACATs have been involved: Southern Adelaide ACAT and Western Adelaide ACAT. ACAT involvement is limited to assessment and approval. Once this is done, ECH Support Coordination Service and ECH Community Care Program coordinators (essentially, the RVCP coordinators) manage client care. The wait for ACAT assessment is generally between one and 6 weeks, though it can be longer for a low care client.

One client had ACAT approval for high care on entry to the project (other ACAT approvals were for low care). Five evaluation clients were subsequently reassessed by ACAT and approved for high care.

Table B7.6: ECH RVCP, number of clients by source of referral

Referral source	Number of clients
ECH retirement village	28
Self-referral	7
Aged Care Assessment Team	1
Other service	1
Family member	1
Total	**38**

Clients had mostly completed an ACAT assessment before services commenced. One ACAT assessment was completed more than one year earlier (Table B7.7).

The care of ECH RVCP clients is managed by a registered nurse (16 clients) and welfare and community workers (22 clients).

Care plans are monitored and reviewed using verbal reports from care workers and regular visits by coordinators plus feedback received from residents and their families, some of whom are very active in monitoring their relative's care. Formal case review is conducted at least six monthly, at which time assessments are completed using the Modified Barthel Index and a tool for IADL.

Table B7.7: ECH RVCP, number of clients by days between completion of ACAT assessment and service commencement

Completion of ACAT assessment	Number of clients
Before service commencement	
0–20 days	16
21–30 days	2
31–90 days	10
91–180 days	1
181–365 days	3
Over 1 year	1
Total	*33*
After service commencement	
Between 2 and 32 days after service commencement	5
Total	**38**

Health conditions and health status on entry

The number of health conditions recorded for ECH RVCP clients at entry ranges from one to seven with a mode of three conditions recorded by 12 clients. Seventeen clients had four or more health conditions recorded on entry. Table B7.8 lists primary health conditions recorded for evaluation clients.

Nine clients had both hearing and vision impairment at time of entry and 19 clients were assessed as being at risk of falls due to impaired gait or balance. Four clients had been diagnosed with depression (Table B7.9).

Table B7.8: ECH RVCP, number of clients by primary health condition at entry to the RVCP

Primary health condition	Number of clients
Rheumatoid arthritis, other arthritis and related disorders	11
Heart disease, hypertension and other circulatory system diseases and disorders	6
Cancer, including lung cancer, skin cancer and other neoplasms	3
Dementia in Alzhiemer's disease	2
Chronic lower respiratory disease	2
Diseases of the intestinal tract and digestive system	2
Skin and subcutaneous tissue infections and diseases	2
Osteoporosis	2
Diabetes mellitus—type II	2
Other specified diseases and disorders	6
Total	**38**

Table B7.9: ECH RVCP, number of clients by presence of selected health conditions at entry

Health condition	Number of clients
Impaired gait or balance—at risk of falls	19
Vision impairment	21
Hearing impairment	15
Both hearing and vision impairment	9
Missing or non-functional limb/s	1
Diagnosis of depression	4
Disorientation/confusion	—

— Nil.

ECH RVCP clients were taking between zero and 17 different medications at the time of reporting. Eleven clients were taking seven different medications.

Each client (or carer on behalf of a client) was asked to assess their current state of health and change in health status over the past 12 months using a five-point Likert scale. These self-assessment ratings of health status data are available for 22 clients. Ratings were taken from nine clients and three carers. One client reported being in excellent health. Three clients reported being in very good health, 11 clients reported being in good health, five reported being in fair health, and six clients reported poor health. Two clients reported that their health was somewhat better than it was 12 months earlier; three clients said that their health was about the same; four said that their health was somewhat worse; and five clients reported being in a much worse state of health than a year earlier.

Level of core activity limitation

One client experienced a severe level of core activity limitation. With the exception of this client, most instances of core activity limitation among ECH clients are in the mild to moderate range. Core activity limitations are more likely to be mobility related than related to either self-care or communication (Table B7.10).

Table B7.10: ECH RVCP, number of clients by type and level of core activity limitation at entry

	Level of activity limitation				
Core activity	No limitation	Mild	Moderate	Severe or profound	Total
Self-care	15	16	6	1	**38**
Mobility	7	24	6	1	**38**
Communication	30	6	1	1	**38**

Use of medical and hospital services prior to entry

Baseline profiles contain information about a client's use of medical and hospital services in the 6 months prior to entering the RVCP—the 'pre-entry period'. All but one client reported

consulting a medical practitioner at least once in the pre-entry period. The reported number of consultations varies from zero to 13 per client, with an average of six visits per client. Cumulatively, the 37 clients recorded 212 visits to a medical practitioner outside of a hospital setting over an estimated 6,660 person days.

Ten clients contributed to a total of 11 hospital admissions in the pre-entry periods. Five clients had planned admissions only. The remaining five clients with one or more hospital admissions recorded solely unplanned/urgent admissions. These five clients collectively accumulated 186 hospital bed days for urgent or unplanned admissions over approximately 900 person days. Individually, they recorded between one and 100 days in hospital for unplanned admissions.

Conditions recorded as occasioning admission to hospital for ECH RVCP clients in the pre-entry period include:

- heart disease
- diabetes mellitus
- cancer
- influenza and pneumonia
- blackouts, fainting, convulsions.

Six clients experienced a serious medical emergency during the 12 months prior to entry. Three clients suffered a fall with injury, and four clients were rendered immobile and without assistance for more than 30 minutes in the pre-entry period.

7.3 Client assessment results

Activities of daily living

Five clients withheld consent to functional assessments, leaving 33 clients with partial or complete baseline functional measures.

At entry to the project, all 33 clients were independently mobile, although most either needed help or were completely unable to use stairs and five clients needed help to transfer to and from bed or a chair (Appendix Table B13). Up to five clients needed help with bathing, dressing and grooming.

Baseline Modified Barthel Index (MBI) scores ranged from 13 to 20 out of a total 20 points. The mean score was 17.4 points with a standard deviation of 1.7 (median 18 points; Table B7.11).

Using a classification for the Barthel Index (Shah et al. 1989), 27 clients classified as moderately dependent in ADL on entry to the project. Three clients classified as independent, and three as slightly dependent in ADL. MBI scores were in general agreement with the levels of core activity limitation recorded for ECH clients. The mean socre of 17.4 points was in the range of moderate dependency in ADL.

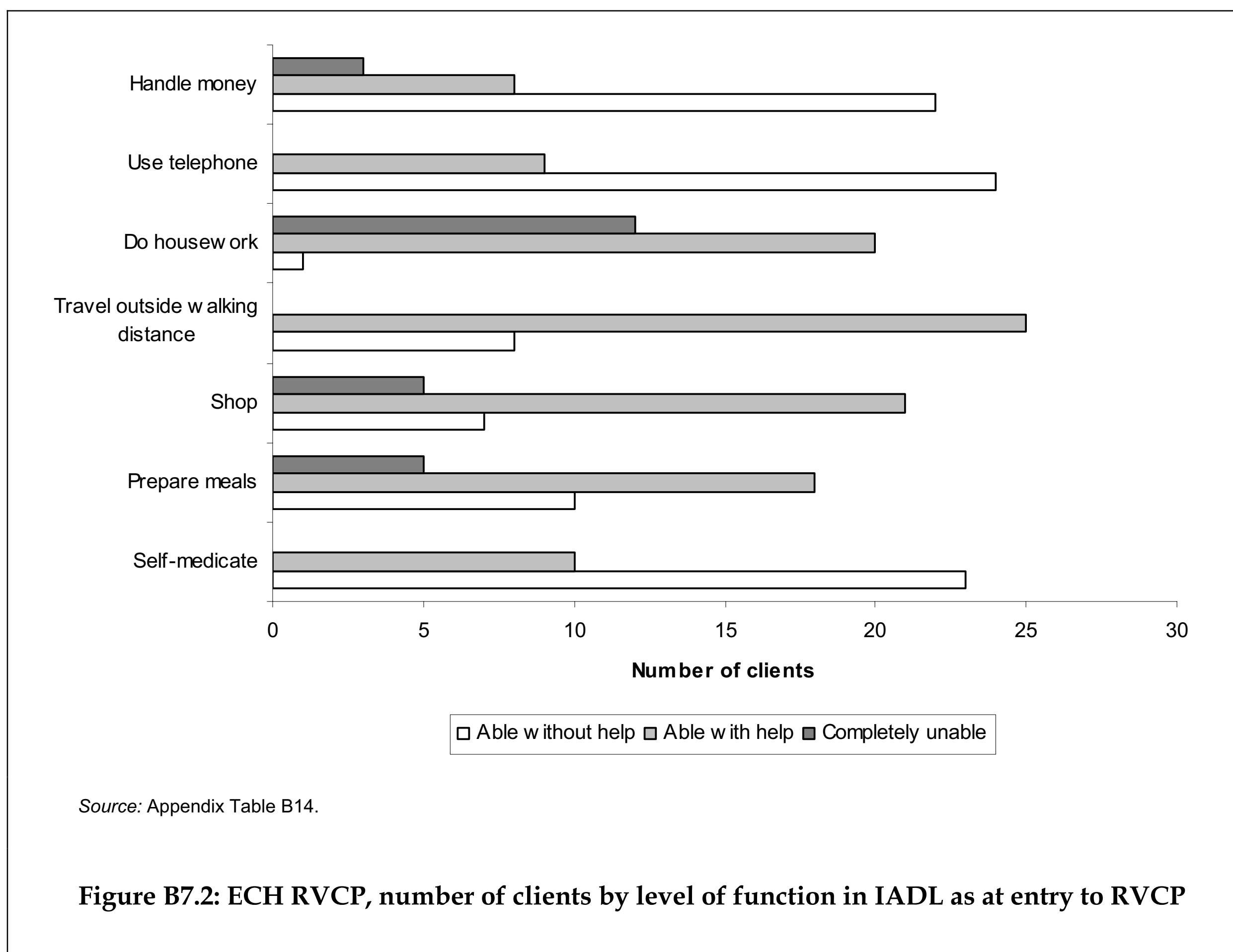
Most clients showed a need for assistance with shopping, housework and meal preparation when they entered the project (Figure B7.2; data for 33 clients). On average, ECH clients were independent in less than 2.5 out of seven IADL at the time of entry. Four clients were independent in six IADL, which is the highest level of IADL function recorded by the project. In other words, all clients had lost function in at least one area of IADL. The median

baseline score on the OARS IADL scale for IADL is 9 points, with scores ranging from 4 to 13 out of a possible maximum of 14 points.

Although all clients registered as independently mobile on the Modified Barthel Index, the mobility item on the IADL scale reveals that in all but eight cases, independent mobility was limited to the home environment.

Final assessments were conducted on average 19.6 weeks after entry.

Changes in the MBI between baseline and final assessments range from –2 (a 2-point decline in ADL function) to 8 points (an 8-point improvement). The median change score is zero (Table B7.11), indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments. Among clients who recorded a non-zero change score, most improved from baseline to final assessment by changing dependency category (independent, mild, moderate or severe).



Source: Appendix Table B14.

Figure B7.2: ECH RVCP, number of clients by level of function in IADL as at entry to RVCP

The median change score for IADL function between baseline and final assessments was zero, with variation within the range of –2 to 5 points (Table B7.11). Thirty-nine per cent of clients registered an improvement in IADL function between baseline and final assessments.

Table B7.11: ECH RVCP, summary measures for ADL and IADL baseline and change scores[(a)]

	Number of clients	Median	Mean	Standard deviation
ADL				
Baseline MBI	33	18	17.4	1.7
Change in MBI	33	0	0.1	1.9
IADL				
Baseline IADL	33	9	9.1	2.6
Change in IADL	33	0	0.9	1.7

(a) Score at final assessment minus score at baseline for an individual client.

7.4 Carer assessment results

Three of the 16 carers agreed to take part in carer assessments. Self-reported health status of carers is available for just these three carers at baseline, who reported being in very good or good health.

Only one carer completed the Caregiver Strain Index, scoring 4 out of 13 points, which is below the validated threshold for carer strain.

7.5 Accommodation outcomes

Seven of the 42 RVCP care recipients who were active during the September and December 2004 quarters were discharged from the project during that period. Follow-up was completed for evaluation clients on 10 June 2005 (Table B7.12).

Table B7.12: ECH RVCP, number and per cent of evaluation clients by discharge outcome, June 2005

	Number of clients	Per cent
At home		
With RVCP	27	71.1
With HACC	—	—
Without formal services	—	—
Total at home	*27*	*71.1*
Institutional care		
Hospital	1	2.6
Residential aged care total	9	23.7
Respite care	1	2.6
Low care	3	7.9
High care	5	13.2
Total in care	*10*	*26.3*
Deceased	1	2.6
Total	**38**	**100.0**

— Nil.

8 Resthaven Incorporated

8.1 Project description

Resthaven Incorporated is the approved provider for an RVCP project at Murray Bridge, a rural township of approximately 14,000 residents south-east of Adelaide. The project provides services to a fully independent organisation, Murray Bridge Lutheran Homes Inc.

Resthaven Incorporated is a community service that operates under the auspice of Uniting*Care,* part of the Uniting Church in Australia (South Australia Synod). Resthaven Incorporated has been providing assistance for older people and their carers since 1935 and offers a range of community programs, therapy and residential services, and is the local provider of Community Aged Care Packages in the Murray Bridge community. Other service delivery includes Extended Aged Care at Home packages, home care coordination for Department of Veterans' Affairs, therapy services (podiatry, speech, physiotherapy and occupational therapy), in-home respite care and Home and Community Care services. Resthaven has participated in the Acute Transition Alliance, a project in the Innovative Care Rehabilitation Services stream of the Aged Care Innovative Pool pilot.

Resthaven received an allocation of 15 flexible care places, including seven high care places, for the project which commenced on 16 October 2003 (a public launch was held on 10 November 2003).

The project operates from the Community Care Division of Resthaven Incorporated to deliver services to residents of the Murray Bridge Lutheran Homes Retirement Village. All units at the village are self-care. Each unit has an on-call button but the Vital Call personal alarm system is an optional service which residents pay to have installed. The village itself does not provide care services, even if a resident is willing to pay.

Resthaven Incorporated indicated that the project was established to meet high levels of unmet need for community care. Retirement village residents in Murray Bridge have ready access to ACAT assessment; however, direct care packages and services are said to be in short supply. The Murray Bridge Council delivers HACC services, and there is some domiciliary care available in the area. CACP services in the area can offer up to 5 hours of direct care per week. The project coordinator reported that some people in the community are being maintained on 'pseudo-CACPs' made up of high hours of HACC service plus respite care. Many CACP recipients require a high level of service at entry (7 to 8 hours per week minimum), and over half of the clients on a CACP have previously been assessed as RCS high care. There are 20 CACP-funded places for Murray Bridge. Resthaven Incorporated carries an additional two to four unfunded CACP care recipients at any one time. At the time of the site visit, the CACP waiting list was fluctuating at between 50 and 60 people. EACH packages were not available in the area at the time.

In mid-2004 the waiting list for Resthaven's residential care facility in the area was sitting at around 70 names. It was suggested that people are carried on CACP packages and other community-based services for too long because of the shortage of aged care beds. The effect is that a package becomes inadequate for meeting a person's care needs and lower level community care is not freed up for new clients who are more appropriately served by this type of care.

Resthaven RVCP has negotiated the supply of smaller aids and equipment from Domiciliary Care and hires larger items on behalf of clients. Home modifications are also procured through Domiciliary Care, though units in the village tend to be well-designed for the provision of care. Allied health services such as physiotherapy and occupational therapy are brokered as needed. Access to allied health care in Murray Bridge is reasonable, though there can be waiting periods of up to 2 months for free services. The RVCP project improves access to allied health care because project funds can be used to pay for services privately which is not possible through CACP. A geriatrician visits the area regularly, but the waiting time for an appointment is around 4 months which means it can be a long and difficult process to obtain a formal diagnosis for people with suspected dementia.

A significant number of clients have negotiated reduced fees. Factors dictating the level of fees payable include the cost associated with a maintenance program and costs associated with maintaining existing hobbies and social commitments.

The service mix is tailored to individual client needs and a set of goals that the client identifies through the early assessment process. Clients' level of willingness to accept help also influences the services that are delivered, particularly in the weeks immediately after entry to the project. The project focuses on tailoring packages so that they are flexible and respectful of the client's priorities and standards. There is greater scope for customising care to meet individual needs and fluctuating needs than there is with a CACP package.

In the first four months of operation the Resthaven project received 14 referrals and delivered services to 14 clients. The early client group averaged 84 years of age and 13 of the first 14 clients were women. All but one client in the first 2 months lived alone. The initial service profile indicated that clients received an average of 5.5 hours of service per week, with a minimum of 4.5 hours and a maximum of 14 hours per client per week. One in two clients received personal assistance, averaging 7 hours per week in personal assistance alone. Similarly, one in two clients received nursing care during this period, with an average of 5.5 hours per week of nursing care per client who received nursing care. During the first 4 months, two clients transferred to other services: a private cleaning service and the council transport service.

RVCP services are delivered by:

- a registered nurse (approximately 6 hours per week)
- two home support workers, Monday to Friday
- one home support worker on weekends and public holidays
- a coordinator and a manager, each at 16 hours per week
- on-call staff, available 24 hours, 7 days a week.

Staff continuity is important for package recipients and other residents in the village—two to three staff are present in the village during the week, and one or two on weekends. The staff is trained in dementia care by Resthaven Incorporated and Alzheimer's Australia.

The service model focus is to provide a brief period of intense services when the care recipient begins, which in many cases tapers off as needs stabilise. This may be a feature of the fact that most people entering the program so far have been in a crisis situation. Resthaven, Murray Mallee ACAT and management at Lutheran Homes Retirement Village have an established effective communication, which has enabled RVCP recipients to commence services within a short timeframe. The project assists residents to maintain their current lifestyle and encourage independence in daily living. Feedback has been positive,

with package recipients stating that individual goals have been achieved and independence maximised. All parties reported that the service model is working well.

A higher level of funding and flexibility distinguish RVCP packages from CACP. Resthaven values the flexibility afforded by the RVCP funding model especially as it provides for the delivery of important therapeutic services such as allied health care. This has led to the development of a 'rehabilitation mindset' where services are aimed at *improvement* where possible, not just maintenance or managed decline. Flexible packages can respond instantly to changing needs and circumstances, such as the death of a carer or an acute event such as a fall. The project can also sustain a number of clients on very high hours within the budget. The coordinator believes that a 'CACP plus EACH' package which allowed care recipients to transfer back and forth between higher and lower levels of care would provide similar flexibility to the RVCP packages.

Co-location of care recipients within one retirement village means that staff can provide up to four short visits to a client in a day, for example, to change a dressing, help with medications, or just to call in to say hello to promote a feeling of security and being cared for. This is not usually possible with less flexible funding and care recipients across multiple sites. Staff can also back each other up on shifts, for example, if a care recipient falls there is another staff member who can respond to a request for help within minutes.

The ACAT reported that the RVCP is reducing hospitalisation rates among package recipients, and that some in the project would be in residential care now if they did not have a package. The Murray Bridge Council reports that the project has freed up HACC services for non-retirement village residents. The retirement village Residents' Association reported that the RVCP has given all residents of the village a sense of security and much of the burden of caring for sick and frail neighbours has been lifted from the healthier residents. The residents also get to know the care staff, and become more comfortable asking for assistance when they need it rather than waiting for a crisis. Staff and residents reported increased social activity since the project was launched. Previously isolated residents are now observed to take part in group activities such as exercise classes, walking, and talking to neighbours.

Risk factors for continuing care

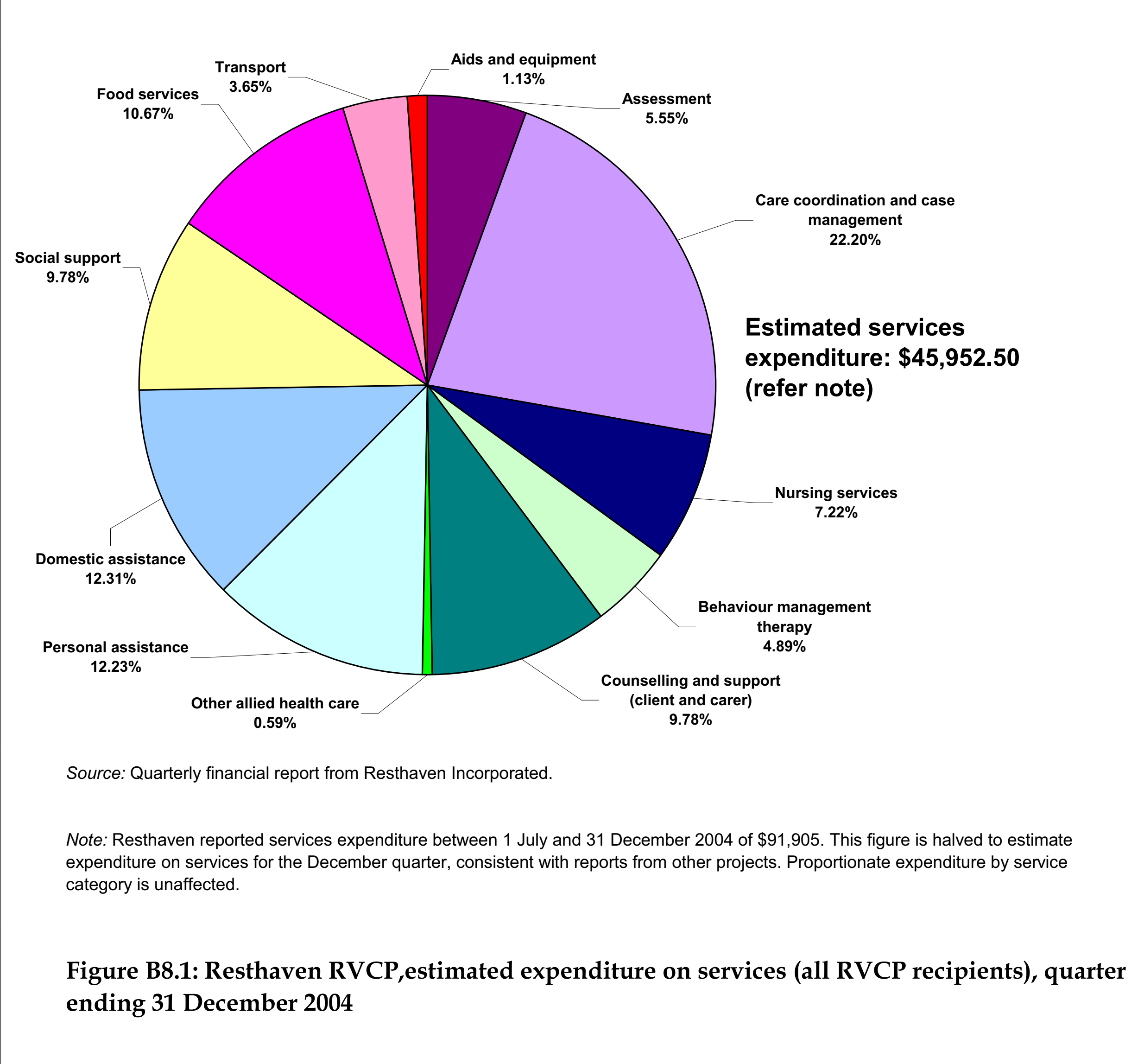
The coordinator reported that fear of living alone (or otherwise opting for residential aged care) and very high levels of carer strain are risk factors for entry into residential aged care. The RVCP parameters provide for the flexibility of frequent short, planned episodes of care and visits but may not provide for more constant supervision, for example, due to wandering or high-risk behaviours, or constant and immediate access to nursing care.

High carer strain that is unlikely to subside in the short term is another factor that might preclude community care through the RVCP. The project can accommodate clients with mobility restrictions and would accept clients who need hoist-assisted transfer provided the client is cognitively intact and there are no other obvious occupational health and safety risks.

Profile of expenditure on services to care recipients

The Resthaven project at Lutheran Homes Retirement Village reported one of the more varied patterns of expenditure on client services seen in the Pilot. No one type of assistance dominates the services expenditure pattern: approximately equal proportions of services

expenditure were recorded for the delivery of personal assistance, domestic assistance, social support and food service. This project recorded one of the higher levels of expenditure on nursing care relative to total services expenditure. Behaviour management and counselling/carer support services are other noteworthy features of this project's services expenditure profile.



Source: Quarterly financial report from Resthaven Incorporated.

Note: Resthaven reported services expenditure between 1 July and 31 December 2004 of $91,905. This figure is halved to estimate expenditure on services for the December quarter, consistent with reports from other projects. Proportionate expenditure by service category is unaffected.

Figure B8.1: Resthaven RVCP,estimated expenditure on services (all RVCP recipients), quarter ending 31 December 2004

8.2 Case studies

Recipients of RVCP services have had many and varied reasons for participating in the Pilot. Primarily, age-related frailty and multiple medical problems are the cause of new and high care needs. Secondary reasons often involve distant or little family support. Transport and advocacy are high priority needs for many such clients.

Resthaven Incorporated provided two case study reports.

Case study 1

'The client has multiple medical diagnoses, two of which impact greatly on lifestyle and wellbeing. These include diabetes mellitus and cognitive impairment.

This client has a background in agriculture and the role of being wife and mother to eight children. The need to "save" and cater for constantly hungry children remain paramount in this lady's mind. Despite her confusion and failing abilities, she manages her finances and day-to-day affairs. The client developed a growing concern about her financial position which led to her deciding that she could no longer afford to remain living in the village.

Staff initially visited the client to assist with "medical problems". Relationships between staff and the client quickly evolved to the state where the client voiced her concerns about ability to pay for accommodation. Staff worked with the client to establish shopping lists to prevent unnecessary purchases and compulsive buying (the freezer and cupboards were full to overflowing with food supplies). Staff assisted with shopping expeditions and gently encouraged her to shop from the list they had helped to prepare.

RVCP staff contacted family members who held power of attorney to assist with the client's accounts. With the client's permission, power and telephone accounts were redirected to family with power of attorney.

Staff escorted and acted as advocates during visits to doctors, which has resulted in the client receiving better medical care. Previously, the client had forgotten to tell the GP about various health conditions. Medication is now supervised. The project monitors the client's blood sugar level for ongoing diabetes management.

Private podiatry has been arranged by the RVCP staff to manage acute and chronic conditions affecting the client's feet. The client is encouraged to attend a day centre several times a week and staff members have helped renew the client's interest in gardening.

It is envisaged that, with ongoing assistance and support, this client may stay in the retirement village for the foreseeable future.'

Case study 2

'The client has a history of retinal haemorrhage and lives alone. RVCP staff received a telephone call from the retirement village manager, asking for assistance with a resident who overnight had suffered a haemorrhage in the one remaining "good" eye and was now "blind". Staff immediately visited and escorted the resident to an eye specialist later in the day. It was confirmed that the resident had only marginal peripheral vision in that eye. The resident had been completely independent until the morning of the haemorrhage. The previous day the resident had driven to a plant nursery to buy vegetable seedlings for the garden.

A referral was sent to the ACAT, which responded within 48 hours. RVCP staff continued to assist the resident with meal preparation and medications. They monitored blood glucose levels and supervised insulin administration. The resident was allocated a package and has received continuous support from the project since the morning of the incident in addition to help from a good support network in the village. Neighbours help to tidy the courtyard to assist in the prevention of falls since the onset of blindness.

Staff helped the client to plant the seedlings which have grown into a flourishing vegetable garden. The client has regained confidence in the kitchen and now cooks many meals. RVCP staff encouraged visits to the impaired vision group in Murray Bridge, which the client now attends regularly. Two home visits from the Royal Society for the Blind and an occupational therapist have greatly improved the client's independence in the home environment. The project provides transport assistance, client advocacy and support, and household support.

The availability and responsiveness of the RVCP project, the astuteness and support of the Lutheran Homes manager and ACAT staff, and support from friends and relatives have enabled this client to remain at home with as little disruption as possible following a very acute and distressing episode of illness.'

8.3 Client profiles

Sixteen care recipients were active during the September and December 2004 quarters. Resthaven provided data on 14 clients for the evaluation, representing approximately 87.5% of clients who were active during the reporting period.

Age and sex

The Resthaven evaluation group included 12 females and two males. Clients averaged 83 years of age (ages ranged from 67 to 94 years). Six of the 14 clients were aged 85 years or over (Table B8.1).

Table B8.1: Resthaven RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
Less than 65	—	—	—
65–74	—	1	1
75–84	1	6	7
85+	1	5	6
Total	**2**	**12**	**14**
		(per cent)	
Less than 65	—	—	—
65–74	—	7.1	7.1
75–84	7.1	42.9	50.0
85+	7.1	35.7	42.9
Total	**14.3**	**85.6**	**100.0**

— Nil.

Language and communication

All clients could communicate effectively in spoken English.

Accommodation and living arrangement

All clients were living in independent living units within the Murray Bridge Lutheran Homes Retirement Village. Most clients lived alone (Table B8.2).

Table B8.2: Resthaven RVCP, number of clients by usual accommodation setting, living arrangement and accommodation setting at time of referral to RVCP

	Usual living arrangement			
Accommodation setting	Alone	With family	Total usual accommodation	Accommodation at referral
Retirement village—independent living	12	2	14	13
Hospital	—	—	—	1
Total	**12**	**2**	**14**	**14**

— Nil.

Years at Lutheran Homes Retirement Village ranged from two to 18, with an average of nine. Six clients had been living at the village for 10 or more years.

Carer availability

There was no direct involvement by a family carer for Resthaven RVCP clients at the time of the evaluation. This may be due to the rural locality, with family based in the metropolitan area or interstate.

Income and concession status

Government pensions were the primary source of cash income for 13 clients (Table B8.3). No client was recorded as holding a health care concession card and none had received a discounted daily co-payment for the RVCP.

Table B8.3: Resthaven RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number of clients	Per cent
Principal source of cash income		
Age Pension	13	92.9
Superannuation or annuities	1	7.1
Total	**14**	**100.0**
Health care concession card holder	—	—
RVCP concession status	—	—

— Nil.

Previous use of government-funded community care programs

More than two-thirds of the clients were not receiving assistance through government community care programs before the RVCP (Table B8.4).

Table B8.4: Resthaven RVCP, number of clients by use of government support programs prior to RVCP

Previous use of government support programs	Number of clients	Per cent
Previous government support program		
Community Aged Care Packages	2	14.3
Home and Community Care	1	7.1
Total with previous government support	*3*	*21.4*
No previous government support	11	78.6
Total	**14**	**100.0**

No evaluation client was reported to have been on a waiting list for residential aged care.

Referral and assessment

Referrals to the project have been sourced from the retirement village manager, hospital, general practitioner or HACC workers and residents sometimes make an initial contact directly. Generally the referral source screens a potential client before a referral is made to ACAT. Referred persons are often receiving HACC services or are known to the ACAT. The project has developed a good working relationship with the local ACAT. Generally, clients referred to ACAT for assessment for the RVCP are seen within 48 hours if fast turnaround is requested.

More than half of the client group has entered the project at a crisis point. In some emergency cases Resthaven commenced service delivery before the ACAT assessment was completed. Resthaven Incorporated, Lutheran Homes and the ACAT have developed processes to achieve earlier intervention and avoid crises. For clients who are not at crisis point on entry to the project, the coordinator conducts an initial assessment using the Resident Classification Scale as the main assessment tool (which is found to be difficult to apply in the community setting). Clients may also have a nursing needs assessment if the coordinator, a registered nurse, believes it is necessary. A care plan including short- and long-term goals is developed and reviewed after 3 months. Resthaven also conducts client surveys.

ACAT staff value the project because of the immediacy of care services for approved clients. Rapid response is most important for clients in crisis situations and the ACAT staff member interviewed for this report could immediately think of three clients who would have entered residential care were it not for the project. The ACAT reported that all referrals so far have been appropriate. Sources of referral during the evaluation period are shown in Table B8.5.

Table B8.5: Resthaven RVCP, number of clients by source of referral

Referral source	Number of clients
Other agency	7
Person other than client or family member	3
Hospital	2
Lutheran Homes Retirement Village	1
Family member	1
Total	**14**

Twelve clients had completed an ACAT assessment prior to service commencement (Table B8.6). Clients whose ACAT assessment was completed months before entering the project may have experienced an increase in need for assistance in the intervening period. The capacity to provide higher level care with an RVCP package meant that reassessment by ACAT was not required for a client in this situation to commence services.

One evaluation client had ACAT approval for high care; other clients were approved for low care on entry to the project. By the time follow-up was completed in mid-2005, four clients with ACAT approval for low care were assessed by the project coordinator to be at high care level. An important benefit of the RVCP for these clients has been their ability to remain at home with an appropriate level of support that has not required further ACAT assessment or referral to another service.

Table B8.6: Resthaven RVCP, number of clients by days between date of referral to the project and service commencement

Completion date of ACAT assessment	Number of clients
Before service commencement	
0–20 days	5
21–30 days	1
31–90 days	4
91–180 days	—
181–365 days	2
Total	*12*
After service commencement	
Between 4 and 7 days after service commencement	2
Total	**14**

— Nil.

A registered nurse managed the care of all Resthaven RVCP clients.

Health conditions and health status on entry

The number of health conditions recorded for Resthaven RVCP clients at entry to the RVCP ranges from one to seven. Six clients had four or more health conditions on entry. Table B8.7 lists the primary health conditions recorded for Resthaven RVCP clients.

Table B8.7: Resthaven RVCP, number of clients by primary health condition at entry to RVCP

Primary health condition	Number of clients
Diabetes mellitus (type I or II)	4
Arthritis and related disorders	3
Fracture	2
Other specified diseases and disorders[(a)]	5
Total	**14**

(a) Includes psychoses and depression/mood affective disorders; other neurotic, stress-related and somataform disorders; osteoporosis.

Ten clients were assessed as being at risk of falls due to impaired gait or balance, and two clients had diagnosed depression (Table B8.8).

Table B8.8: Resthaven RVCP, number of clients by presence of selected health conditions at entry to RVCP

Health condition	Number of clients
Impaired gait or balance—at risk of falls	10
Vision impairment	2
Hearing impairment	—
Both hearing and vision impairment	—
Diagnosis of depression	2
Disorientation/confusion	1

— Nil.

Clients were taking between one and 13 different medications. Eleven clients were taking five or more different medications.

Clients were asked to report on their health status and change in health status over the past 12 months using a five-point Likert scale. Eight clients reported good health and six clients said they were in a fair state of health. Two clients reported as somewhat better health than 12 months prior to starting in the RVCP; three clients felt that their health was about the same as a year earlier; 19 clients reported being in somewhat worse health than 12 months earlier.

Level of core activity limitation

No client is recorded as having a severe or profound core activity limitation on entry to the RVCP. Ten clients had mild self-care or mobility limitation. A moderate level of activity limitation is less common in both self-care and mobility (Table B8.9).

These results suggest a higher level of function in self-care and mobility than ADL baseline measures recorded using the Modified Barthel Index. According to the latter, one client was severely dependent in ADL on entry to the project and nine clients measured moderate ADL dependency.

Table B8.9: Resthaven RVCP, number of clients by type and level of core activity limitation as at entry

	Level of activity limitation				
Core activity	No limitation	Mild	Moderate	Severe or profound	Total
Self-care	—	10	4	—	**14**
Mobility	2	10	2	—	**14**
Communication	8	5	1	—	**14**

— Nil.

Use of medical and hospital services prior to entry

Baseline profiles contain information about client use of medical and hospital services in the 6 months prior to entering the RVCP—the 'pre-entry period'. All but one client had consulted a medical practitioner at least once in the pre-entry period. The reported number of visits to a medical practitioner varies from zero to six per client, with a mode of three visits (five clients). Cumulatively, the 13 clients recorded 47 visits to a medical practitioner outside of a hospital setting over an estimated 2,340 person days.

Eight clients contributed to a total of nine hospital admissions in the pre-entry periods. Two clients had planned admissions only. The remaining six clients with one or more hospital admissions recorded either solely unplanned/urgent admissions, or both unplanned/urgent and planned admissions.

The six clients who recorded at least one unplanned hospital admission collectively accumulated 92 urgent/unplanned hospital bed days over approximately 1,080 person days. Individually, they recorded between two and 40 days in hospital for unplanned admissions.

Conditions recorded as occasioning admissions to hospital for Resthaven RVCP clients in the pre-entry period include:

- injury to leg/knee/foot/ankle/hip
- falls (frequent with unknown aetiology)
- influenza and pneumonia
- psychoses and depression/mood affective disorders
- diabetes mellitus—type I
- urinary tract infection
- colorectal cancer
- other diseases of the ear and mastoid process
- other diseases of the eyes and adnexa.

Ambulatory care sensitive conditions (conditions with a high potential for primary care management) are represented in the above list, for example, diabetes mellitus, influenza and pneumonia and urinary tract infection.

Three clients had experienced a serious medical emergency during the 12 months prior to entering the RVCP. One client had suffered a fall with injury.

8.4 Client assessment results

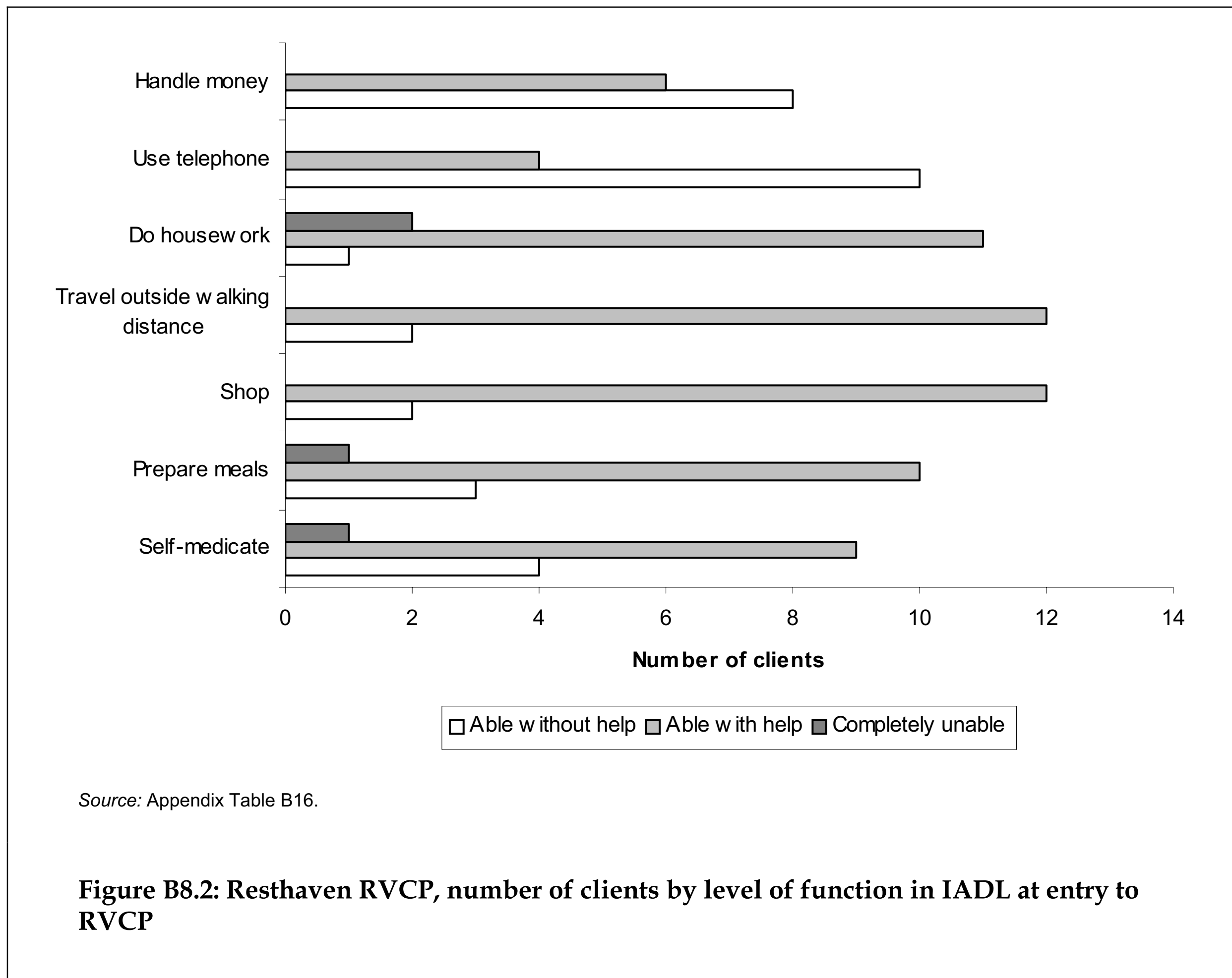
Activities of daily living

At entry to the RVCP, most Resthaven clients were independently mobile but five clients needed help with transfers (getting in or out of bed or a chair) and most needed help to use stairs (Appendix Table B15). The majority of clients were either independent in self-care tasks or could manage self-care with assistance. Bathing, dressing and grooming are activity areas where a higher proportion of clients had a need for assistance.

Baseline Modified Barthel Index (MBI) scores ranged from 8 to 20 out of a total 20 points. The mean score was 16.4 points (standard deviation 3.1 points; median 16.5). According to a classification scheme for the Barthel Index (Shah et al. 1989), on entry to the project one client was severely dependent in ADL; nine clients showed moderate dependency; three clients were slightly dependent and one client was independent in ADL. These results reflect a higher level of dependency in self-care and mobility at baseline than ratings of client core activity limitations.

The median baseline MBI score indicates that the middle of the MBI distribution for Resthaven RVCP clients was in the range of moderate dependency in ADL (Table B8.10).

The median baseline score on the OARS IADL scale is 9 points, with scores ranging from 6 to 12 out of a possible maximum of 14 points. All Resthaven RVCP clients had lost some IADL function by the time they entered the project and there was considerable variation in the extent of functional loss among new clients. Most clients needed assistance or were unable to perform household chores, shop, travel away from home, prepare meals and manage medication when they entered the project (Figure B8.2). Although most clients measured independently mobile on the Modified Barthel Index, the mobility item on the IADL scale reveals that for all but two clients, independent mobility was limited to the home environment.



Source: Appendix Table B16.

Figure B8.2: Resthaven RVCP, number of clients by level of function in IADL at entry to RVCP

Final assessments were conducted on average 26.9 weeks after entry.

Change scores calculated as the difference between an individual's MBI score at the baseline and final assessments ranged from zero (no change) to 9 points (a 9-point improvement in ADL function). The median change score was zero (Table B8.10), indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments. Of the clients who recorded a non-zero change score, most improved from baseline to final assessment by changing MBI category (independent, mild, moderate or severe).

The median change score for IADL function between baseline and final assessments was also zero, with variation in the range from zero to 1 point (Table B8.10), that is, stable over the measurement period.

Table B8.10: Resthaven RVCP, summary measures for ADL and IADL baseline and change scores[(a)]

	Count	Median	Mean	Std dev.
ADL				
Baseline MBI	13	16	16.1	3.0
Change in MBI	13	0	1.5	2.7
IADL				
Baseline IADL	13	9	8.8	1.7
Change inIADL	13	0	0.2	0.4

(a) Score at final assessment minus score at baseline for an individual client.

8.5 Accommodation outcomes

By completion of follow-up on 10 June 2005, 12 clients remained in the project and two clients had entered an aged care facility (Table B8.11).

Table B8.11: Resthaven RVCP, number of clients by discharge outcome, June 2005

	Number of clients	Per cent
At home		
With RVCP	11	78.6
With HACC	—	—
Without formal services	1	7.1
Total at home	*12*	*85.7*
Institutional care		
Hospital	—	—
Residential aged care total	2	14.3
Low care	2	14.3
High care	—	—
Total in care	*2*	*14.3*
Deceased	—	—
Total	**14**	**100.0**

— Nil.

9 Mandurah Retirement Village

9.1 Project description

An RVCP project in Mandurah, Western Australia, offers services to residents at the Mandurah Retirement Village in the seaside township approximately 80 kilometres south of Perth. Mandurah Retirement Village RVCP is funded for 18 flexible care places, including six high care places. RVCP service delivery commenced in December 2003.

The approved provider is Mandurah Retirement Village Incorporated, a not-for-profit community organisation founded in 1969 and managed by a board of volunteers from the local community. Mandurah Retirement Village Incorporated is an approved provider of residential aged care (permanent and respite care).

The retirement village opened in 1972 and a hostel service commenced in 1975. An additional 15 low care hostel places were added in 1995, bringing total residential low care places to 47. In 2001, the hostel was replaced by serviced apartments; in 2002, 32 high care places were approved; and in early 2005, a nursing home adjacent to the retirement village was opened. Entry to the retirement village is relatively low-cost. Units can be purchased for around $60,000.

The RVCP project represents a first venture into package care delivery for the Mandurah Retirement Village. Mandurah Retirement Village Inc. aims to build and demonstrate capacity in community care through the project.

Mandurah is one of two RVCP projects with the highest proportion of clients who were not previously receiving assistance from government support programs. Three participants in the evaluation are recorded as previously accessing government support programs (two HACC clients and one unspecified program). This project recorded a relatively high proportion of clients in receipt of a pension from the Department of Veterans' Affairs, but none recorded a history of assistance from DVA support programs, although a report from the project coordinator indicated that some RVCP recipients at Mandurah have transferred from DVA programs. None of the evaluation clients was a previous CACP recipient.

Staff reported that many residents' needs were unrecognised prior to the RVCP and, despite the retirement village providing a basic level of unpaid assistance, a number of residents would have had to move to hostel care if it were not for the project. It is thought that most residents at Mandurah would benefit from, and would probably be eligible for, RVCP services. Potential package recipients are prioritised based on need, for example, mobility limitations, risk of falls and need for medication prompts. All evaluation clients live alone and only one client has a carer. These two characteristics distinguish the Mandurah client group from other RVCP projects.

The stated objective of Mandurah Retirement Village for the RVCP is to offer more options to an existing client base, focusing on client-centred care services and the capacity for multiple daily services per client where required. The Pilot has provided greater scope to identify the needs of individual residents. Specific unmet needs that the project is seeking to address include transport, domestic assistance, personal care, socialisation and nursing care and the need for on-call assistance 24 hours per day, 7 days a week (24-hour assistance is not

ordinarily available to residents). Out of hours calls go through to the hostel, allowing the project to capitalise on existing infrastructure.

Existing infrastructure facilitates RVCP service delivery and this is said to differentiate the project from CACP service delivery to village residents. For example, volunteers in the village help RVCP clients; clients are transported for group outings into the community, and overall, there is greater flexibility in aspects of service delivery though village coordination.

At the time of the AIHW visit to Mandurah Retirement Village, all funded places were filled and the waiting list contained two names. The main services being delivered to RVCP clients at that time included socialisation, home help and personal care and transport. The RVCP project delivers group transport to facilitate community participation and personal transport to give clients access to specialist diagnosis and treatment in Perth. This service has proved particularly valuable to clients with dementia.

RVCP non-specialist services are delivered entirely by retirement village and hostel staff. The project employs four care workers and two care managers (coordinators) to a full-time equivalent of 4.25 staff. Hostel staff respond to the 24-hour emergency on-call system that is part of the RVCP. A registered nurse is responsible for assessments, clinical care and referral to specialists. Allied health and specialist services are purchased when required. Clients who have dementia or suspected dementia are referred to a geriatrician and may attend a memory clinic in Perth since these services are not available locally. The project provides assistance for clients to make the one-hour journey by road to Perth.

The flexibility of the RVCP and the efficiencies of using the existing infrastructure of the retirement village and hostel are seen as distinct advantages over mainstream care packages. Services can be adjusted to meet increasing or decreasing need as a care recipient's condition changes. ACAT reports that the case management provided by the project has reduced the need for ACAT staff to provide extra assistance and case management, which sometimes occurs when a client is placed onto CACP.

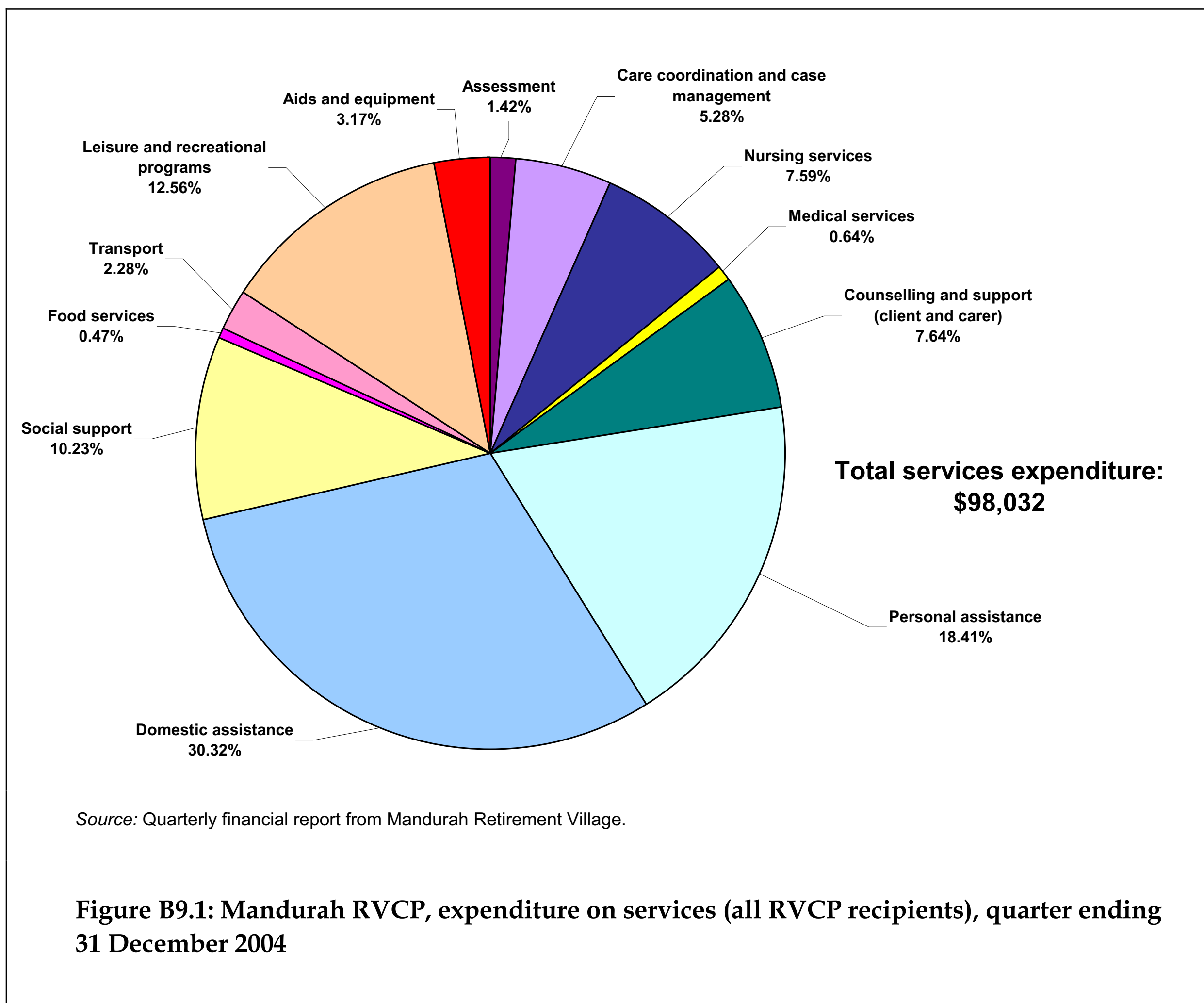
Risk factors for continuing care

Chief risk factors for discharge from the project include a high risk of falls, problem wandering or other need for constant supervision, and need for palliative care.

Profile of expenditure on services to RVCP recipients

Mandurah Retirement Village reported expenditure on services to RVCP recipients inclusive of overhead costs.

Approximately 60% of services expenditure in the Mandurah project in the quarter ending 31 December 2004 was directed to delivery of personal assistance, domestic assistance and social support (Figure B9.1). Mandurah Retirement Village reported expenditure across a varied range of service types. Relatively high proportions of services expenditure were recorded against nursing care and leisure programs, compared to other projects. Client-level data reveal high weekly levels of food and transport services to clients and most clients at Mandurah received these types of assistance. However, expenditure on transport and food services actually comprised relatively small proportions of total services expenditure.



Source: Quarterly financial report from Mandurah Retirement Village.

Figure B9.1: Mandurah RVCP, expenditure on services (all RVCP recipients), quarter ending 31 December 2004

9.2 Project coordinator's report

Mandurah Retirement Village provided the following report to illustrate the RVCP experience at Mandurah. Case studies are woven into the report by firstly describing a benefit of the RVCP and then citing examples to demonstrate. The RVCP is seen to benefit care recipients, family members and other residents at Mandurah.

'Having a structured environment within the retirement village has enabled multiple visits within a cost-efficient timeframe.

- For example, most of our clients have a service delivery of around two visits per day but in addition due to the confinement of the village the carers are able to socialise with and monitor clients by way of a one-on-one chat or quick check-in when the client is unwell over the course of the day, as they go about providing services to other clients within the retirement village. This has enabled the difficulties often associated with old age—isolation, loneliness, boredom and helplessness—to be addressed.

Residents have the added security of knowing that there is a carer within walking distance and if they are in need of emergency assistance the personal alarm which all RVCP clients have in their units can be activated to provide quick efficient help.

- Call-out alarm response time within the day is within 3–5 minutes and in the evening, within 5–10 minutes. After dark a security guard is there within 15 minutes and all possess a first aid certificate. Within the last 6 months the after-hours (between 2100 hours and 0700 hours) call out has been used 10 times—two were false alarms, two were calls from clients in need of ambulance assistance and six clients required a registered nurse to assess their situation. In one case the client had gone to the bathroom just on midnight and had collapsed from vomiting a large amount of blood. The consequences of not having had the pendant alarm could have been devastating.

Activities for clients have also been implemented, with crafts, afternoon movies, happy hours and social outings or local scenic tours with afternoon tea.

- The response has been very positive with clients interacting more and now clients are organising activities amongst themselves. One example is a client who organised a monthly sing-a-long with invitations extended to residents from the aged care facility. Increased self-respect, self-esteem and enthusiasm has been clearly demonstrated in clients' personal presentation and appearance as well as the interaction with other people.

A *Stay on Your Feet* seminar was recently held within the village social hall with around 96 members of the village and public attending.

- It gave great insight into prevention of falls within the village structure but also the training the staff received was invaluable in helping to promote awareness for existing and new clients. We have introduced ongoing assessment safety checks within the *Stay on Your Feet* guidelines and also planning to keep a regular seminar to promote awareness.

The village infrastructure allows us to have access to an occupational therapist, physiotherapist and podiatrist as well as clinical medical services delivered by our care manager or the registered nurse.

- This has been a benefit for clients who have received surgery such as hip replacement when personal care, clinical care and ongoing medical attention are a prerequisite for staying at home. We have the structure in place to allow the pathway from hospital to home care as part of the service delivery. We have also noticed clients are electing for surgery such as cataracts whereas before they would delay treatment because no after-care was available.

Palliative care has been one area which has allowed the clients' and families' wishes to stay in their unit to be fulfilled.

- In collaboration with Peel Palliative Care Service, clients and family have all the support services available. Clients are treated with dignity and respect and the families have given us positive feedback and are grateful that this service delivery was provided.

Many of our clients are aged in the range 75–97 years and their siblings have commenced to either enter or have progressed into the retirement era.

- The family unit of the daughter/son being there to assist a parent with shopping, appointments, etc. is not always possible, sometimes due to ill health or other commitments. One of the benefits with the RVCP is there is now more quality time when the family gets together. One of our client's daughters has been diagnosed with cancer and the prognosis is poor. She has been spending time with her mother and family. Staff

have been able to give emotional and domestic support to the client, as well as transport to and from the daughter's home when needed. The family has stated that a burden has been taken off their shoulders as their mother had already lost one daughter and they are relieved by the support given by RVCP staff and to know that ongoing care is available when it is needed most.

In the past 6 months we have had to transfer three residents to our high care nursing home due to their deterioration and an inability to continue to support themselves in their unit. But recently due to the infrastructure we have in place a resident who was in a high care facility has been able to take residence in one of our independent living units with a package—a complete reversal.

- The client had a stroke approximately 12 months ago and was told she would never walk again. She was in hospital for approximately 3 months before being transferred to a high care facility. With ongoing support from family and the physiotherapist and occupational therapist at the hospital, the client was able to recover, obtaining movement to her left arm and legs. One of her goals was to be able to return to an independent living unit, a goal which was achieved. As we had the RVCP service in place, the transition into an independent living unit was made more obtainable through personal service delivery and care plans being adjusted to meet the client's care needs on a regular basis. Liaison with the occupational therapist and family made the client's goal achievable and with care staff helping to promote independence, the client was able to recuperate and adapt to the independent living unit in a safe environment and in her own timeframe. This client is an inspiration to many and her determination is a reward for all who know her.

Clients who exit from the RVCP are given an exit strategy, which involves the family unit.

- One example is a resident who was unsure about moving to a high care nursing home due to ill health. To help with transition, over a few weeks we assisted family visits at different times of the day. The care manager who is also part of the RVCP was able to alleviate many of the fears of being "institutionalised". We organised a few nights stay to enable the client to become acquainted with the new environment and regular care staff from the RVCP remained involved with her daily care. Once transition was complete, staff would visit and organise for the client to go on her usual outings with RVCP and then this was eventually transferred to outings with the nursing home residents. This also incorporated the family, whereby staff from RVCP would give emotional support during the transition time to alleviate many of the fears so that family and mother did not see it as being institutionalised, rather, as another move.

Pharmaceutical issues are a concern with many of our clients and the amount of medications that they acquire or store. With the *Stay on Your Feet* seminar we were able to address the issue of polypharmacy and the need for a medical review. There have been many incidents and medication problems; families have either requested the supervision of medication use or for medication to be administered through a webster delivery service from the pharmacy.

- A request to a client's usual GP for a medication review found that the client had a few medications prescribed by another doctor which were causing side effects that the client had put down to a virus. Medication was changed and "the virus" was gone. Another client was being prescribed pain relief by three different doctors. Concerns were addressed to her regular doctor who reviewed with the pharmacist and other doctors.

Trained staff are able to identify underlying health concerns which most older people in their own homes might regard as part of growing old.

- Example: urinary tract infection, which can cause confusion amongst the elderly causing family to be concerned with their mental health and safety. Staff having the advantage of multiple visits have been able to pick up on behavioural changes and identify related symptoms and address them with a simple ward test; this has been able to alleviate a potential health concern.

Aged Care Assessment Teams and residents of the Mandurah Retirement Village have contacted Mandurah Retirement Village with potential clients.

- At present we have 18 places funded and three unfunded clients and within the last 6 months have had the potential to accept another five clients due to a range of problems. The main issues addressed by the people who were seeking support were help with domestic work, social support and personal care. A resident of the village had approached us with concerns about his wife who had Alzheimer's and needed support over the last week but didn't know who to turn to. We provided him with alternatives as we had no places available and he then contacted ACAT who assessed the situation. While this was taking place the lady deteriorated and we were able to utilise staff to attend to her personal care and the clinical nurse was able to attend to the medical issues. Assessments were carried out and an emergency care plan was in place within a few hours and the doctor was contacted for a home visit. The doctor was admitting her to the hospital but as there would be no bed available until the following day we kept a clinical and personal care plan in place. The wife actually passed away in hospital a few days later, but the husband was very grateful for the support during this time of need and appreciated the efficiency of all staff involved.

Flexibility of the RVCP to adapt a range of service types to suit each individual, with assessment and care plans implemented in a short timeframe and reviewed with individual needs. We have seen clients' needs addressed with a smooth transition.

- A client who recently was accepted into RVCP at Mandurah was quite confused and emotional. She had no family left in Australia and a friend was her enduring power of attorney and support. She had been in rehabilitation for approximately 3 months after a fall in her home and after moving into an independent living unit found all ADLs hard to manage. Her friend had requested for the staff to supervise all medications and as she needed a GTN patch for high blood pressure, a daily blood pressure test and recording. Assessment and a care plan were implemented and over a few months other assessments were initiated due to problems the RVCP care workers identified including hearing loss, incontinence, bowel and urinary tract infection. Staff addressed all issues promptly and efficiently. The client's friend who oversees her affairs is able to liaise with staff in regards to ongoing care and has been impressed with the flexibility of the level of service the RVCP can provide when needed. '

9.3 Client profiles

Twenty-two care recipients were active in the project during the September and December 2004 quarters. Data on 20 clients were provided for the evaluation, representing 90.9% of clients who were active at the time.

Age and sex

Evaluation clients including 15 females and five males had an average age of 85 years (a range of 68–95 years) at the time of the evaluation. Nine clients were aged 85 years (Table B9.1).

Table B9.1: Mandurah Retirement Village RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
65–74	1	—	1
75–84	3	7	10
85+	1	8	9
Total	**5**	**15**	**20**
		(per cent)	
65–74	5.0	—	5.0
75–84	15.0	35.0	50.0
85+	5.0	40.0	45.0
Total	**25.0**	**75.0**	**100.0**

— Nil.

Language and communication

All clients could communicate effectively in spoken English.

Accommodation and living arrangement

Eight clients were in serviced apartments when they joined the project and the remaining 12 clients were living in independent living units (Table B9.2). All clients lived alone, which is a distinguishing feature of this group.

Table B9.2: Mandurah Retirement Village RVCP, number of clients by usual accommodation setting, living arrangement and accommodation setting at time of referral to RVCP

	Usual living arrangement				
Accommodation setting	Alone	With family	With others	Total usual accommodation	Accommodation at referral
Retirement village—independent living	12	—	—	12	12
Retirement village—supported living	8	—	—	8	8
Total	**20**	**—**	**—**	**20**	**20**

— Nil.

Years at Mandurah Retirement Village ranged from less than one to 20 years. Four clients had been living at Mandurah Retirement Village for over 10 years.

Carer availability

Only one evaluation client had a family carer. This project recorded the second lowest carer availability among the RVCP projects.

Income and concession status

Government pensions were the primary source of cash income for all clients (Table B9.3). All but three clients held a health care concession card. One-quarter of the group received a discounted rate of client co-payment.

Table B9.3: Mandurah Retirement Village RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number of clients	Per cent
Principal source of cash income		
Age Pension	13	65.0
DVA pension	7	35.0
Total	**20**	**100.0**
Health care concession card holder	17	85.0
RVCP concession status	5	25.0

Previous use of government-funded community care programs

Three clients had been receiving assistance through government community care programs before the RVCP (Table B9.4). The other clients reported no history of government-funded community care.

Table B9.4: Mandurah Retirement Village RVCP, number of clients by use of government program support prior to RVCP

Previous use of government support programs	Number of clients	Per cent
Program		
Home and Community Care (HACC)	2	10.0
Other program	1	5.0
Total	*3*	*15.0*
No previous government support program	17	85.0
Total	**20**	**100.0**

Five clients were on a waiting list for residential aged care during the evaluation.

Referral and assessment

Most referrals came from within Mandurah Retirement Village, either through self-referral as a result of an awareness campaign when the RVCP was establishing, or through the initiative of staff (Table B9.5).

Table B9.5: Mandurah Retirement Village RVCP, number of clients by source of referral

Referral source	Number of clients
Self-referral	8
Mandurah Retirement Village	6
Family member	5
Friend	1
Total	**20**

The project conducts an initial screening assessment before referring a resident to the ACAT. All clients had completed an ACAT assessment before services commenced (Table B9.6). All clients had ACAT approval for low care.

A care manager conducts a pre-admission interview before formally accepting a client into the project. Any necessary further assessments are arranged and a care plan is developed. Once a client is established on a package they are monitored and further assessments are conducted as needed.

Table B9.6: Mandurah Retirement Village RVCP, number of clients by days between completion of ACAT assessment and service commencement

Completion date of ACAT assessment	Number of clients
Before service commencement	
0–20 days	15
21–30 days	1
31–90 days	4
91–180 days	—
181–365 days	—
Total	**20**

— Nil.

The care manager for Mandurah Retirement Village RVCP clients is a registered nurse.

Health conditions and health status on entry

The number of health conditions recorded per client at date of entry ranges from one to seven. Sixteen clients had three or more health conditions when they commenced in the RVCP. Table B9.7 lists the recorded primary health condition categories.

Table B9.7: Mandurah Retirement Village RVCP, number of clients by primary health condition at entry

Primary health condition	Number of clients
Heart and other circulatory system disease	6
Diseases of musculoskeletal system and connective tissue[(a)]	4
Blindness or poor vision	3
Diseases of nervous system	3
Lower limb amputation (traumatic)	1
Lumbar fracture	1
Diabetes mellitus type I	1
Chronic lower respiratory disease	1
Total	**20**

(a) Includes cases of arthritis, osteoporosis, back problems.

On entry to the project, two clients had missing or non-functional limbs and 15 clients were at risk of falls due to impaired gait and balance. Seven clients were vision impaired and 11 were hearing impaired (Table B9.8).

Table B9.8: Mandurah Retirement Village RVCP, number of clients by presence of health conditions at entry

Health condition	Number of clients
Impaired gait or balance—at risk of falls	15
Vision impairment	7
Hearing impairment	11
Both hearing and vision impairment	5
Missing or non-functioning limbs	2
Diagnosis of depression	4
Disorientation/confusion	—

— Nil.

The number of different medications in use recorded at baseline varies from one to nine per client. Fourteen clients were taking at least four different types of medication.

At the start of the evaluation, each client was asked to assess how their health had changed over the past 12 months. Five said that they were in about the same state of health as 12 months earlier. The other 15 clients said that they were in somewhat worse (11 clients) or much worse health (four clients).

Clients also reported any significant health events in the 12 months before entering RVCP. Five clients had had a fall that resulted in a fracture or other significant injury. Four clients had been rendered immobile by a fall or accident and left unable to summon assistance for 30 minutes or more. Six clients said they had experienced a life-threatening medical event that resulted in a severe decline in health status in the 12-month period (missing values are recorded for one client). This is one of the higher rates of adverse events reported by projects.

Level of core activity limitation

At entry to the RVCP, most clients experienced mild to moderate limitation in self-care and mobility (Table B9.9). Communication limitation is less common, although seven clients are reported to have mild communication limitation.

One client is recorded as having a severe or profound level of core activity limitation.

Table B9.9: Mandurah Retirement Village RVCP, number of clients by level of core activity limitation at entry

	Level of activity limitation				
Core activity	No limitation	Mild	Moderate	Severe or profound	Total
Self-care	1	13	5	1	**20**
Mobility	—	13	7	—	**20**
Communication	13	7	—	—	**20**

— Nil.

Use of medical and hospital services prior to entry

Baseline profiles contain information about client use of medical and hospital services in the 6 months prior to entering the project—the 'pre-entry period'. All 20 clients had visited a medical practitioner at least once in the pre-entry period. The reported number of visits varies from two to 18 per client. Cumulatively, the 20 clients recorded 115 visits to a medical practitioner outside of a hospital setting over an estimated 3,600 person days.

Nine clients had not visited a hospital emergency department and had not been admitted to hospital in the pre-entry period. Two clients had been to a hospital or emergency department but details are not known. The remaining nine clients are recorded as having contributed to a total of 10 known hospital admissions for the group, nine of which were urgent or unplanned admissions. Cumulative hospital bed days (per client) for all urgent admissions in the pre-entry period ranged from one to 21. On average, those clients who had been admitted to hospital for urgent or unplanned treatment had spent 8.6 days in hospital during the 6 months prior to commencing in RVCP.

9.4 Client assessment results

Activities of daily living

At entry to the RVCP, most Mandurah Retirement Village clients were independent in the activities of daily living apart from negotiating stairs (Appendix Table B17). This client group has recorded a lower proportion of clients with need for assistance in self-care than most other projects.

Baseline Modified Barthel Index (MBI) scores ranged from 11 to 20 out of a total 20 points. The mean score at baseline was 18.3 points with a standard deviation of 2.3 (median 19; Table B9.10). A classification scheme for the Barthel Index (Shah et al. 1989), indicates that on entry to the project, one client showed severe dependency in ADL and six clients were moderately dependent. The remaining clients showed either slight dependency (eight clients) or were independent (five clients) in self-care and mobility on entry to the project.

The median and mean baseline MBI scores indicate that the middle of the MBI distribution was in the range of slight to moderate dependency in ADL.

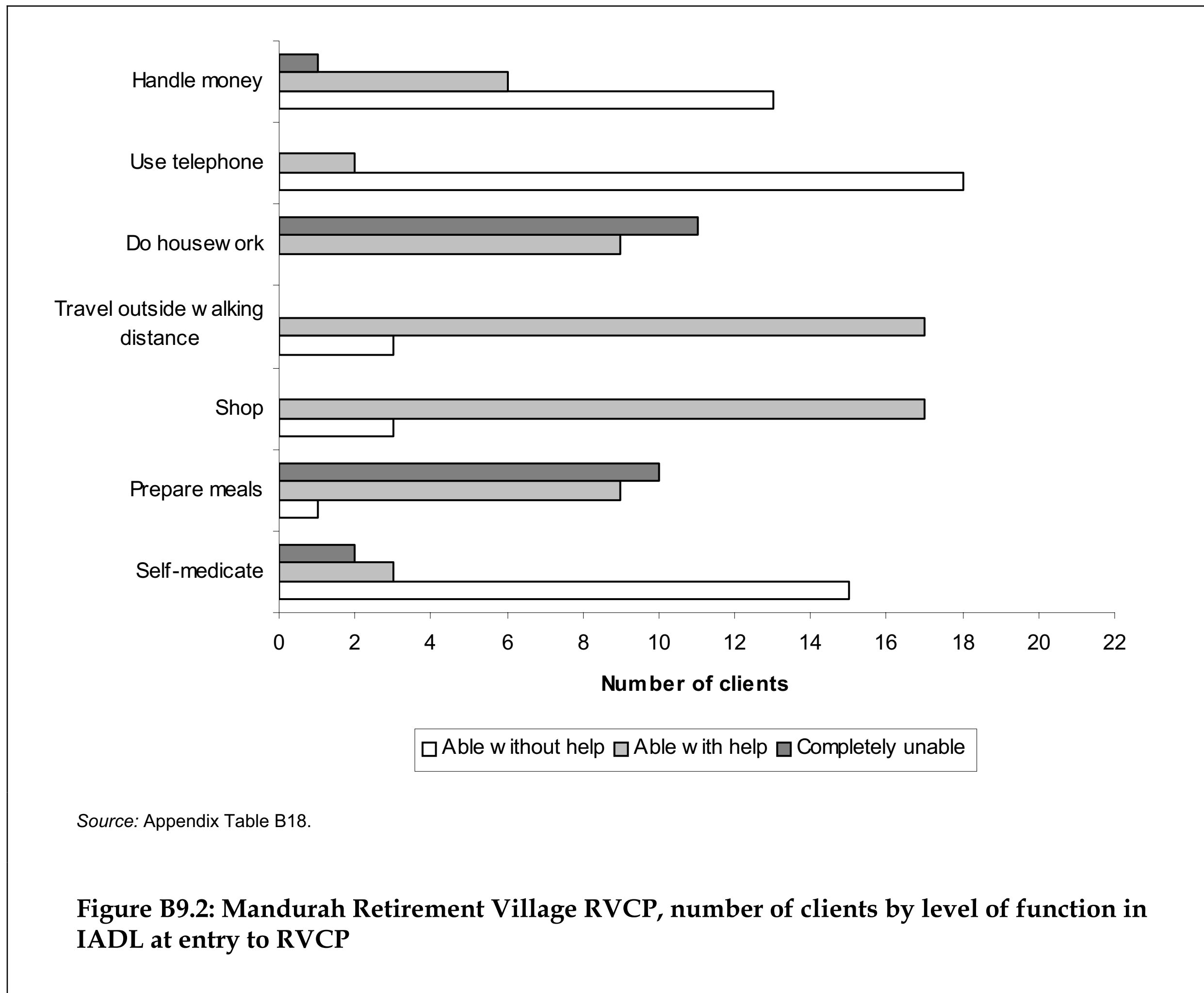
In IADL, household chores and meal preparation are the areas where most Mandurah clients needed assistance when they joined the project (Figure B9.2). At baseline, the typical Mandurah Retirement Village RVCP client was completely dependent in one out of seven IADL. One client was completely dependent in four IADL at entry to the RVCP. The median baseline score on the OARS IADL scale (IADL) was 9 points, with scores ranging from 3 to 11 out of a possible maximum of 14 points. Baseline results indicate that all clients had lost some IADL function by the time they joined the project and that there was considerable variation in the extent of functional loss among clients at entry.

Final assessments were conducted on average 28.1 weeks after entry.

Changes in the MBI between baseline and final assessments range from –8 (an 8-point decline in ADL function) to 1 point (a 1-point improvement). Change scores (final minus baseline score) have a median of zero (Table B9.10), indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments. Of the clients who recorded a non-zero change score, most changed from one

level of dependency to the next highest or lowest level, for example, from moderate to severe or from moderate to slight dependency.

The median IADL change between baseline and final assessments was zero, with variation within the range of –7 to 0 points (Table B9.10). Twenty-six percent of clients registered a decline in IADL function between baseline and final assessments.



Source: Appendix Table B18.

Figure B9.2: Mandurah Retirement Village RVCP, number of clients by level of function in IADL at entry to RVCP

Table B9.10: Mandurah retirement Village RVCP, summary measures for ADL and IADL baseline and change scores[(a)]

	Number of clients	Median	Mean	Std dev.
ADL				
Baseline MBI	19	19	18.3	2.3
Change in MBI	19	0	–1.0	2.4
IADL				
Baseline IADL	19	9	8.4	1.7
Change in IADL	19	0	–1.1	2.2

(a) Score at final assessment minus score at baseline for an individual client.

9.5 Accommodation outcomes

By completion of follow-up (17 June 2005), 11 clients remained in the project and seven clients had entered residential aged care (Table B9.11).

Table B9.11: Mandurah Retirement Village RVCP, number of clients by discharge outcome, June 2005

	Number of clients	Per cent
At home		
With RVCP	11	55.0
Total at home	*11*	*55.0*
Institutional care		
Hospital	—	—
Residential aged care total	7	35.0
Low care	4	20.0
High care	3	15.0
Total in care	*7*	*35.0*
Deceased	2	10.0
Total	**20**	**100.0**

— Nil.

10 Aged Care Services Australia

10.1 Project description

An RVCP project of 40 flexible care places was established in Perth under the auspice of Aged Care Services Australia Incorporated (ACSA). ACSA is a subsidiary of the St Ives Group, a large for-profit organisation which operates retirement villages, hostels, community care services and a real estate agency. In addition to the RVCP project, ACSA delivers a range of services including:

- over 200 CACP places for people residing in their own homes in metropolitan Perth, Alice Springs and, through joint ventures, in Canberra and Victoria
- the operation of two Commonwealth Carelink Centres in metropolitan Perth
- homecare assessment and coordination programs in Perth for the Department of Veterans' Affairs
- operation of the community service component of an innovative Transitional Care Pilot service in Perth (30 packages)
- two residential aged care hostels in Perth
- a wide range of private homecare services in Perth, both in retirement villages and the wider community.

The project was allocated funding for 30 low care and 10 high care places. At the time of the evaluation, the project was delivering services into two retirement villages owned by the St Ives Group and seven villages owned by other organisations, all in and around Perth. The first client commenced in late October 2003.

All participating retirement villages offer a 24-hour emergency call system for residents, and some offer additional services. Serviced apartments in addition to independent living units are to be found in some of the villages; all evaluation clients live in independent living units.

ACSA Community Care Division employs seven care coordinators and a team of service coordinators who work across all of the community care programs including the RVCP. Care coordinators are responsible for assessment, care planning, monitoring and client review. Service coordinators administer the programs. Care coordinators work in multidisciplinary teams that include registered nurses and social workers. ACSA employs a pool of approximately 145 care staff on a part-time or casual basis, and staff members work across all ACSA programs. Clients are allocated a care coordinator and services are delivered by between one and four care workers, depending on client needs and staff availability.

A place in the RVCP project costs a client the same as the standard CACP client co-payment. In practice, the type and amount of services provided through the RVCP is similar to a CACP. High care RVCP clients receive up to 17 hours of care per week and low care averages approximately 6.5 hours per week.

Early referrals to the project from Fremantle ACAT were for people who would otherwise have been referred to a CACP provider. There is a long waiting list for CACP and during the evaluation, EACH was available within a very limited area of approximately a 10-kilometre radius. Both ACAT and project staff view the flexibility of RVCP packages as an important

innovative feature in comparison to mainstream care packages in that it allows services to be tailored to changing needs—care packages can evolve over time to allow clients to access additional services without the need for additional assessments and waiting periods. Transition from low care to a higher level of care is effected seamlessly; the client retains the same care workers and further ACAT assessment is avoided. The coordinator indicated that the project is filling a gap that exists between low level community care provided by HACC and CACP and high level care provided through EACH packages. The coordinator believes that RVCP clients with higher level needs would be in residential aged care if not for the Pilot.

In the first 5 months of operation 35 of the 40 places were filled. There were 39 commencements and four cessations (one to residential care, one to hospital, one transfer to CACP and one death) during this period. The client group in March 2004 was 83% female and the average age at entry to the RVCP was 85.5 years, with age at entry ranging from 66 to 95 years. Weekly hours of direct care were ranging from 3 hours to 14 hours, with an average of 6.5 hours per client. Initial assessment and care planning was typically requiring around 2.75 hours with a follow-up one-hour care plan review and around 35 minutes per client per week for monitoring and service coordination. Including ongoing case management time, a client on an established and stable care plan would typically receive approximately 7 hours of care per week.

ACAT members have expressed concern that the RVCP is discriminatory because only residents of approved retirement villages are eligible. These residents are perceived to be financially advantaged compared to residents of other retirement villages and many older people in the community. ACATs have noted that territorial issues arise because ACSA is a commercial operation. Thus, while there have been no difficulties so far in making referrals for high care clients, this is because all such clients assessed by the ACAT live in a St Ives Group village. ACAT can see difficulties arising in the provision of service to a high care client who lives in a village that is not managed by the auspice body.

On balance, the availability of RVCP packages can be seen to reduce one source of demand for other packages. Assuming that all referrals to the RVCP are appropriate, any inequity that may exist is in the form of prioritisation. As to the second point, when CACP and RVCP packages are viewed as a combined pool, the supply of RVCP low care packages by ACSA into St Ives villages is essentially no different to the supply of CACP services by ACSA. This is because of the necessary involvement of ACAT in eligibility assessment. The key issue appears to be that the RVCP project can offer higher levels of care than CACP in a catchment area where the mainstream community alternative for high care, EACH packages, are in short supply. Notwithstanding the counter arguments, it remains that in some quarters the RVCP is regarded as an inequitable distribution of resources.

Despite these criticisms of the concept, all referring ACATs have come to see the benefits of the Pilot and are pleased to have RVCP packages as a referral option.

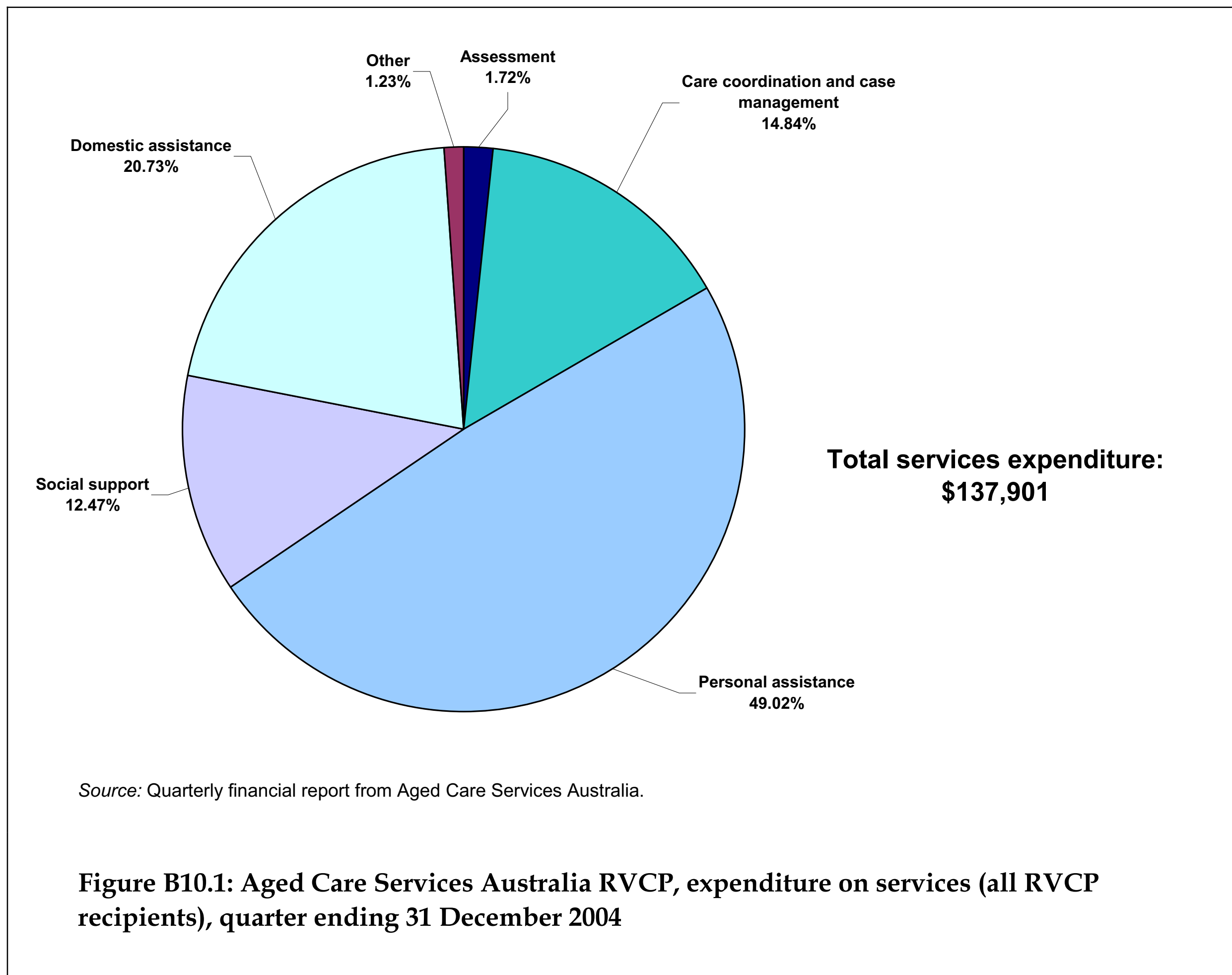
Risk factors for continuing care

Package recipients are at risk of discharge from the project if their health deteriorates to the point that community care is no longer appropriate. Care levels are monitored within the context of the case load across the entire project, particularly in relation to accepting new clients.

Profile of expenditure on services to care recipients

ACSA reported expenditure on a limited range of service types. Just under 50% of total services expenditure in the quarter ending 31 December 2004 went on personal assistance. Almost all evaluation participants (32 out of 37) received personal assistance during the reporting period, at an average of 1.6 hours per week.

Personal assistance, domestic assistance and social support services accounted for over 80% of services expenditure. ACSA did not report expenditure on nursing care or allied health care.



Source: Quarterly financial report from Aged Care Services Australia.

Figure B10.1: Aged Care Services Australia RVCP, expenditure on services (all RVCP recipients), quarter ending 31 December 2004

10.2 Case studies

Aged Care Services Australia supplied the following case study reports.

Case study 1

'Mrs X lived with her husband, who was very physically frail and unwell. She had been receiving a CACP of seven hours per week. Her husband also received some respite support. Mrs X was doubly incontinent, and had mobility problems. She was very paranoid about what her husband might do (that is, "run off with someone"). This meant that she wouldn't let him out of her sight, and was very clingy with him. Therefore, he never got a break from caring, and was becoming extremely worn down.

At the time of referral to the project, the situation was desperate as Mr X was becoming increasingly stressed and just wasn't coping well. Although family lived next door they were providing very little support due to a previous disagreement. Mr X admitted that he had previously made a pact with his wife that they would never be separated and had considered ways of "departing this world together". Despite having reached this point, Mr X was initially reluctant to accept the total available hours of service.

Services commenced within a few days to provide personal care and companionship along with respite for Mrs X and daily assistance for domestic support for Mr X. This made a big difference to Mr X's coping abilities.

In October, once Mr X was diagnosed with a terminal illness, situations again reached crisis point. He was strongly advised to access residential respite for his wife to give him some time to himself but when respite was arranged for his wife she began threatening that she no longer wished to live and that he had promised this would never happen. A crisis care intervention was arranged, whereby a carer stayed with the couple for 72 hours until the situation settled and the couple felt confident that they could stay at home safely.

Following the crisis intervention care began to be provided in the X's home, seven days a week. This included domestic assistance, personal care, assistance with meal preparation, and spending companionship time with Mrs X in order that Mr X have a break. After this episode I managed to convince Mr X to reconsider his wife attending day centre care as this would give him full days of respite. Mrs X agreed to start attending a day respite centre. She now attends four days a week, and loves it. She is picked up and dropped off by the centre's bus. She always enjoys her time there, and Mr X reports that she sleeps much more soundly at night after the daytime stimulation. This is a great relief for him.

Outcome

Since the carers have developed a trusting relationship with Mrs X, they are able to support her in her grief on the occasions when she is lucid. The X's family were encouraged and is now much more supportive, and this is a great help to the couple. Grief counselling has been arranged through the Alzheimer's Association for Mr and Mrs X, and plans are being made for residential care for Mrs X, due to Mr X's illness so that he feels happy that arrangements are in place.

Currently Mr X feels much stronger and able to cope with the day-to-day issues and he is no longer reluctant to ask for assistance. Family assist in the evenings to prepare Mrs X for bed as he finds minimal exertion exhausting.

Mrs X entered residential care following a hospital admission in January, 2005. She had some initial behavioural issues but Mr X still enjoys taking his wife home twice a week for several hours, to have a meal. His own health continues to deteriorate but he is content to be able to spend most of his day at the nursing home with his wife and receives support from HACC services for himself now.'

Case study 2

'Mrs Y was referred to the program by the geriatric medicine team of a local health service in November 2003. At the time she had been receiving a CACP totalling 7 hours a week. The CACP care staff had been unable to manage to provide the care required.

Mrs Y was not taking her medications. She was not eating properly, and would not allow the care staff to cook, clean or assist her with personal care. Her food handling caused concern, as she would leave food out in the heat or defrost and then re-freeze food, putting herself at risk of food poisoning. She was also not showering, and her clothes were old, dirty and ripped. If staff tried to carry out any personal care, she became very agitated and physically and verbally aggressive. Service times varied greatly which made it very difficult for any routine to be established.

Mrs Y was frail, stooped in posture and often wandered the grounds of the retirement complex she lived in. She was paranoid about people stealing her money and possessions, and would often approach the village administration staff about these concerns. Mrs Y presented as depressed, a condition that had persisted since the death of her husband several years before.

Mrs Y lacked insight into her abilities which made it very difficult for any successful interventions and she constantly complained about all the strangers entering her home and interfering with her possessions. The CACP care staff found that they were unable to establish a rapport with Mrs Y, especially within the time restrictions. She had no family support, and only one supportive friend. Mrs Y strongly wished to remain in her home, and was thus referred to our program.

Initially, the RVCP support workers offered companionship to Mrs Y. Due to her prior reluctance to allow care services, the priority was seen to be building a rapport and a sense of trust. She verbalised concerns at her initial assessment that we were trying to put her in "a home" and became quite distressed by this. Much reassurance was required to convince her that our priority was to assist her to stay in her home and to provide friendship rather than to take over her life.

Medication prompts and meal prompts were given. After about 3 months the support workers had developed a good relationship with Mrs Y, and she would allow them to assist her with personal care, including showering. Soon after that she decided to recommence attending a day centre which she used to attend.

Some other strategies included performing some duties when she was not at home so that she wouldn't become distressed, for example, doing the washing while she was out having lunch with her friend. The hours of care were increased so that the support workers could take her for outings and to the shops, which she loved. Domestic services were provided one day a week, while she went out with her friends. Mrs Y's package then increased to the full hours available.

Outcome

With the above care and services Mrs Y coped well. She loved the social interaction provided by the visits from support workers. She especially loved a cup of tea, and this provided an important time for the relationship-building process to take place. Her wandering virtually ceased. She was prescribed an antidepressant medication by her doctor and her mood continued to fluctuate, but there was an overall improvement. Her paranoia diminished, and she was no longer complaining to the village staff as often about things going missing. Her physical health improved greatly as she began eating regular, healthy meals.

Unfortunately for Mrs Y, the building she was living in was scheduled for demolition, and she was forced to relocate. Some of her behaviours began to escalate again as she felt under pressure from the village administration to go into residential care. Some of the accommodation being offered was inappropriate hence we made an application for a public guardian to be appointed to assist us in ensuring that her best interests would be met.

In September 2004 Mrs Y moved to dementia-specific hostel accommodation. Some of her problems resurfaced following the move, but she has since settled into her new environment. Hostel staff members expressed surprise that she had been able to live alone at home for so long, given the severity of her dementia. Mrs Y is still able to enjoy the companionship of others along with regular outings and activities. An interim period of support was given by her community support workers to assist with her settling in process. However, if she had not been forced to relocate she would have been able to continue to live in her own home for longer with the assistance of her Flexible Care Package.'

Case study 3

'Mrs Z was living alone. She received support through a CACP totalling 7 hours a week. Over a period of a year or so she had become very depressed and withdrawn. She had isolated herself from everyone, even her family. She never left the house and always kept the curtains and windows shut, so that she was sitting in a darkened house. She would also binge eat, which was causing weight and health problems as she was diabetic. Mrs Z would also wear soiled clothing over and over, not attend to domestic duties and was fast becoming reclusive.

Our service began slowly, with support workers simply visiting Mrs Z and talking with her to build rapport and trust. She would allow people in and speak with them, but maintained that she didn't need any help. The visits continued three times each day. After about two weeks Mrs Z began to allow the support workers to assist her with personal care. She began to wear clean clothes and use continence aids. She also allowed the support workers to prepare her meals and snacks. Medication prompts were given, as Mrs Z had not been remembering to take her tablets. She accepted these prompts and took her medications as prescribed. Mrs Z enjoyed the social aspects of the visits, and the companionship they provided. She began to allow the curtains and the windows to be opened, slowly reconnecting her to the outside world.

Mrs Z has a supportive family who are astounded at her improvement. They had been so concerned before commencement of the service, but their attempts to help had been to no avail.

Outcomes

After about two months Mrs Z began to go out grocery shopping with the support workers. She enjoyed these outings, when prior to this she had not left her house for over a year.

Now Mrs Z's GP has reported that her health has significantly improved. She has lost weight, and her diabetes is under control. She loves going out, not only shopping, but to cafes and a theatre group as well. With prompting she will even attend doctors' appointments by herself. She has been able to take the initiative to buy flowers for her daughter-in-law and arrange for them to be sent. She has been reading books and writing letters again with prompting. Support workers started accompanying her on walks around the river and now Mrs Z has purchased a pedometer, which she uses to make sure she gets enough exercise.

Now that she is taking her medication as prescribed, eating a healthy diet and enjoying a good level of social interaction, Mrs Z's Mini-Mental State Examination Score has improved by eight points, from 16 to 24. Correspondingly, her level of functioning has improved markedly, and she is certainly enjoying a much better quality of life. Her family are also very pleased with her transition.

Recently, Mrs Z has been able to enjoy a ferry trip across to Rottnest Island with a support worker as she frequently talked about her love of the ocean, the smells of the beach and the sounds of the waves crashing in on the shore. Her biggest concern was that her bathers may no longer fit!!'

10.3 Client profiles

Evaluation data were provided for 37 ACSA care recipients who were active during the evaluation period. These data are summarised below to reflect client group characteristics during 2004 and for certain measures, as at entry to the project.

Age and sex

The mean age of clients in the evaluation was 86.3 years at the time (ages ranged from 70 to 97 years). Twenty-six clients were aged 85 years or over (Table B10.1).

Table B10.1: Aged Care Services Australia RVCP, number of clients by age group and sex

Age (years)	Males	Females	Persons
		(number)	
Less than 65	—	—	—
65–74	—	2	2
75–84	1	8	9
85+	10	16	26
Total	**11**	**26**	**37**
		(per cent)	
Less than 65	—	—	—
65–74	—	5.4	5.4
75–84	2.7	21.6	24.3
85+	27.0	43.2	70.2
Total	**29.7**	**70.2**	**100.0**

Language and communication

All clients could communicate effectively in English.

Accommodation and living arrangement

All clients were living in independent living units when they joined the project. One client was in hospital at the time of referral.

Table B10.2: Aged Care Services Australia RVCP, number of clients by usual accommodation setting, usual living arrangement and accommodation setting at time of referral to RVCP

	Usual living arrangement			
Accommodation setting	Alone	With family	Total usual accommodation	Accommodation at referral
Retirement village—independent living	28	9	37	36
Hospital	—	—	—	1
Total	**28**	**9**	**37**	**37**

— Nil.

Years at usual accommodation ranged from one to 10 years and averaged 4.5 years. Four clients had been living in their usual place of residence for 10 years when they entered the pilot. Years at usual place of residence was not reported for 16 clients.

Carer availability

Seventeen clients had a family carer, 10 of whom agreed to take part in the evaluation. Carer details were not recorded for one client. Four carers lived with the care recipient. Most participating carers were non-resident daughters (Table B10.3). The project supplied age for two carers only.

Table B10.3: Aged Care Services Australia RVCP, number of clients by carer availability, carer relationship to client and co-residency status

Carer relationship to client	Number of clients
Spouse or partner	4
Son or daughter	10
Son- or daughter-in-law	1
Other relative	1
Not stated	1
Total clients with a carer	*17*
Clients without a carer	20
Total clients	**37**
Per cent of clients with a carer	45.9

Income and concession status

Source of income was recorded for 20 of the 37 clients. Two clients received primary cash income from superannuation/annuities, and one client received the Age Pension (Table B10.4). Health care concession card status was reported for 19 clients (11 had a card). Twelve clients received a discounted rate of co-payment for the project due to financial hardship. The full daily rate of co-payment was $5.65; discounted rates range from $1.60 to $4.91 per day.

Table B10.4: Aged Care Services Australia RVCP, number of clients by principal source of cash income, health care concession card status and RVCP concession status

	Number	Per cent
Principal source of cash income		
Age Pension	1	2.7
Superannuation or annuities	2	5.2
Not stated	16	54
Missing	18	48.6
Total	**37**	**100.0**
Health care concession card holder	11	29.7
RVCP concession status	11	29.7

Previous use of government-funded community care programs

Around two-fifths of clients were not receiving assistance from government community care programs before the RVCP. A similar proportion had transferred to the project from CACP (Table B10.5).

Table B10.5: Aged Care Services Australia RVCP, number of clients by previous government program support

Previous use of government support programs	Number of clients	Per cent
Government support program		
Community Aged Care Packages	15	40.5
Home and Community Care	3	8.1
Veterans' Home Care	2	5.4
Other program	1	2.7
Total with previous government support	*21*	*56.8*
No previous government program support	16	43.2
Total	**37**	**100.0**

Two clients were on a waiting list for residential aged care during the evaluation period. Waiting list status is missing for 12 clients.

Referral and assessment

ACSA RVCP receives referrals from a variety of sources, with most sourced (20 clients) (Table B10.6). Five clients had completed their most recent ACAT assessment more than one year prior to service commencement (Table B10.7). These assessments were completed in 1998, 2001 or 2002. All clients with an invalid ACAT assessment had transferred to the RVCP project from a CACP service.

Table B10.6: Aged Care Services Australia RVCP, number of clients by source of referral

Referral source	Number of clients
Aged Care Services Australia	20
Hospital	5
ACAT	9
Family	2
General practitioner	1
Total	**37**

Table B10.7: Aged Care Services Australia RVCP, number of clients by days between completion date of ACAT assessment and service commencement

Completion date of ACAT assessment	Number of clients
Before service commencement	
0–20 days	16
21–30 days	4
31–90 days	2
91–180 days	4
181–365 days	4
Over 1 year	5
Total	*35*
After service commencement	
51 and 97 days after service commencement	2
Total	**37**

For eligibility, all evaluation clients were ACAT approved for low care. Two clients were reassessed and approved for high care after the start of the evaluation.

A welfare and community worker (19 clients) or another professional (18 clients) manages the care of ACSA RVCP clients.

Health conditions and health status on entry

The number of health conditions recorded for ACSA RVCP clients ranges from one to 9. Twenty-six clients had four or more health conditions on entry. Table B10.8 lists the primary health conditions recorded on the Aged Care Client Records for ACSA RVCP clients.

Table B10.8: Aged Care Services Australia RVCP, number of clients by primary health condition at entry

Primary health condition	Number of clients
Arthritis and related disorders	6
Dementia	4
Circulatory system diseases	4
Osteoporosis	3
Chronic lower respiratory diseases	3
Diseases and disorders of the eye, including poor vision	3
Falls (frequent with unknown aetiology) and gait abnormality	3
Fractures	2
Back problems—dorsopathies	2
Other specified diseases and disorders	7
Total	**37**

Twelve clients had both hearing and vision impairment at time of entry; 31 clients were assessed as being at risk of falls due to impaired gait or balance (Table B10.9).

Table B10.9: Aged Care Services Australia RVCP, number of clients by presence of selected health conditions at entry to the project

Health condition	Number of clients
Impaired gait or balance—at risk of falls	31
Vision impairment	16
Hearing impairment	21
Both hearing and vision impairment	12
Total or partial paralysis	2
Missing or non-functional limb/s	3
Diagnosis of depression	6

Number of medications is recorded for 10 clients only. These clients were taking between two and seven different medications. Five clients were taking five or more different types of medication.

Level of core activity limitation

Most ACSA RVCP clients experienced mild or moderate activity limitation in the core areas of self-care (26 clients) and mobility (26 clients) (Table B10.10).

Table B10.10: Aged Care Services Australia RVCP, number of clients by level of core activity limitation at entry to RVCP

	Level of activity limitation				
Core activity	No limitation	Mild	Moderate	Severe or profound	Total
Self-care	1	10	16	10	**37**
Mobility	2	19	7	9	**37**
Communication	28	4	4	1	**37**

Use of medical and hospital services prior to entry

Baseline profiles contain information about client use of medical and hospital services in the 6 months prior to entering the RVCP—the 'pre-entry period'. These data are available for 11 clients, all of whom had visited a medical practitioner at least twice in the pre-entry period. The reported number of visits to a medical practitioner in this period varies from two to 15 per client. Cumulatively, the 11 clients recorded 92 visits to a medical practitioner outside of a hospital setting over an estimated 1,980 person days.

Four clients contributed to a total of six hospital admissions in the pre-entry periods (an additional 11 clients are recorded as having attended a hospital emergency department and/or having been admitted to hospital, but details of their hospital usage are not recorded). One client reported planned admissions only. The remaining three clients with

reports of hospital admissions recorded either solely unplanned/urgent admissions, or both unplanned/urgent and planned admissions. Urgent/unplanned hospital bed days were reported for two of these clients, who collectively accumulated 23 urgent/unplanned hospital bed days over approximately 360 person days.

Conditions which occasioned hospital admissions include:

- injuries to leg/knee/foot/ankle/hip
- other diseases of the nervous system
- delirium
- hypertension.

Three clients had experienced a serious medical emergency during the 12 months prior to entering the project (missing data for 18 clients). Seven clients suffered a fall with injury (missing data for 13 clients). Two clients were rendered immobile and without assistance for more than 30 minutes in the same period (missing data for 17 clients).

10.4 Client assessment results

Activities of daily living

On entry to the project, half to two-thirds of ACSA RVCP clients needed help with bathing, dressing and grooming (Appendix Table B19). Most clients were able to mobilise and transfer independently but were unable to use stairs without assistance. Baseline Modified Barthel Index (MBI) scores ranged from 7 to 20 out of a total 20 points. The mean score was 15.5 points with a standard deviation of 2.8 (median 16).

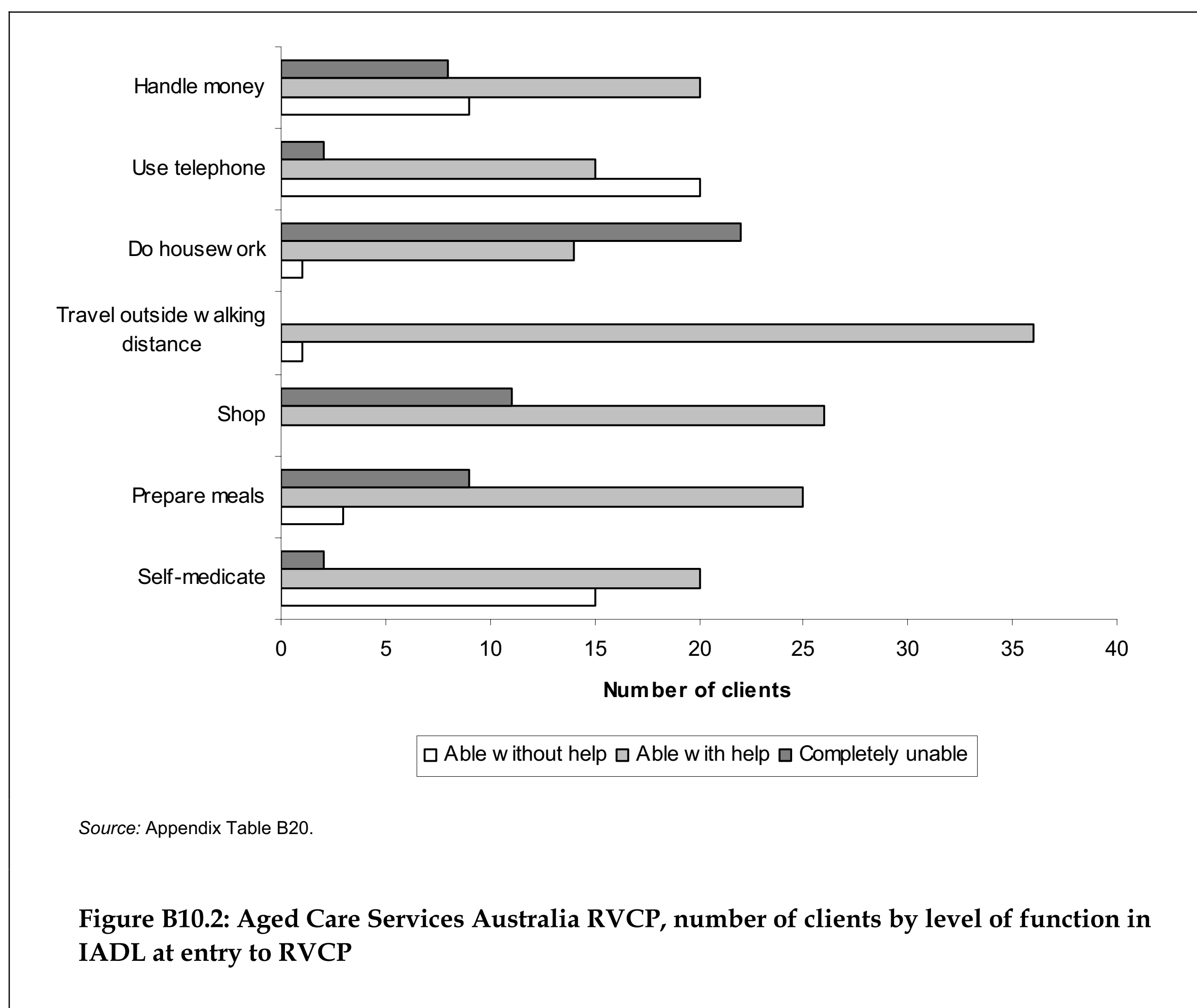
According to a classification for the Barthel Index (Shah et al. 1989), the MBI results indicate that 29 clients were moderately dependent in self-care and mobility at the time of entry to the project. The mean baseline score indicates that the middle of the score distribution was in the range of moderate dependency in ADL.

Most St Ives RVCP clients were moderately or highly dependent in IADL at the time of the baseline assessment (Figure B10.2). On average, St Ives RVCP clients were completely dependent in one out of seven IADL. The median baseline score on the IADL scale was 7 points, with scores ranging from 1 to 12 out of a maximum possible 14 points. Baseline results indicate that all ACSA RVCP clients had lost some IADL function and that there is considerable variation in the extent of functional loss among clients entering the project. Most clients needed assistance with shopping, meal preparation, household chores and travelling away from home.

Although all clients registered as being able to walk or use a wheelchair independently on the Modified Barthel Index, the mobility item on the IADL scale reveals that in all but one case, independent mobility was limited to the home environment.

Changes in the MBI between baseline and final assessments ranged from –5 (a 5-point decline in ADL function) to 3 points (a 3-point improvement). The median change was zero, indicating that on average, level of functioning in ADL as measured by the MBI did not change between the baseline and final assessments (Table B10.11).

The median change score for IADL (OARS IADL scale) between baseline and final assessments was also zero and showed variation in the range of –2 to 3 points (Table B10.11).



Source: Appendix Table B20.

Figure B10.2: Aged Care Services Australia RVCP, number of clients by level of function in IADL at entry to RVCP

Table B10.11: Aged Care Services Australia RVCP, summary measures for ADL and IADL baseline and change scores[(a)]

	Count	Min.	Median	Max.	Mean	Std dev.
ADL						
Baseline MBI	36	7	16	20	15.7	2.7
Change in MBI	36	–5	0	3	–0.1	1.6
IADL						
Baseline IADL	36	1	7	12	6.9	2.6
Change in IADL	36	–2	0	3	0	0.9

(a) Score at final assessment minus score at baseline assessment.

10.5 Carer assessment results

Three carers completed the Caregiver Strain Index (Robinson 1983) on entry to the project, scoring between 7 and 9 points, all above the case threshold for carer strain of 7 points. These carers were likely to need a considerable amount of support to sustain the caring role.

10.6 Accommodation outcomes

By completion of follow-up (16 June 2005), 27 clients remained with the project and three clients had been discharged to the community. Three clients had entered an aged care facility (Table B10.12).

Table B10.12: Aged Care Services Australia RVCP, number and per cent of clients by discharge outcome, June 2005

	Number of clients	Per cent
At home		
With RVCP	27	73.0
With HACC	1	2.7
Without formal services	2	5.4
Total at home	*30*	*81.1*
Institutional care		
Hospital	3	8.1
Residential aged care total	3	8.1
Low care	3	8.1
High care	—	—
Total in care	*6*	*16.2*
Deceased	1	2.7
Total	**37**	**100.0**

— Nil.

Appendix tables for Part A

Table A1: RVCP evaluation, number of clients by type of retirement village accommodation

Usual accommodation setting	Number	Per cent
Independent living in a retirement village	199	84
Assisted living in a retirement village	39	16
Total	**238**	**100**

Table A2: RVCP evaluation, number of clients by frequency of social contact

Frequency of contact with family or friends	Number of clients	Per cent
Family or friends visit most days	68	28.6
Family or friends visit at least once a week	89	37.4
Family or friends visit regularly, less than weekly	40	16.8
Family or friends in contact but do not visit often	22	9.2
Infrequent contact with family or friends	7	2.9
Little or no direct contact with family or friends	4	1.7
Not stated or missing	8	3.4
Total	**238**	**100.0**

Table A3: RVCP evaluation, number of clients by previous use of respite care services, by type of respite care

Previous experience of respite care	Number of clients	Per cent
Respite care not needed	107	45.0
Respite care needed but not used	6	2.5
Mainly residential respite	10	4.2
Mainly in-home respite	1	0.4
Not known	19	8.0
Missing	95	39.9
Total	**238**	**100.0**

Table A4: RVCP evaluation, number of clients by primary source of cash income

Source of income	Number	Per cent
Age pension	128	53.8
Veterans' pension	41	17.2
Superannuation/annuities	24	10.1
Disability pension	4	1.7
Other unspecified source	3	1.3
Total non-missing values	*200*	*84.0*
Missing value	38	16.0
Total	**238**	**100.0**

Table A5: RVCP evaluation, number and per cent of clients by type of previous government program support, by project

Project	None	HACC	VHC	HACC & VHC	Day Therapy Centre	CACP	Other	Not stated	Total
					(number)				
HN McLean Memorial Retirement Village	12	8	0	0	0	0	0	0	20
Australian Unity RLS	17	1	0	0	0	0	0	3	21
Morshead Home	7	8	1	0	0	3	0	0	19
Forest Place	24	0	0	0	0	0	1	3	28
Southern Cross Care	7	9	1	0	0	1	0	0	18
Kingston City Council	2	11	2	7	0	0	1	0	23
ECH Inc.	27	4	2	0	1	1	3	0	38
Resthaven Inc.	11	1	0	0	0	2	0	0	14
Mandurah Retirement Village	17	2	0	0	0	0	1	0	20
Aged Care Services Australia	16	3	2	0	0	15	1	0	37
Total	**140**	**47**	**8**	**7**	**1**	**22**	**7**	**6**	**238**
					(per cent)				
HN McLean Memorial Retirement Village	60.0	40.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0
Australian Unity RLS	81.0	4.8	0.0	0.0	0.0	0.0	0.0	14.3	100.0
Morshead Home	36.8	42.1	5.3	0.0	0.0	15.8	0.0	0.0	100.0
Forest Place	85.7	0.0	0.0	0.0	0.0	0.0	3.6	10.7	100.0
Southern Cross Care	38.9	50.0	5.6	0.0	0.0	5.6	0.0	0.0	100.0
Kingston City Council	8.7	47.8	8.7	30.4	0.0	0.0	4.3	0.0	100.0
ECH Inc.	71.1	10.5	5.3	0.0	2.6	2.6	7.9	0.0	100.0
Resthaven Inc.	78.6	7.1	0.0	0.0	0.0	14.3	0.0	0.0	100.0
Mandurah Retirement Village	85.0	10.0	0.0	0.0	0.0	0.0	5.0	0.0	100.0
Aged Care Services Australia	43.2	8.1	5.4	0.0	0.0	40.5	2.7	0.0	100.0
Total	**58.8**	**19.7**	**3.4**	**2.9**	**0.4**	**9.2**	**2.9**	**2.5**	**100.0**

Table A6: RVCP evaluation, summary statistics for average weekly service hours per client, by ACAT approval

	Average weekly service hours						
ACAT approval on entry	Clients	Minimum	50th percentile (median)	75th percentile	Maximum	Mean	Std deviation
High care	13	5.9	11.0	16.2	19.4	11.8	4.64
Low care	216	—	3.3	5.3	26.9	4.3	3.53

— Rounded to zero.

Table A7a: RVCP evaluation, mean and median weekly service units per client, by type of assistance and project

	HNM		AU RLS		MOR		FPG		KCC		SCC		ECH		RI		MRV		ACSA		RVCP	
Type of assistance	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med
Weekly hours per client (types of assistance measured in time units)																						
Personal assistance	1.5	1.3	1.9	1.3	3.0	2.4	5.0	4.0	1.8	1.3	3.0	1.6	2.6	2.4	2.6	2.4	1.4	1.1	1.6	1.4	2.6	2.0
Domestic assistance	1.8	1.7	2.0	1.9	2.9	2.8	1.1	0.9	1.1	1.0	1.4	0.8	3.1	2.7	1.5	1.3	2.1	2.1	1.1	1.0	1.8	1.6
Food service other	1.3	1.2	0.9	1.0	0.7	0.6	1.8	1.3	0.8	0.8	—	—	2.3	1.8	0.2	0.2	0.6	0.6	1.2	0.9	1.5	1.3
Social support	—	—	0.8	0.3	—	—	2.5	2.6	0.3	0.2	—	—	0.8	0.6	1.2	0.6	1.1	0.9	0.7	0.5	0.9	0.5
Allied health	0.3	0.1	—	—	—	—	—	—	0.2	0.1	0.1	0.1	0.0	0.0	0.3	0.2	0.4	0.4	—	—	0.2	0.1
In-home respite	2.9	3.2	—	—	—	—	—	—	2.5	2.5	2.0	2.0	4.1	4.1	—	—	—	—	—	—	2.8	2.5
Nursing care	1.2	1.3	—	—	—	—	3.1	2.6	2.3	2.3	1.0	1.0	—	—	1.2	1.3	0.2	0.1	—	—	1.7	1.3
Weekly service units per client (types of assistance measured in units other than time)																						
Medication reviews	0.1	0.0	—	—	—	—	0.1	0.1	0.1	0.1	—	—	—	—	0.2	0.1	0.1	0.1	—	—	0.1	0.1
GP consultations	0.2	0.2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0.2	0.2
Nursing/medical contacts	0.1	0.1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0.1	0.1
Other allied health contacts	0.3	0.1	—	—	—	—	—	—	0.2	0.1	0.1	0.1	—	—	0.3	0.2	0.4	0.4	—	—	0.3	0.4
Dementia care/behaviour management contacts	—	—	—	—	—	—	0.4	0.4	0.1	0.1	—	—	—	—	4.1	5.5	—	—	—	—	1.6	0.6
Recreation/leisure events	0.8	0.5	—	—	—	—	—	—	0.2	0.2	—	—	—	—	—	—	—	—	—	—	0.5	0.4
Transport (trips)	0.1	0.1	—	—	0.7	0.7	—	—	0.9	0.8	0.9	0.9	1.1	0.9	3.0	2.7	—	—	0.7	0.4	1.4	0.9
Delivered meals (number)	5.1	4.6	—	—	14.3	14.3	11.0	10.5	4.6	4.6	10.3	5.74	—	—	4.1	4.5	9.6	11.2	—	—	7.4	5.7
Linen service deliveries	—	—	—	—	—	—	5.3	5.3	—	—	—	—	—	—	—	—	1.5	1.5	—	—	2.7	2.3
Personal other (events)	—	—	—	—	—	—	—	—	0.2	0.2	—	—	1.7	2.1	0.4	0.4	6.9	3.4	—	—	4.4	2.6
Information, advice and referral (contacts)	—	—	—	—	—	—	—	—	0.1	0.1	—	—	0.1	0.1	0.4	0.3	0.1	—	—	—	0.1	0.1
Carer support (contacts)	—	—	—	—	—	—	—	—	0.2	0.2	—	—	0.1	0.1	0.2	0.2	0.3	0.3	—	—	0.2	0.2

(continued)

Table A7a (continued): RVCP evaluation, mean and median weekly service units per client, by type of assistance and project

	HNM		AU RLS		MOR		FPG		KCC		SCC		ECH		RI		MRV		ACSA		RVCP	
Type of assistance	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med	Mean	Med
Weekly service units per client (types of assistance measured in units other than time)																						
Aids and equipment ($)	27.4	25.0	—	—	—	—	—	—	6.6	3.2	—	—	8.8	6.8	2.6	1.6	9.6	4.2	—	—	11.0	5.3
Home maintenance and modifications ($)	—	—	—	—	—	—	—	—	4.4	3.4	—	—	—	—	—	—	32.6	18.9	—	—	18.0	6.6

(a) Includes all forms of respite care (not just in-home respite).

(b) Includes home maintenance only (not home modifications).

Note:
Project codes: HNM (HN McLean Retirement Village); AU RLS (Australian Unity Retirement Living Services); MOR (Morshead Home); FPG (Forest Place Retirement Village); SCC (Southern Cross Care Victoria); KCC (Kingston City Council); ECH (ECH Incorporated); RI (Resthaven Incorporated); MRV (Mandurah Retirement Village); ACSA (Aged Care Services Australia).

— Nil or rounded to zero.

. . Not applicable.

Sources: AIHW analysis of RVCP evaluation database; AIHW (2004a): Table A2.10 (CACP statistics).

Table A7b: RVCP and CACP, mean and median weekly service units per client, by type of assistance

Type of assistance	RVCP Mean	RVCP Median	CACP Mean	CACP Median
	Weekly hours per client			
Personal assistance	2.6	2.0	2.3	2.0
Domestic assistance	1.8	1.6	2.3	2.0
Food service other	1.5	1.3	1.7	1.3
Social support	0.9	0.5	2.2	1.8
Allied health	0.2	0.1	. .	. .
In-home respite	2.8	2.5	3.3[(a)]	2.5[(a)]
Nursing care	1.7	1.3	. .	. .
	Weekly service units per client			
Medication reviews	0.1	0.1	. .	. .
GP consultations	0.2	0.2	. .	. .
Nursing/medical contacts	0.1	0.1	. .	. .
Other allied health contacts	0.3	0.4	. .	. .
Dementia care/behaviour management contacts	1.6	0.6	. .	. .
Recreation/leisure events	0.5	0.4	. .	. .
Transport (trips)	1.4	0.9	3.0	2.0
Delivered meals	7.4	5.7	6.1	5.0
Linen service deliveries	2.7	2.3	1.9	1.0
Personal other (events)	4.4	2.6	. .	. .
Information, advice and referral (contacts)	0.1	0.1	. .	. .
Carer support (contacts)	0.2	0.2	. .	. .
Aids and equipment ($)	11.0	5.3	. .	. .
Home maintenance and modifications ($)	18.0	6.6	1.0[(b)]	1.0[(b)]

(a) Includes all forms of respite care (not just in-home respite).

(b) Includes home maintenance only (not home modifications).

. . Not applicable.

Sources: AIHW analysis of RVCP evaluation database; AIHW (2004a): Table A2.10 (CACP statistics).

Table A8: RVCP evaluation, number of clients in receipt of assistance by type of assistance and project

	Project									
Type of assistance	**HNM**	**AU RLS**	**MOR**	**FPG**	**SCC**	**KCC**	**ECH**	**MRV**	**RI**	**ACSA**
Initial needs assessment	20	21	13	28	18	23	38	20	14	35
Case management	20	20	13	27	18	23	28	18	14	29
Needs assessment other	—	—	—	—	17	2	16	19	1	—
Personal assistance	9	7	7	28	17	12	11	14	14	32
Personal other e.g. medication prompt	—	—	—	—	—	1	4	9	2	—
Domestic assistance	18	20	12	22	16	22	36	20	13	30
Delivered meals	3	—	2	3	14	23	—	16	8	—
Food service other	4	3	3	28	—	1	4	5	1	17
Social support	7	16	9	—	—	22	19	9	10	—
Personal transport	1	—	11	—	6	6	18	20	11	13
Community transport	—	—	—	—	—	11	1	14	—	—
Medication review	20	—	—	18	—	1	—	17	11	—
Nursing care	3	—	—	23	2	4	—	16	10	—
GP consultation	10	—	—	—	—	—	—	—	—	—
Nursing/medical other	4	—	—	—	—	—	—	—	1	—
Physiotherapy	1	—	—	—	—	2	—	—	6	—
Occupational therapy	—	—	—	—	—	1	1	—	—	—
Podiatry	4	—	—	—	1	16	6	—	3	—
Alternative therapies	3	—	—	—	—	—	—	1	—	—
Dietetics	—	—	—	—	1	—	—	—	—	—
Allied health other	—	—	—	—	3	—	—	1	—	—
Dementia management	—	—	—	—	—	1	—	—	—	—
Behaviour management	—	—	—	5	—	—	—	—	2	—
Dementia other	—	—	—	—	—	—	—	—	1	—
Recreation/leisure programs	5	—	—	—	—	3	—	—	—	—
Linen service	—	—	—	1	—	—	—	2	—	—
Financial advice	—	—	—	—	—	—	—	2	4	—
Housing/tenancy information	—	—	—	—	—	—	—	3	—	—
Consumer and legal information	—	—	—	—	—	—	—	2	—	—
Referral to other provider	—	—	—	—	—	12	2	—	1	—
Information other	—	—	—	—	7	1	—	—	—	—
Mobility aids	5	—	—	—	—	—	3	—	1	—
Continence aids	—	—	—	—	—	2	—	—	1	—
Nursing and medical supplies	1	—	—	—	—	1	—	8	5	—

(continued)

Table A8 (continued): RVCP evaluation, number of clients in receipt of assistance by type of assistance and project

	Project									
Type of assistance	**HNM**	**AU RLS**	**MOR**	**FPG**	**SCC**	**KCC**	**ECH**	**MRV**	**RI**	**ACSA**
Aids other	3	—	—	—	—	6	9	7	—	—
In-home respite care	5	—	—	—	1	2	1	—	—	—
Carer individual counselling and referral	—	—	—	—	—	—	—	—	1	—
Carer support other	—	—	—	—	—	1	1	1	—	—
Home modifications	—	—	—	—	—	3	—	10	—	—
Home maintenance	—	—	—	—	—	12	—	11	—	—

Note: Project codes: HNM (HN McLean Retirement Village); AU RLS (Australian Unity Retirement Living Services); MOR (Morshead Home); FPG (Forest Place Retirement Village); SCC (Southern Cross Care Victoria); KCC (Kingston City Council); ECH (ECH Incorporated); RI (Resthaven Incorporated); MRV (Mandurah Retirement Village); ACSA (Aged Care Services Australia).

— Nil.

Table A9: Data item definitions for variables used in regression analysis

Model variable	Data type	Number of records with non-missing values
Mean weekly service hours (SERVICE)	Continuous	229
Age in completed years (AGE)	Integer	238
Sex (SEX)	Dichotomous (male/female)	238
ACAT approval (ACAT) [(a)]	Dichotomous (low/high)	238
Living arrangement (LA)	Dichotomous (lives alone/lives with others)	238
Carer availability (CARER)[(b)]	Dichotomous (yes/no)	238
Severe or profound core activity limitation (CAL)	Dichotomous (yes/no)	238
Primary health condition of dementia (DEM)	Dichotomous (yes/no)	238
Primary health condition related to musculoskeletal system or connective tissue (MCT)	Dichotomous (yes/no)	238
Number of health conditions on entry to project (NHC)	Integer	238
Gait or balance abnormality (GBA)	Dichotomous (yes/no)	238
Number of medications (MED)[(c)]	Integer	203
Previous government program support (GPS)	Dichotomous (yes/no)	238
Baseline Modified Barthel Index score (ADL)	Integer 0–20	220
Baseline OARS IADL score (IADL)	Integer 0–14	219
Project ID (PROJ)[(d)]	Set of 9 dichotomous (0/1) dummy variables. Reference group = ACSA.	238

(a) A number of other variables, including ACAT approval type (low or high level care) are confounded with project.

(b) Rates of carer availability vary between the projects. Carer co-residency status could not be entered because of confounding with living arrangement. Since most family carers are non-resident family members, living arrangement (lives alone or with others) and carer availability encompass most arrangements, however there is no means of discerning any differential effect of co-resident versus non-resident carer availability.

(c) Most of the missing values for number of medications occurred in one project.

(d) Average levels of dependency in ADL and rates of severe or profound core activity limitation vary systematically across the projects. Initially, project was not entered into regression models in order to test the explanatory power of client characteristics independent of the effect of project membership.

TableA10: Multiple regression of average weekly service hours on selected client characteristics, estimated regression coefficients and corresponding levels of statistical significance

Independent variable	ACAT low care initial model (n = 180)	ACAT low care final model (n = 206)	ACAT high care (n = 13)
AGE	n.s.	—	—
SEX	n.s.	—	—
LA (lives with others)	–1.37*	–1.27*	
CARER (no carer)	1.41**	n.s.	—
CAL	n.s.	—	—
DEM	n.s.	—	—
MCT	n.s.	—	—
NHC	n.s.	—	—
GBA	n.s.	—	—
MED	n.s.	—	—
GPS	n.s.	—	—
ADL Note 2	–0.38**	–0.33**	—
IADL Note2	–0.45**	–0.25*	–2.4**
PROJECT	—	Parameter estimate varies by project. Significance level of the set of dummy variables representing PROJECT effect: $p < 0.0001$.	—
Reference PROJECT mean weekly service hours	2.8	2.6	—
Model coefficient of determination	$R^2 = 0.28$	$R^2 = 0.42$	$R^2 = 0.72$

(a) Missing values in the dataset meant that differing numbers of client records were available for analysis depending on which independent variables were included. A number of iterations were performed to check that slight differences in numbers of records were not having a material effect on results.

(b) ADL and IADL scores are mean centred on the respective group means (ACAT low care/high care groups).

p < 0.05; ** p < 0.01.

n.s. Not significant.

— Not included in model specification.

Table A11: RVCP, expenditure on services by project (nearest dollar), quarter ending 31 December 2004

	HN McLean	Australian Unity	Morshead Home	Forest Place	Southern Cross Care	Kingston City	ECH Inc.	Resthaven	Mandurah	ACSA	Total
Assessment	$1,050	$1,900		$293	—	—	$2,705	$2,550	$1,376	$2,373	$12,247
Care coordination/management	$10,013	$10,080		$712	$15,783[b]	See (a)	$7,160	$10,200	$5,130	$20,460	$79,538
Nursing services	$3,260	—		$14,441	$143	$712	—	$3,318	$7,384	$75	$29,333
Medical services	—	—		—	$245[b]	—	—	—	$625	—	$870
Physiotherapy/occupational therapy	$1,430	—		—	$105	$1,035	—	—	—	$300	$2,870
Behaviour management therapy	—	—		—	—	—	—	$2,248	—	—	$2,248
Counselling and support	—	—		—	See (b)	—	—	$4,495	$7,425	—	$11,920
Other allied health care	$92	—		—	$155	$1,310	$451	$273	—	—	$2,281
Personal assistance	$5,625	$5,535	Refer Table A15	$29,764	$25,490	$17,591	$4,680	$5,619	$17,901	$67,595	$179,799
Social support	$1,425	$210		$4,869	—	—	$1,631	$4,495	$9,945	$17,203	$39,778
Domestic assistance	$12,256	$14,873		$5,691	$10,312	$8,891	$22,017	$5,619	$27,280	$28,580	$135,518
Food services	$4,845	—		—	—	$13,482	$4,879	$4,904	$461	—	$28,571
Home maintenance	—	—		—	—	$582	$851	—	$800	—	$2,233
Home modifications	—	—		—	—	—	—	—	—	$255	$255
Home linen service	—	—		$332	—	—	—	$39	$2,204	—	$2,575
Transport	$1,250	$10,673		—	$1,310	$853	$945	$1,678	$2,214	$860	$19,782
Provision of aids and equipment	$2,088	—		—	—	$924	$520	$518	$3,078	$200	$7,328
Leisure and recreational programs	$1,238	—		$314	—	—	—	—	$12,191	—	$13,743
Centre-based day care	—	—		—	—	$44	—	—	$18	—	$62
Respite care	$1,103	—		—	—	$1,304	—	—	—	—	$2,406
Total	**$45,675**	**$43,271**		**$56,416**	**$53,543**	**$46,727**	**$45,839**	**$45,953**	**$98,032**	**$137,901**	**$573,355**

(a) Kingston City Council RVCP care coordination and case management costs were not billed to the project.

(b) Southern Cross Care (Vic) RVCP care coordination and case management includes social support and counselling services; RVCP medical services expenditure comprised pharmaceutical costs only.

Note: Figures rounded to nearest dollar. Columns and rows may not add exactly to row and column totals.

— Nil.

Source: Project-supplied quarterly financial reports.

Table A12: RVCP, allocated place days, client service days, new income, total expenditure and expenditure on services per client service day by project, quarter ending 31 December 2004

Project	Total place days	Client service days	Mean weekly hours of service per client[a]	Income[b] per client service day (dollars)	Total expenditure per client service day (dollars)	Service expenditure per client service day (dollars)
HN McLean Memorial Retirement Village	1,840	1,840	3.6	51.34	43.10	24.82
Australian Unity Retirement Living Services	4,876	1,899	3.1	49.40	38.90	22.79
Morshead Home			Refer Table A15			
Forest Place Retirement Village	2,484	2,401	11.0	63.24	37.88	23.50
Southern Cross Care (Victoria)	2,300	2,302	5.6	47.64	34.86	23.26
Kingston City Council	2,024	1,950	3.0	50.09	34.64	23.96
ECH Incorporated	3,220	3,068	4.3	45.63	25.50	14.94
Resthaven Incorporated	1,380	1,235	5.8	73.54	48.37	37.21
Mandurah Retirement Village	1,656	1,653	4.4	58.86	59.79	59.31[c]
Aged Care Services Australia	3,680	3,640	3.1	56.00	49.55	37.88

(a) Includes personal assistance, nursing care, domestic assistance, social support, food service other than delivered meals, allied health care. Excludes transport, delivered meals and other types of assistance not measured in time units. Calculated from evaluation client data.

(b) Includes Australian Government RVCP subsidy, client co-payments and income from other sources.

(c) Mandurah Retirement Village included overheads in its report of expenditure on client services.

Note: Income as reported by projects, exclusive of any carryover from the September quarter. Some discrepancies exist between flexible care subsidy income reported by projects and figures supplied by the Department of Health and Ageing. In most cases these are less than 5% variance, apart from18% variance between official and reported figures for Kingston City Council.

Source: Project-supplied financial and occupancy reports; evaluation database (mean weekly service hours).

Table A13: RVCP, available funds and expenditure by project, quarter ending 31 December 2004

	Reported available funds			Reported expenditure			
Project	**New income**	**Funds carried forward**	**Total**	**On services**	**Other**	**Total**	**Surplus/deficit (new income minus total expenditure)**
HN McLean Memorial Retirement Village	94,465.60	. .	94,465.60	45,674.57	33,623.64	79,298.21	15,167.39
Australian Unity Retirement Living Services	93,810.00	9,343.00	103,153.00	43,271.00	30,607.00	73,878.00	19,932.00
Forest Place Retirement Village	151,833.54	. .	151,833.54	56,415.55	34,542.77	90,958.32	60,875.22
Southern Cross Care (Victoria)	109,661.00	65,907.00	175,568.00	53,543.00	26,694.00	80,237.00	29,424.00
Kingston City Council	97,670.00	. .	97,670.00	46,726.67	20,817.33	67,544.00	30,126.00
ECH Incorporated	139,979.58	. .	139,979.58	45,839.00	32,406.35	78,245.35	61,734.23
Resthaven Incorporated	90,818.00	34,665.00	125,483.00	45,952.50	13,781.50	59,734.00	31,084.00
Mandurah Retirement Village	97,302.00	. .	97,302.00	98,032.00[(a)]	800.00	98,832.00	-1,530.00
Aged Care Services Australia	203,853.00	-142.00	203,711.00	137,900.67	42,472.33	180,373.00	23,480.00
Total	**1,079,392.72**	**109,773.00**	**1,189,165.72**	**573,354.96**	**235,744.92**	**809,099.88**	**270,292.84**
Morshead Home				Refer Table A15			

Note: Income as reported by projects. Some discrepancies exist between flexible care subsidy income reported by projects and figures supplied by the Department of Health and Ageing. In most cases these are small, except for 18% variance between the two figures for Kingston City Council.

(a) Includes overheads apportioned by service category.

. . Not applicable.

***Source:* Project supplied quarterly financial reports.**

Table A14: RVCP, sources of income and total available funds by project (dollars), quarter ending 31 December 2004

	New income					
	Flexible care subsidy	Client co-payments	Other income[(a)]	Total new income	Unspent funds carried over	Total available funds
HN McLean Memorial Retirement Village	94,465.60	—	—	94,465.60	—	94,465.60
Australian Unity Retirement Living Services	82,538.00	8,406.00	2,866.00	93,810.00	9,343.00	103,153.00
Forest Place Retirement Village	126,863.96	24,969.58	—	151,833.54	—	151,833.54
Southern Cross Care (Victoria)	98,873.00	10,788.00	—	109,661.00	65,907.00	175,568.00
Kingston City Council	89,838.00	—	7,832.00	97,670.00	—	97,670.00
ECH Incorporated	134,272.66	5,706.92	—	139,979.58	—	139,979.58
Resthaven Incorporated	83,998.00	6,820.00	—	90,818.00	34,665.00	125,483.00
Mandurah Retirement Village	94,115.00	3,187.00	—	97,302.00	—	97,302.00
Aged Care Services Australia	188,158.00	15,695.00	—	203,853.00	-142.00	203,711.00
Total	**993,122.22**	**75,572.50**	**10,698.00**	**1,079,392.72**	**109,773.00**	**1,189,165.72**
Morshead Home			Refer Table A15			

Note: Income as reported by projects. Some discrepancies exist between flexible care subsidy income reported by projects and figures supplied by the Department of Health and Ageing. In most cases these are small, except for 18% variance between official and reported figures for Kingston City Council.

(a) Includes interest on project funds and charitable donations/bequests.

— Nil.

Source: Project-supplied quarterly financial reports.

Supplement on Morshead Home RVCP consortium financial results

Table A1.5 contains a summary of the financial information provided by Morshead Home RVCP consortium members. Data were not provided for approximately one-third of the allocated places, the data provided do not all relate to the same financial quarter, and lack of occupancy data precluded analysis of income and expenditure on the basis of client service days, performed for other projects. Thus, the information in Table A15 is indicative of general income and expenditure patterns within the project rather than a record of actual income and expenditure across the project in a specific time interval. It is not intended to be used as a basis for comparison with financial results in the December 2004 quarter for the RVCP overall.

Table A15: Morshead Home RVCP, summary of financial information provided by participating villages, quarter ending 31 December 2004 or 31 March 2005, as applicable

	Participating village				
	Morshead	**Canberra Masonic Homes**	**Villaggio**	**Goodwin**	**Total**
Financial quarter reported	Mar 05	Dec 04	Dec 04	—	
Number of places					
High care	1	—	2	—	**3**
Low care	6	6	3	7	**22**
Total places	*7*	*6*	*5*	*7*	***25***
Income					
Unspent funds carried over	—	—	—	n.r.	—
Australian Government RVCP subsidies	$26,628.00	$18,506.00	$11,364.00	n.r.	**$56,498.00**
Client co-payments	$3,224.00	$2,929.00	$1,885.00	n.r.	**$8,038.00**
Gifts/donations	—	$56.00	—	n.r.	**$56.00**
Total income	*$29,852.00*	*$21,491.00*	*$13,249.00*	. .	***$64,592.00***
Expenditure					
Expenditure on services	$15,216.00	n.r.	$13,521.00	n.r.	**$28,737.00**
Non-services expenditure	$5,087.00	. .	$3,006.00	. .	**. .**
Total expenditure	*$20,303.00*	*$12,143.00*	*$16,527.00*	n.r.	***$48,973.00***
Surplus/deficit	**$9,549.00**	**$9,348.00**	**-$3,278.00**[(a)]	**. .**	**$15,619.00**
Total new income per place	$4,264.57	$3,581.83	$2,649.80	. .	**$10,496.20**
Total service expenditure per place	$2,173.71	. .	$2,704.20	. .	**. .**
Total expenditure per place	$2,900.43	$2,023.83	$3,305.40	. .	**$8,229.66**
Surplus/deficit per place	$1,364.14	$1,558.00	-$655.60	. .	**$2,266.54**

a) The project coordinator at Villaggio indicated that the deficit recorded in the financial quarter ending 31 December 2004 was unusual, and that the project generally returns a surplus.

— Nil.

n.r. Not reported.

. . Unable to calculate.

Source: Financial reports provided by project coordinators at Morshead Home, Canberra Masonic Homes and Villaggio sites.

Appendix tables for Part B

Table B1: HN McLean RVCP, number of clients by level of dependency in activities of daily living at entry to RVCP

	Dependency level			Total
	Independent	Partially dependent	Fully dependent	
Bowel management	13	2	5	**20**
Bladder management	13	2	5	**20**
Toilet use	16	2	2	**20**
Bathing/showering	12	. .	8	**20**
Dressing	12	4	4	**20**
Grooming	10	. .	10	**20**
Feeding	19	1	—	**20**
Mobility (level surface)	19	1	—	**20**
Transfers	17	3	—	**20**
Stairs	5	10	5	**20**

. . Not applicable.

— Nil.

Table B2: HN McLean RVCP, number of clients by level of function in IADL at entry to RVCP

	Capability			Total
	Able without help	Able with help	Completely unable	
Monetary transactions (e.g. pay bills)	11	6	3	**20**
Telephone use	15	4	1	**20**
Household chores	1	15	4	**20**
Travel to places outside of walking distance	8	10	2	**20**
Shop for groceries or clothes	1	8	11	**20**
Prepare meals	13	4	3	**20**
Correctly administer own medications	12	5	3	**20**

Table B3:Australian Unity RLS RVCP, number of clients by dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	19	1	1	**21**
Bladder management	20	—	1	**21**
Toilet use	18	2	1	**21**
Bathing/showering	14	. .	7	**21**
Dressing	17	3	1	**21**
Grooming	16	. .	5	**21**
Feeding	19	2	—	**21**
Mobility (level surface)	21	—	—	**21**
Transfers	18	3	—	**21**
Stairs	8	8	5	**21**

. . Not applicable.

— Nil.

Table B4: Australian Unity RLS RVCP, number of clients by functioning in IADL at entry to RVCP

	Capability				
	Able without help	Able with help	Completely unable	Not assessable	Total
Monetary transactions (e.g. pay bills)	12	6	2	1	**21**
Telephone use	14	6	1	—	**21**
Travel to places outside of walking distance	1	16	4	—	**21**
Household chores	1	10	10	—	**21**
Shop for groceries or clothes	—	17	4	—	**21**
Prepare meals	8	10	1	—	**21**
Correctly administer own medications	10	7	3	1	**21**

— Nil.

TableB5: Morshead Home RVCP, number of clients by level of dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	12	2	1	**15**
Bladder management	7	5	3	**15**
Toilet use	13	1	1	**15**
Bathing/showering	6	. .	9	**15**
Dressing	9	5	1	**15**
Grooming	9	. .	6	**15**
Feeding	11	3	1	**15**
Mobility (level surface)	15[(a)]	—	—	**15**
Transfers	12	3	—	**15**
Stairs	2	10	4	**15**

Note: Assessment data are missing for four clients.

(a) Includes two clients who are wheelchair independent.

. . Not applicable.

— Nil.

Table B6: Morshead Home RVCP[(a)], number of clients by level of function in IADL at entry to RVCP

	Capability			
	Able without help	Able with help	Completely unable	Total
Monetary transactions (e.g. pay bills)	6	9	—	**15**
Telephone use	10	5	—	**15**
Household chores	—	6	9	**15**
Travel to places outside of walking distance	2	11	2	**15**
Shop for groceries or clothes	2	11	2	**15**
Prepare meals	3	8	4	**15**
Correctly administer own medications	14	1	—	**15**

(a) Assessment data are missing for four clients.

— Nil.

Table B7: Forest Place RVCP, number of clients by level of dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	18	8	2	**28**
Bladder management	8	11	9	**28**
Toilet use	25	3	—	**28**
Bathing/showering	4	. .	24	**28**
Dressing	7	18	3	**28**
Grooming	12	. .	16	**28**
Feeding	22	6	—	**28**
Mobility (level surface)	26[(a)]	1	1	**28**
Transfers	17	10	1	**28**
Stairs	4	3	21	**28**

(a) Includes two clients who used wheelchairs.

. . Not applicable.

— Nil.

Table B8: Forest Place RVCP, number of clients by functioning in IADL at entry to RVCP

	Capability			
	Able without help	Able with help	Completely unable	Total
Monetary transactions (e.g. pay bills)	4	10	13	**27[(a)]**
Telephone use	7	20	1	**28**
Household chores	—	2	26	**28**
Travel to places outside of walking distance	1	21	6	**28**
Shop for groceries or clothes	1	10	17	**28**
Prepare meals	—	8	20	**28**
Correctly administer own medications	7	20	1	**28**

(a) One client was reported as not assessable on this item.

— Nil.

Table B9: Southern Cross Care RVCP, number of clients by dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	17	—	1	**18**
Bladder management	16	2	—	**18**
Toilet use	16	2	—	**18**
Bathing/showering	15	. .	3	**18**
Dressing	13	5	—	**18**
Grooming	15	. .	3	**18**
Feeding	16	2	—	**18**
Mobility (level surface)	18	—	—	**18**
Transfers	16	2	—	**18**
Stairs	4	13	1	**18**

. . Not applicable.

— Nil.

Table B10: Southern Cross Care RVCP, number of clients by level of function in IADL at entry to RVCP

	Capability			
	Able without help	Able with help	Completely unable	Total
Monetary transactions (e.g. pay bills)	7	6	5	**18**
Telephone use	12	5	1	**18**
Household chores	—	13	5	**18**
Travel to places outside of walking distance	4	14	—	**18**
Shop for groceries or clothes	4	9	5	**18**
Prepare meals	1	13	4	**18**
Correctly administer own medications	11	6	1	**18**

— Nil.

Table B11: Kinston City Council RVCP, number of clients by level of dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	8	12	3	**23**
Bladder management	7	12	4	**23**
Toilet use	20	3	—	**23**
Bathing/showering	11	. .	12	**23**
Dressing	17	6	—	**23**
Grooming	16	. .	7	**23**
Feeding	21	2	—	**23**
Mobility (level surface)	22	1	—	**23**
Transfers	13	10	—	**23**
Stairs	4	13	6	**23**

. . Not applicable.

— Nil.

Table B12: Kingston City Council RVCP, number of clients by level of function in IADL at entry to RVCP

	Capability			
	Able without help	Able with help	Completely unable	Total
Monetary transactions (e.g. pay bills)	9	14	—	**23**
Telephone use	19	4	—	**23**
Household chores	—	10	13	**23**
Travel to places outside of walking distance	5	18	—	**23**
Shop for groceries or clothes	5	17	1	**23**
Prepare meals	—	19	4	**23**
Correctly administer own medications	12	11	—	**23**

— Nil.

Table B13: ECH RVCP, number of clients by level of dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	31	2	—	**33**
Bladder management	26	7	—	**33**
Toilet use	30	3	—	**33**
Bathing/showering	21	. .	5	**33**
Dressing	28	4	1	**33**
Grooming	31	. .	4	**33**
Feeding	25	2	—	**33**
Mobility (level surface)	33	—	—	**33**
Transfers	28	4	1	**33**
Stairs	5	13	15	**33**

. . Not applicable.

— Nil.

Table B14: ECH RVCP, number of clients by level of functioning in IADL at entry to RVCP

	Capability			
	Able without help	Able with help	Completely unable	Total
Monetary transactions (e.g. pay bills)	22	8	3	**33**
Telephone use	24	9	—	**33**
Household chores	1	20	12	**33**
Travel to places outside of walking distance	8	25	—	**33**
Shop for groceries or clothes	7	21	5	**33**
Prepare meals	10	18	5	**33**
Correctly administer own medications	23	10	—	**33**

— Nil.

Table B15: Resthaven RVCP, number of clients by level of dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	11	2	1	**14**
Bladder management	9	2	3	**14**
Toilet use	11	3	—	**14**
Bathing/showering	10	. .	4	**14**
Dressing	8	7	—	**14**
Grooming	9	. .	5	**14**
Feeding	13	1	—	**14**
Mobility (level surface)	13	1	—	**14**
Transfers	9	4	1	**14**
Stairs	2	11	1	**14**

. . Not applicable.

— Nil.

Table B16: Resthaven RVCP, number of clients by level of function in IADL at entry to RVCP

	Capability			
	Able without help	Able with help	Completely unable	Total
Monetary transactions (e.g. pay bills)	8	6	—	**14**
Telephone use	10	4	—	**14**
Household chores	1	11	2	**14**
Travel to places outside of walking distance	2	12	—	**14**
Shop for groceries or clothes	2	12	—	**14**
Prepare meals	3	10	1	**14**
Correctly administer own medications	4	9	1	**14**

— Nil.

Table B17: Mandurah Retirement Village RVCP, number of clients by level of dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	18	2	—	**20**
Bladder management	17	3	—	**20**
Toilet use	19	—	1	**20**
Bathing/showering	18	. .	2	**20**
Dressing	18	1	1	**20**
Grooming	18	. .	2	**20**
Feeding	19	—	1	**20**
Mobility (level surface)	20	—	—	**20**
Transfers	16	4	—	**20**
Stairs	12	5	3	**20**

. . Not applicable.

— Nil.

Table B18: Mandurah Retirement Village RVCP, number of clients by level of function in IADL at entry to RVCP

	Capability			
	Able without help	Able with help	Completely unable	Total
Monetary transactions (e.g. pay bills)	13	6	1	**20**
Telephone use	18	2	—	**20**
Household chores	—	9	11	**20**
Travel to places outside of walking distance	3	17	—	**20**
Shop for groceries or clothes	3	17	—	**20**
Prepare meals	1	9	10	**20**
Correctly administer own medications	15	3	2	**20**

— Nil.

Table B19: Aged Care Services Australia RVCP, number of clients by level of dependency in activities of daily living at entry to RVCP

	Dependency level			
	Independent	Partially dependent	Fully dependent	Total
Bowel management	35	2	—	**37**
Bladder management	23	14	—	**37**
Toilet use	30	5	2	**37**
Bathing/showering	12	. .	24	**36**[(a)]
Dressing	16	17	4	**37**
Grooming	18	. .	19	**37**
Feeding	30	5	2	**37**
Mobility (level surface)	36[(b)]	1	—	**37**
Transfers	32	4	1	**37**
Stairs	2	18	17	**37**

(a) One client was not assessed on this item

(b) Includes one client who used a wheelchair.

. . Not applicable.

— Nil.

Table B20: Aged Care Services Australia RVCP, number of clients by level of function in IADL at entry to RVCP

	Capability			
	Able without help	Able with help	Completely unable	Total
Monetary transactions (e.g. pay bills)	9	20	8	**37**
Telephone use	20	15	2	**37**
Household chores	1	14	22	**37**
Travel to places outside of walking distance	1	36	—	**37**
Shop for groceries or clothes	—	26	11	**37**
Prepare meals	3	25	9	**37**
Correctly administer own medications	15	20	2	**37**

— Nil.

Appendix 1 Assessment tools

Modified Barthel Index (adapted)

The Barthel Index measures functional independence in personal care and mobility. Please rate the client's level of need for assistance on each personal care and mobility item and record ratings directly onto the *Client Profile and Assessment Form* where indicated at *Section B.6 Client Functional Assessment* for Baseline, Interim and Final Assessments.

Bowels (preceding week)

0 = incontinent (or needs to be given enemata)

1 = occasional accident (once/week)

2 = continent

Bladder (preceding week)

0 = incontinent (or catheterised and unable to manage)

1 = occasional accident (maximum once per 24 hours)

2 = continent (for over 7 days, or catheterised and can completely manage the catheter alone)

Grooming (preceding 24–48 hours)

0 = needs help with personal care

1 = independent face/hair/teeth/shaving (implements can be provided)

Toilet use

0 = dependent

1 = needs some help, but can do some things alone

2 = independent (can reach toilet/commode, undress sufficiently, clean self, dress and leave)

Feeding

0 = unable

1 = needs help cutting, spreading butter, etc.

2 = independent (able to eat any normal food, not only soft food, cooked and served by others but not cut up)

Please turn over and continue on the next page

Transfer (from bed to chair and back)

0 = unable—no sitting balance

1 = major help (one strong/skilled or two people, physical, can sit)

2 = minor help (verbal or physical, one person easily can assist if necessary)

3 = independent

Mobility

0 = immobile

1 = wheelchair independent including corners, etc.

2 = walks with help of one person (verbal or physical)

3 = walks with use of a walker, crutches or aid other than stick

4 = independent (may use stick)

Dressing

0 = dependent

1 = needs help, but can do about half unaided

2 = independent (can select and put on all clothes, which may be adapted, including buttons, zips, laces, etc.)

Stairs

0 = unable

1 = needs help (verbal, physical, help to carry walking aid)

2 = independent up and down, carries own walking aid if applicable

Bathing

0 = dependent

1 = needs help to get in or out of bath or shower but can bathe without supervision

2 = independent (can get in and out unsupervised and wash self)

Source: Collin C, Wade DT, Davies S & Horne V 1988. The Barthel ADL Index: a reliability study. International Disability Studies 1988 (adapted). In: McDowell & Newell 1996. Measuring health: a guide to rating scales and questionnaires. 2nd edn. New York: Oxford University Press.

OARS Instrumental Activities of Daily Living (modified)

The OARS IADL (modified) measures personal functioning status for some important activities of daily living. Please rate the client's level of functioning for each activity and record ratings directly onto the *Client Profile and Assessment Form* where indicated at *Section B.6 Client Functional Assessment* for Baseline, Interim and Final Assessments.

Can the client use the telephone…

0 = completely unable to use the telephone

1 = with some help (can answer phone or dial in an emergency, but needs a special phone or help in getting the number or dialling)

2 = without help, including looking up numbers and dialling

9 = unable to assess

Can the client get to places outside of walking distance…

0 = unable to travel unless emergency arrangements are made for a specialised vehicle such as an ambulance

1 = with some help (needs someone to help him/her or go with him/her when travelling)

2 = without help (drives own car, or travels alone on buses or in taxis)

9 = unable to assess

Can the client go shopping for groceries or clothes (assuming he/she has transportation)…

0 = completely unable to do any shopping

1 = with some help (needs someone to go with him/her on all shopping trips)

2 = without help (can take care of shopping needs him/herself, assuming he/she has transportation)

9 = unable to assess

Please turn over and continue on the next page

Can the client prepare his/her own meals…

0 = completely unable to prepare any meals

1 = with some help (can prepare some things but is unable to cook full meals him/herself)

2 = without help (can plan and cook full meals for him/herself)

9 = unable to assess

Can the client do his/her housework

0 = completely unable to do any housework

1 = with some help (can do light housework but needs help with heavy work)

2 = without help (can clean floors, etc.)

9 = unable to assess

Can the client take his/her own medicine…

0 = completely unable to take his/her medicines

1 = with some help (can take medication if someone prepares it for him/her and/or reminds him/her to take it)

2 = without help (can take the right dose at the right time)

9 = unable to assess

Can the client handle his/her own money…

0 = completely unable to handle money

1 = with some help (can manage day-to-day buying but needs help managing chequebook and paying bills)

2 = without help (writes cheques, pays bills, etc.)

9 = unable to assess

Source: Fillenbaum G 1988. Multidimensional function assessment of older adults: the Duke Older Americans Resources and Services procedures. New Jersey: Lawrence Erlbaum Associates.

Caregiver Strain Index

Here is a list of things that other people have found to be difficult when caring for someone who needs support. Please circle **YES** if they apply to you or **NO** if they do not apply to you.

1.	My sleep is disturbed (e.g. because the person I care for is in and out of bed or wanders around all night)	YES / NO
2.	It is inconvenient (e.g. because helping takes so much time or it's a long drive over to help)	YES / NO
3.	It is a physical strain (e.g. because of lifting in and out of chair; effort of concentration is required)	YES / NO
4.	It is confining (e.g. helping restricts my free time or I cannot go visiting)	YES / NO
5.	There have been family adjustments (e.g. because helping has disrupted routine; there has been no privacy)	YES / NO
6.	There have been changes in personal plans (e.g. had to turn down a job; could not go on holiday)	YES / NO
7.	There have been other demands on my time (e.g. from other family members)	YES / NO
8.	There have been emotional adjustments (e.g. because of severe arguments)	YES / NO
9.	Some behaviour is upsetting (e.g. incontinence, trouble remembering things, or accusing people of taking things)	YES / NO
10.	It is upsetting to find the person I care for has changed so much from his/her former self (e.g. he/she is a different person than he/she used to be)	YES / NO
11.	There have been work adjustments (e.g. because of having to take time off)	YES / NO
12.	It is a financial strain	YES / NO
13.	Feeling completely overwhelmed (e.g. because of worry about the person I care for; concerns about how I will manage)	YES / NO
Total score (count YES responses):		

Transfer total score to Section B.6 as indicated on the *Client Profile and Assessment Form* for Baseline, Interim and Final Assessments

Source: Robinson BC 1983. Validation of a caregiver strain index. Journal of Gerontology 38(3):344–8.

Appendix 2
Care Experience Survey results

Summary of results

Overall, results from the Care Experience Survey reveal that RVCP projects are targeting clients with self-identified needs falling mainly in the areas of domestic assistance, transport and accompaniment for medical appointments and outings in the community. Approximately 43% of clients reported not having received assistance, either formal or informal, prior to the RVCP (Table 3). One in five respondents indicated the client was receiving assistance from their retirement village management and staff prior to the RVCP (Table 4). Eighty-eight of the 178 respondents indicated that they had unmet need in at least one of the 13 areas covered in question 4, and 90 respondents indicated partially met need in at least one area (Table 6). Fifty-six of the 178 respondents did not record unmet or partially met need in any of the 13 areas.

Responses to questions about the quantity and quality of service delivered through the RVCP and project staffing arrangements are overwhelmingly positive. No significant differences between projects in the total number of negative comments made by respondents across the survey were evident*. Isolated cases of dissatisfaction with Pilot services exist and appear related to the circumstances of individual clients rather than project implementation models; dissatisfaction does not appear to be systematic or widespread.

The majority of carers and family members who identified themselves as receiving support and services through the RVCP (for example, respite services) were satisfied with the type and amount of support and services provided to them. Most carers and family members (72%) indicated that the RVCP project was a suitable care option for their family member for the foreseeable future (Table 14). Where respondents expressed doubts over whether the project would be suitable in the longer term, they generally cited need for more supervision or higher level care than the project could provide (for example, because of worsening dementia) or concerns about whether project services would be sufficient to cope with needs which may increase in the future.

A sample of responses to selected open-ended questions, taken from several projects, follows.

To the question of client and family expectations of the pilot program:

'Provide enough support to remain in my/his own unit safely. At times to meet need appropriately in cooperation with other services (private).'

'The pilot program would give assistance to the client on a day-to-day basis. Reduced stress on partner and other family members. Hoping this assistance will enable us to keep the couple together for a longer period.'

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* The Kruskal Wallis test statistic on 8 and 149 degrees of freedom equals 13.75, prob > 0.05 (Siegel & Castellan 1988).

‘Greater frequency of invigilation to check for potential problems. More help with washing and cleaning, checking on meals and appetite, assistance with social interaction.’

‘Relief through massage, improved mobility through exercises. Extension of washing/ironing service to include drying. Improved bed-making arrangements.’

‘No expectation but thankful for the program.’

‘Help with the housework and taking my pills.’

To the question of how the project helps or doesn't help to meet needs and aspects most liked, clients say:

[Previously] ‘being unable to peg items on a line, no longer have to struggle to get the wet washing to the Laundromat…[now] can stay in own unit.’

‘That I am able to stay in my own unit, without going into a nursing home.’

‘The program helps give me a better quality of life.’

‘All the services are provided in the apartment. The staff are caring and they take the pressure out of the day-to-day living.’

‘Security of people coming around. Like talking to people.’

And carers and relatives say:

‘Greater invigilation has helped a lot.’

‘Less worry that his needs may not be met and that assistance is always close at hand.’

‘The additional help has achieved our initial goals, service has been excellent…the pilot has been very helpful as previously stated has taken [away] some of the stress of day-to-day care needed.’

‘Regular assistance increases confidence. Client needs time to understand how or what to ask for to meet needs…supervisor takes personal interest and gets to know client so that client is comfortable requesting assistance. Daily assistance is good for family peace of mind.’

‘Respite and the pressure off me for personal care.’

‘No actual registered nurse involved is a real deficit. At this stage in someone's care wound care and continence support are essential on a regular basis. ‘

Comments on experience in accessing community care before the RVCP:

‘Client healthy and totally independent and driving until 14 months ago. After hospitalisation ACAT and repat home care cleaning. Had to lobby hard with hospital to actually get discharge support organised and activated. Had worked in community care since 1984…change to carer a whole new ball game and rather a shock finding the deficits.’

‘We paid for “hostel-type” help [in the retirement village], but this was not sufficient—there were too few staff to invigilate and help.’

‘Previous experience was good but we just needed extra care and personal attention.’

‘Very confusing at first—no clear avenue for seeking help. Resistance from client to accept help/advice at first.’

‘On wife's admittance to nursing home, home care immediately ceased. Was reinstated after a fresh application was made but at a reduced rate.’

'HACC—OK.'

Overview of survey aims and methodology

The RVCP Care Experience Survey was designed to elicit client and family perspectives of:

- level of need for assistance
- the extent to which needs were met prior to the RVCP
- RVCP project capacity to address previously unmet needs
- quality and appropriateness of RVCP services
- the suitability of RVCP services for long-term care.

Satisfaction surveys of home care service recipients reported in the literature consistently show overwhelmingly high levels of satisfaction. Factors which may contribute to an overrepresentation of satisfaction include (Cooper & Jenkins 1998):

- social desirability—responses in line with prevailing social norms rather than accurate personal opinions
- acquiescent response—agreement with statements regardless of their content
- fear of reprisal—fear of losing access to assistance, or fear of retribution from staff
- gratitude—feeling that 'anything is better than nothing' and that clients are fortunate to be receiving any assistance at all
- low expectations
- loyalty to staff.

Anonymity, direct questions about specific aspects of services, and open-ended questions asking clients to record both good and bad aspects of services, and opportunities to provide criticisms of service delivery overall rather than criticisms of particular staff members can help to mitigate these factors and provide meaningful client satisfaction data (Cooper & Jenkins 1998).

Project coordinators were asked to issue the care experience questionnaire to each participating client allowing for services to have been in place for at least four weeks. The client or a carer was to complete the form and mail it directly to the AIHW. The survey was anonymous, though responses can be linked to client profile and assessment data using the unique client identification code recorded by the project coordinator on the front of each questionnaire before issue.

The questionnaire includes a combination of closed, limited response and open-ended questions. Respondents were asked to compare the care received from a project to 'usual care' and to report whether the project is meeting previously unmet and under-met needs. Respondents were able to comment on specific aspects of service delivery such as care planning and coordination; continuity of care; the range and availability of services; choice; convenience; privacy and security; and the physical environment. Carers were asked to assess the support and assistance they receive from the project to assist them in the caring role and to assess the suitability of project services as an option for longer term care for the care recipient.

Analysis of 178 completed questionnaires received by 31 January 2005 is summarised below. The data were analysed with frequency and cross-tabulation procedures in the SPSS computer package.

Response rate

As at 31 January 2005, 178 of the 237 questionnaires distributed had been completed and returned to the AIHW (Table 1). Response rates for individual projects range between 50% and 100%, with an overall response rate of 75%.

Table 1: RVCP Care Experience Survey, questionnaire forms distributed and received by project: analysis of survey responses to 31 January 2005

Project	Number of forms distributed	Number of forms received	Response rate (per cent)	Per cent of total response
HN McLean Memorial Retirement Village, NSW	20	12	60.0	6.7
Australian Unity RLS Incorporated, NSW	22	16	72.7	9.0
Morshead Home, ACT	21	15	71.4	8.4
Forest Place Retirement Village, Qld	28	23	82.1	12.9
Southern Cross Care, Vic	18	15	83.3	8.4
Kingston City Council, Vic	23	22	95.7	12.4
ECH Incorporated	35	24	68.6	13.5
Resthaven Incorporated, SA	14	14	100.0	7.9
Mandurah Retirement Village, WA	20	19	95.0	10.7
Aged Care Services Australia, WA	36	18	50.0	10.1
Total	**237**	**178**	**75.1**	**100.0**

Respondent identity

Respondents were asked to indicate who completed the questionnaire. It was permissible to record more than one respondent identity on each questionnaire, for example, where a carer assisted the client to complete the questionnaire, both 'client' and 'carer' are recorded. Respondent identities for most projects are varied, with the exception of questionnaires from Resthaven Inc. in South Australia which were all completed by clients with the assistance of project staff (no Resthaven clients have a carer). One hundred and twenty questionnaires were completed with the input of a client (Table 2).

Wherever possible, project coordinators were instructed to encourage completion of the questionnaire by the client with or without assistance from a carer or other involved family member. This was not always possible and 29 surveys were completed with assistance from project staff, for example, due to client's poor eyesight or impaired fine motor skills. Surveys completed with the assistance of project staff were excluded from analysis of questions directly relating to satisfaction with project staffing arrangements (Table 11). Staff assistance had the potential to influence client responses to other questions relating to project implementation, such as the quality of services, convenience of project service delivery and project planning and coordination. All surveys completed with the assistance of staff

expressed high satisfaction with all areas of project implementation; however, surveys completed without staff assistance also tended to be highly positive.

Table 2: RVCP Care Experience Survey, respondent identity by project: analysis of survey responses to 31 January 2005

Project	Client	Carer	Other relative	Project coordinator	Other advocate	Total
			(number)			
HN McLean Memorial RV	9	5	2	1	—	17
Australian Unity RLS	10	8	1	—	1	20
Morshead Home	9	6	2	2	—	19
Forest Place RV	12	11	4	3	—	30
Southern Cross Care	12	5	2	4	—	23
Kingston City Council	17	11	1	2	6	37
ECH Incorporated	15	7	3	—	4	29
Resthaven Incorporated	14	—	—	14	—	28
Mandurah RV	13	3	1	3	—	20
Aged Care Services Australia	9	9	2	—	—	20
Total	**120**	**65**	**18**	**29**	**11**	**243**
			(per cent)			
HN McLean Memorial RV	75.0	41.7	16.7	8.3	—	100.0
Australian Unity RLS	62.5	50.0	6.3	—	6.3	100.0
Morshead Home	60.0	40.0	13.3	13.3	—	100.0
Forest Place RV	52.2	47.8	17.4	13.0	—	100.0
Southern Cross Care	80.0	33.3	13.3	26.7	—	100.0
Kingston City Council	77.3	50.0	4.5	9.1	27.3	100.0
ECH Incorporated	62.5	29.2	12.5	—	16.7	100.0
Resthaven Incorporated	100.0	—	—	100.0	—	100.0
Mandurah RV	68.4	15.8	5.3	15.8	—	100.0
Aged Care Services Australia	50.0	50.0	11.1	—	—	100.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Note: Multiple responses permissible.

— Nil.

Coding framework

The AIHW engaged an external consultant to develop and test a coding framework for responses to open-ended questions and perform analysis of completed forms in their entirety.

Development of the coding framework was an iterative process. The consultant completed a thematic analysis of a small number of hand-written responses to five key open-ended questions. The first two of these questions focus on needs and expectations. Two initial lists

of 20 to 30 recurring themes were constructed, one by the consultant and one by the AIHW evaluation team. A high level of agreement was apparent and the process of cross-referencing the two lists produced a set of core themes for the initial coding framework. This list was further expanded and refined to accommodate responses to three more open-ended questions on the adequacy and quality of the project services and staffing.

The AIHW evaluation team reviewed the resulting set of codes. A number of additional codes were subsequently added to the framework until it was shown that responses to the five key open-ended questions in 50 completed questionnaires could be coded satisfactorily. The final coding framework consists of:

- 30 core themes
- 10 themes specifically associated with how the projects meet or fail to meet client needs
- nine themes that deal specifically with staffing issues
- nine themes associated with aspects of the Pilot that attract positive feedback from respondents
- nine themes associated with aspects of the Pilot that attract negative feedback from respondents
- 15 themes to cover general comments, both positive and negative.

Over 80 themes were identified in the global coding framework and used in the interim analysis. The framework has been designed so that specific themes can be combined into more general categories for reporting purposes.

The consultant tested the inter-rater reliability of coding based on responses to the most commonly answered open-ended question on a randomly selected sample of 20 completed forms. A total of 23 categories from the coding framework featured in this analysis. Ten categories had perfect agreement and a further eight categories deviated very slightly. The intraclass correlation coefficient for agreement was 0.967, indicating a very high inter-rater reliability.

Survey results

Prior sources of assistance

Seventy-seven of the 178 clients are reported as having had no assistance (from any source) prior to the RVCP (Table 3).

The most common source of assistance prior to the RVCP was family and/or friends living outside of the retirement village (73 clients).

In the 12 months prior to entering the RVCP:

- 35 clients indicated that their retirement village was a source of ongoing assistance
- 24 clients were receiving assistance from friends and/or neighbours within their retirement village.

Table 3: RVCP Care Experience Survey, sources of assistance prior to entering the project: analysis of survey responses to 31 January 2005

Source of assistance	Number of responses	Per cent
No assistance received	77	43.3
Family/friends not living in the retirement village	73	41.0
Other organisation	41	23.0
Retirement village staff	35	19.7
Friends/neighbours in the retirement village	24	13.5
District nursing service	16	9.0
Home care organised by a hospital	12	6.7
Other	20	11.2
Total respondents	**178**	**100.0**

Note: Multiple responses permissible.

More than half of respondents indicated that the client did not receive any type of service or assistance from their retirement village (98 respondents) or other community organisation (96 respondents) in the 12 months prior to entering the Pilot.

In cases where a client was receiving assistance from within the retirement village prior to the RVCP, that assistance was most likely to be home maintenance† (39 respondents), domestic assistance (30 respondents) or delivered meals (25 respondents) (Table 4). Domestic assistance (58 respondents), delivered meals (31 respondents), transport (27 respondents) and personal care (18 respondents) were the most common types of assistance received from an organisation other than the retirement village.

† This figure should be interpreted with caution—home maintenance is provided by some retirement villages as a matter of course, however, residents may not recognise this as a 'service' in the context of community aged care services. Consequently the number of clients identified as receiving this service previously may be under-estimated.

Table 4: RVCP Care Experience Survey, types of assistance received from the retirement village and other community organisations in the 12 months prior to entering the projects: analysis of survey responses to 31 January 2005

Type of assistance	Retirement village	Other organisation
	(number)	
Not applicable / none previously	99	96
Domestic assistance	30	51
Delivered meals	28	38
Home nursing	11	15
Medication prompting/supervision	14	9
Transport to appointments and/or social events	17	27
Assistance to manage financial/legal affairs	6	13
Home maintenance	39	10
Assistance to access aids and equipment	7	12
In-home respite	3	4
Respite outside of the home	6	2
Personal care	11	18
Manual handling	5	3
Assistance to manage behavioural and psychological symptoms of dementia	2	1
	(per cent)	
Not applicable/none previously	55.1	53.9
Domestic assistance	16.9	28.7
Delivered meals	15.7	21.3
Home nursing	6.2	8.4
Medication prompting/supervision	7.9	5.1
Transport to appointments and/or social events	9.6	15.2
Assistance to manage financial/legal affairs	3.4	7.3
Home maintenance	21.9	5.6
Assistance to access aids and equipment	3.9	6.7
In-home respite	1.7	2.2
Respite outside of the home	3.4	1.1
Personal care	6.2	10.1
Manual handling	2.8	1.7
Assistance to manage behavioural and psychological symptoms of dementia	1.1	0.6

Self-identified needs

Responses to question 4 give an indication of respondents' views of how well their needs in each of 13 areas were being met prior to entering the RVCP. The highest numbers of RVCP clients with any level of need for assistance (including unmet, partially met and fully met need) fall in the areas of domestic assistance, transport and assistance to access medical services (Table 5).

Eighty-eight of the 178 respondents indicated that they had unmet need in at least one of the 13 areas covered in question 4, and 90 respondents indicated partially met need in at least one area (Table 5). Fifty-six of the 178 respondents did not record unmet or partially met need in any of the 13 areas. The areas with the highest number of clients who had previously partially met or unmet need are domestic assistance (93 clients), transport (80 clients), help to access medical services (64 clients), and accompaniment at home and in the community (61 clients).

The areas of need in which fall the highest numbers of responses indicating an adequate level of assistance prior to the RVCP include home maintenance (56 clients), help to access medical services (52 clients), domestic assistance (51 clients), and transport to appointments and social events (49 clients).

Around one-third of respondents said that the client had been receiving domestic assistance but more domestic assistance was needed (56 clients). Other areas where the level of assistance prior to RVCP is reported as inadequate include transport (37 clients), help to access medical services (30 clients), and accompaniment at home and in the community (29 clients).

Transport to appointments and social events is the most frequently reported area of need where no assistance was being received prior to the RVCP (43 clients), followed by domestic assistance (37 clients), help to access medical services (34 clients), and accompaniment at home and in the community (32). The least commonly reported areas of need, that is, those most often listed as 'not applicable', are continence management, mobility assistance, nursing care at home, and help to manage the behavioural and psychological symptoms of dementia, although at least 29 respondents indicated some level of need for assistance in these areas.

These results are consistent with results from the activity of daily living assessments of RVCP clients, which show that, at baseline, most RVCP clients needed assistance with housework, meal preparation and travelling to places outside the home.

Table 5: RVCP Care Experience Survey, assessment of the adequacy of assistance received from all sources prior to RVCP: analysis of survey responses to 31 January 2005

Assistance type	Had enough help	Had some help, but more was needed	Did not have help, but help was needed	Total with identified need	Total with identified unmet/under-met need	Not applicable/did not need help[a]	Total
				(number)			
Domestic assistance	51	56	37	144	93	34	178
Home maintenance	56	23	26	105	49	73	178
Transport to appointments & social events	49	37	43	129	80	49	178
Help to get aids and equipment	37	19	23	79	42	99	178
Accompaniment at home & in community	40	29	32	101	61	77	178
Help to see a doctor when needed	52	30	34	116	64	62	178
Medication prompting/supervision	33	16	18	67	34	111	178
Personal assistance	24	16	22	62	38	116	178
Continence management	13	7	16	36	23	142	178
Mobility assistance	15	6	10	31	16	147	178
Nursing care at home	19	8	19	46	27	132	178
Physiotherapy and occupational therapy	20	11	20	51	31	127	178
Help to manage behavioural & psychological symptoms of dementia	9	5	15	29	20	149	178

(continued)

Table 5 continued: RVCP Care Experience Survey, assessment of the adequacy of assistance received from all sources prior to RVCP: analysis of survey responses to 31 January 2005

	Had enough help	Had some help, but more was needed	Did not have help, but help was needed	Total with identified need	Total with identified unmet/under-met need	Not applicable/did not need help[a]	Total
				(per cent)[b]			
Domestic assistance	35.4	38.9	25.7	. .	. .	. .	100.0
Home maintenance	53.3	21.9	24.8	. .	. .	. .	100.0
Transport to appointments & social events	38.0	28.7	33.3	. .	. .	. .	100.0
Help to get aids and equipment	46.8	24.1	29.1	. .	. .	. .	100.0
Accompaniment at home & in community	39.6	28.7	31.7	. .	. .	. .	100.0
Help to see a doctor when needed	44.8	25.9	29.3	. .	. .	. .	100.0
Medication prompting/supervision	49.3	23.9	26.9	. .	. .	. .	100.0
Personal assistance	38.7	25.8	35.5	. .	. .	. .	100.0
Continence management	36.1	19.4	44.4	. .	. .	. .	100.0
Mobility assistance	48.4	19.4	32.3	. .	. .	. .	100.0
Nursing care at home	41.3	17.4	41.3	. .	. .	. .	100.0
Physiotherapy and occupational therapy	39.2	21.6	39.2	. .	. .	. .	100.0
Help to manage behavioural & psychological symptoms of dementia	31.0	17.2	51.7	. .	. .	. .	100.0

(a) Includes missing values (assumed to be 'not applicable').

(b) Number of responses as a percentage of number of respondents who indicated the service was being received.

— Nil.

. . Not applicable.

Table 6: RVCP Care Experience Survey, respondents with unmet or under-met needs prior to entering RVCP: analysis of survey responses to 31 January 2005

	Yes	No	Total
Unmet need	88	90	**178**
Under-met need	90	88	**178**
Unmet or under-met need	122	56	**178**

Respondents' expectations of the RVCP

- 36 respondents either stated that they had no prior expectations of the project or were unsure of what to expect, or did not provide any comment.
- 164 statements related to expectations of receipt of specific types of assistance, with domestic assistance being the most commonly cited category (54 responses) (Table 7).
- 118 statements of expectation relate to intangible benefits, with increased/maintained independence most commonly cited (29 responses).
- 29 statements of expectation relate to improved service quality and value, the most common of which was enhanced service (20 responses).

Table 7: RVCP Care Experience Survey, respondents' hopes and expectations of what a project would deliver: analysis of survey responses to 31 January 2005

Theme	Number
Specific instrumental assistance/services	
Domestic assistance	54
Transport	30
Personal assistance	24
Assistance with shopping	19
Assistance with meals	13
Access to specialist services	6
Other specific instrumental assistance/services	18
Total specific instrumental assistance/services	*164*
Intangible benefits	
Independence	29
Global assistance	26
Participation	20
Reducing the burden on family/friends	20
Safety	10
Confidence/reassurance	10
Other intangible benefits	3
Total intangible benefits	*118*

(continued)

Table 7 continued: RVCP Care Experience Survey, respondents' hopes and expectations of what a project would deliver: analysis of survey responses to 31 January 2005

Theme	Number
Improved service quality and value	
Enhanced service	19
Financial assistance	7
Enhanced quality of care	4
Other improved service quality and value	7
Total improved service quality and value	*37*
No expectations, unsure, no comment	36

Note: Multiple responses permissible.

Quality and appropriateness of services

The majority of respondents (79.9%) believe that their RVCP project is addressing previously unmet needs (Table 8).

- All but one respondent believed that the pilot was addressing areas of previously unmet need, at least to some extent.
- Twenty-six respondents stated that their project was addressing some areas of unmet need, but not to the extent that they had hoped.
- Ninety-four respondents either did not comment on this aspect, or stated that they did not have any comments, or said that they were unsure of how the project helped or did not help to meet the client's needs.
- Of the themes mentioned in comments on quality and appropriateness of services, 113 were positive and 25 were negative.
- Forty-three of the positive themes relate to intangible benefits of the project, 33 relate to specific services or types of assistance the pilot provides, and specific services or assistance, and 27 are non-specific positive comments, for example, 'service is wonderful', 'everything is excellent'.
- Most negative themes related to restricted services or inflexible service delivery (17 comments).

The majority of respondents rated the quality of health and personal care services, and home and community access services as satisfactory or good to very good (Tables 9 and 10). Respondents identified a total of 63 services or aspects of projects as less than satisfactory.

Table 8: RVCP Care Experience Survey, extent to which Pilot is meeting previously unmet needs by project, analysis of survey responses to 31 January 2005

Project	Yes	Partly	No	Not stated	Total
			(number)		
HN McLean Memorial RV	11	—	—	1	12
Australian Unity RLS	13	2	—	1	16
Morshead Home	9	5	—	1	15
Forest Place RV	18	4	—	1	23
Southern Cross Care	11	4	—	—	15
Kingston City Council	22	—	—	—	22
ECH Incorporated	19	4	1	—	24
Resthaven Inc.	14	—	—	—	14
Mandurah RV	18	1	—	—	19
Aged Care Services Australia	12	6	—	—	18
Total	**147**	**26**	**1**	**4**	**178**
			(per cent)		
HN McLean Memorial RV	91.7	—	—	8.3	100.0
Australian Unity RLS	81.3	12.5	—	6.3	100.0
Morshead Home	60.0	33.3	—	6.7	100.0
Forest Place RV	78.3	17.4	—	4.3	100.0
Southern Cross Care	73.3	26.7	—	—	100.0
Kingston City Council	100.0	—	—	—	100.0
ECH Incorporated	79.2	16.7	4.2	—	100.0
Resthaven Inc.	100.0	—	—	—	100.0
Mandurah RV	94.7	5.3	—	—	100.0
Aged Care Services Australia	66.7	33.3	—	—	100.0
Total	**82.6**	**14.6**	**0.6**	**2.2**	**100.0**

Note: Includes surveys completed with the assistance of pilot project staff.

— Nil.

Table 9: RVCP Care Experience Survey, ratings of the quality of health and personal care assistance: analysis of survey responses to 31 January 2005

Type of assistance	Good to very good	Satisfactory	Less than satisfactory	Not applicable[(a)]	Total
			(number)		
Medication prompting/supervision	47	15	2	114	178
Weekend/evening emergency assistance	42	28	3	105	178
Provision of aids and equipment	41	18	3	116	178
Personal assistance	60	19	2	97	178
Continence management	19	10	2	147	178
Mobility assistance	17	17	2	142	178
Nursing care	44	12	1	121	178
Management of behavioural and psychological symptoms of dementia	9	12	5	152	178
Physiotherapy and occupational therapy	22	7	4	145	178
			(per cent)[(b)]		
Medication prompting/supervision	73.4	23.4	3.1	. .	. .
Weekend/evening emergency assistance	57.5	38.4	4.1	. .	. .
Provision of aids and equipment	66.1	29.0	4.8	. .	. .
Personal assistance	74.1	23.5	2.5	. .	. .
Continence management	61.3	32.3	6.5	. .	. .
Mobility assistance	47.2	47.2	5.6	. .	. .
Nursing care	77.2	21.1	1.8	. .	. .
Management of behavioural and psychological symptoms of dementia	34.6	46.2	19.2	. .	. .
Physiotherapy and occupational therapy	66.7	21.2	12.1	. .	. .

(a) Includes missing values.

(b) Number of responses as a percentage of number of respondents who indicated they received the service.

Note: Includes surveys completed with the assistance of pilot project staff.

. . Not applicable.

Table 10: RVCP Care Experience Survey, ratings of the quality of home and community access assistance: analysis of survey responses to 31 January 2005

Type of assistance	Good to very good	Satisfactory	Less than satisfactory	Not applicable[a]	Total
			(number)		
Domestic assistance	120	34	4	20	178
Food service (meal preparation or delivered meals)	74	29	5	70	178
Assistance with laundry	70	29	7	72	178
Home maintenance	38	14	9	117	178
Home modifications	29	11	4	134	178
Social support and accompaniment	63	18	5	92	178
Transport to appointments and social events	74	27	3	74	178
Day leisure and recreational programs	32	17	4	125	178
Interpreting and translating service	5	3	—	170	178
			(per cent)[b]		
Domestic assistance	75.9	21.5	2.5	. .	. .
Food service (meal preparation or delivered meals)	68.5	26.9	4.6	. .	. .
Assistance with laundry	66.0	27.4	6.6	. .	. .
Home maintenance	62.3	23.0	14.8	. .	. .
Home modifications	65.9	25.0	9.1	. .	. .
Social support and accompaniment	73.3	20.9	5.8	. .	. .
Transport to appointments and social events	71.2	26.0	2.9	. .	. .
Day leisure and recreational programs	60.4	32.1	7.5	. .	. .
Interpreting and translating service	62.5	37.5	—	. .	. .

(a) Includes missing values.

(b) Number of responses as a percentage of number of respondents who indicated they received the service.

Note: Includes surveys completed with the assistance of pilot project staff.

. . Not applicable.

—- Nil.

Across the projects, the majority of respondents rated staffing arrangements as good to very good (108 responses) or satisfactory (35 responses) (Table 11). Very few respondents from any project rated staffing arrangements as less than satisfactory (six respondents).

Table 11: RVCP Care Experience Survey, ratings of project staffing arrangements by project: analysis of responses to 31 January 2005

Project	Good to very good	Satisfactory	Less than satisfactory	Total
		(number)		
HN McLean Memorial RV	8	3	—	11
Australian Unity RLS	14	2	—	16
Morshead Home	8	3	2	13
Forest Place RV	14	5	1	20
Southern Cross Care	9	2	—	11
Kingston City Council	19	1	—	20
ECH Incorporated	16	5	3	24
Mandurah RV	13	3	—	16
Aged Care Services Australia	7	11	—	18
Total	**108**	**35**	**6**	**149**
		(per cent)		
HN McLean Memorial RV	72.7	27.3	—	100.0
Australian Unity RLS	87.5	12.5	—	100.0
Morshead Home	61.5	23.1	15.4	100.0
Forest Place RV	70.0	25.0	5.0	100.0
Southern Cross Care	81.8	18.2	—	100.0
Kingston City Council	95.0	5.0	—	100.0
ECH Incorporated	66.7	20.8	12.5	100.0
Mandurah RV	81.3	18.8	—	100.0
Aged Care Services Australia	38.9	61.1	—	100.0
Total	**72.5**	**23.5**	**4.0**	**100.0**

Note: Excludes the 29 surveys completed with assistance from pilot project staff.

— Nil.

Examples of responses to question 12: How would you rate the staffing arrangements for delivery of pilot program services?

'Excellent staff—caring, attentive and always pleasant and professional.'

'Difficult at beginning as no communication with family/principal carer.'

'Often not proactive.'

'Some staff are excellent.'

'The two ladies who care for my mother are lovely and Mum is very happy thank you.'

'I understand there are teething problems in such programs in the beginning but now it is very good and the coordinator is most helpful and is doing an excellent job.'

‘Very friendly and most cooperative at all times.’

‘Numerous difficulty [sic] with staff changes and suitability of carers. At times services (e.g. home carers) did not arrive at the arranged time.’

‘Meal preparation skills inadequate [but] in general very happy with delivery.’

A majority of respondents reported that services were delivered in a convenient manner most or all of the time (163 respondents) (Table 12). Six respondents reported that project services were sometimes or often inconvenient, and nine respondents were undecided or did not answer the question.

Table 12: RVCP Care Experience Survey, ratings of convenience of project services by project: analysis of responses to 31 January 2005

Project	Always or mostly convenient	Sometimes inconvenient	Often inconvenient	Undecided	Missing	Total
			(number)			
HN McLean Memorial RV	11	1	—	—	—	12
Australian Unity RLS	14	1	—	1	—	16
Morshead Home	8	2	1	1	3	15
Forest Place RV	22	—	—	1	—	23
Southern Cross Care	14	1	—	—	—	15
Kingston City Council	21	—	—	1	—	22
ECH Incorporated	22	—	—	1	1	24
Resthaven Inc.	14	—	—	—	—	14
Mandurah RV	19	—	—	—	—	19
Aged Care Services Australia	18	—	—	—	—	18
Total	**163**	**5**	**1**	**5**	**4**	**178**
			(per cent)			
HN McLean Memorial RV	91.7	8.3	—	—	—	100.0
Australian Unity RLS	87.5	6.3	—	6.3	—	100.0
Morshead Home	53.3	13.3	6.7	6.7	20.0	100.0
Forest Place RV	95.7	—	—	4.3	—	100.0
Southern Cross Care	93.3	6.7	—	—	—	100.0
Kingston City Council	95.5	—	—	4.5	—	100.0
ECH Incorporated	91.7	—	—	4.2	4.2	100.0
Resthaven Inc.	100.0	—	—	—	—	100.0
Mandurah RV	100.0	—	—	—	—	100.0
Aged Care Services Australia	100.0	—	—	—	—	100.0
Total	**91.6**	**2.8**	**0.6**	**2.8**	**2.2**	**100.0**

Note: Includes surveys completed with the assistance of pilot project staff.

— Nil.

Table 13: RVCP Care Experience Survey, aspects of services rated less than satisfactory by at least one respondent: analysis of survey responses to 31 January 2005

Service rated less than satisfactory	Number responses	Number projects	Reasons
Weekend, evening & emergency assistance	2	2	Limited availability
Staffing	2	2	Limited availability Problems with staff
Domestic services:			
Meal preparation	3	2	Inconvenient Other factors
Assistance with laundry	7	6	Limited availability Inconvenient Problems with staff
Shopping	1	1	Problems with staff
Home maintenance and gardening	7	4	Limited availability Other factors
Medical services and allied health	6	4	Limited availability Inconvenient Other factors
Aids, equipment and home modifications	5	4	Other factors
Management of behavioural and psychological symptoms of dementia	4	4	Limited availability Problems with staff Other factors
Social support	5	4	Limited availability Other factors
Leisure and recreation	3	3	Limited availability Problems with staff
Transport services	2	2	Inconvenient Other factors
Unspecified	7	4	Limited availability Too costly Inconvenient Problems with staff

Table 13 shows that negative ratings for specific services are recorded against between one and six projects, depending on the particular service type. There is no instance of a relatively high number of negative responses to any one or more service types across all projects. High cost does not feature prominently as a reason for dissatisfaction; poor ratings are more likely to be related to staffing issues or limited availability.

In summary, where a higher number of negative responses to a particular service type occur, they appear across a number of projects and there is generally no consistent pattern of negative responses emanating from specific projects.

Examples of aspects of projects identified as unsatisfactory by respondents:

'Wound management too little too late.'

'[Client] would like to socialise more, limited by transport, appropriate activities and low level dementia.'

'Taking too long to replant garden.'

'Physiotherapy and occupational therapy (client unwilling to participate).'

'Painting unsatisfactory.'

'Management of behavioural and psychological symptoms of dementia—no help.'

'Staff time too short.'

Support provided to carers and family members

Part C of the questionnaire asks carers and family members for their perspective of the RVCP. Seventy-eight forms were completed with the input of a carer and/or other family member.

- 57 carers and family members (73%) believed that the project increased their awareness of the support services available to them, four did not feel the project had increased their awareness, and five were undecided.
- 54 carers and family members (69%) reported that the project provided them with enough help to support them in their caring role, five felt that the project did not provide them with enough support, and six were undecided.
- 29 carers and family members (37%) rated the respite options provided to them by the project as suitable, two believed that the respite options provided by the project were unsuitable, and 15 were undecided.
- 22 carers and family members (28%) indicated that they were receiving enough respite through the project, two did not feel the amount of respite they were receiving was enough, and eight were undecided.

Overall, the majority carers and family members who identified themselves as receiving support and services through the RVCP (for example, respite services) were satisfied with the type and amount of support and services provided.

The survey also asked carers and family members about who they had approached for advice or assistance to care for their relative or friend prior to the RVCP, and their awareness of Commonwealth-funded carer support and information services.

- Carers and family members had most commonly approached retirement village staff (46%), an Aged Care Assessment Team (37%) and/or their general practitioner (31%) for advice or assistance prior to the RVCP.
- Awareness of Commonwealth carer support and information services is low, even after participation in the RVCP. Seven out of the 78 respondents had heard of Commonwealth Carelink Centres, two had heard of Commonwealth Carer Resources Centres, 12 had heard of Commonwealth Carer Respite Centres, and six had heard of the Dementia Helpline (1800 freecall number).

RVCP model as a long-term care option

Carers and family members were asked to assess the suitability of their project as a long-term care option for the care recipient (Table 14). Fifty-six of the 78 carers and family members (72%) believe the RVCP project could support the client for the foreseeable future. Three respondents believe that the RVCP project is unsuitable, and seven were unsure about the project's suitability in the longer term.

Table 14: RVCP Care Experience Survey, carers' and family members' assessment of projects as a long-term care option for the care recipient: analysis of survey responses to 31 January 2005

Project	Suitable	Unsuitable	Unsure	Not applicable	Missing data
			(number)		
HN McLean Memorial RV	6	—	—	1	7
Australian Unity RLS	3	—	1	4	8
Morshead Home	4	—	3	—	7
Forest Place RV	9	—	1	4	14
Southern Cross Care	5	1	—	—	6
Kingston City Council	10	—	—	1	11
ECH Inc.	6	1	1	2	10
Mandurah RV	4	—	—	—	4
Aged Care Services Australia	9	1	1	—	11
Total	**56**	**3**	**7**	**12**	**78**
			(per cent)		
HN McLean Memorial RV	85.7	—	—	14.3	100.0
Australian Unity RLS	37.5	—	12.5	50.0	100.0
Morshead Home	57.1	—	42.9	—	100.0
Forest Place RV	64.3	—	7.1	28.6	100.0
Southern Cross Care	83.3	16.7	—	—	100.0
Kingston City Council	90.9	—	—	9.1	100.0
ECH Inc.	60.0	10.0	10.0	20.0	100.0
Mandurah RV	100.0	—	—	—	100.0
Aged Care Services Australia	81.8	9.1	9.1	—	100.0
Total	**71.8**	**3.8**	**9.0**	**15.4**	**100.0**

— Nil.

Respondents who believe that the RVCP is a suitable care option in the longer term commented:

'At the moment, my mother is able to stay in her own home. I am in the process of investigating hostel accommodation as she will need more intensive care in the near future.'

'If through careful counselling we are able to hand over some of the care. It has the potential to enable us to keep our family member happy in her own home. '

'Assuming Mum's health remains constant.'

'I think we are very well treated. I am quite happy here.'

'Without the program we would be looking at nursing care. Her needs are long term. This would be cost saving as her dementia would accelerate and she would need high level care.'

'For someone […] with no wound care and RN areas it would be fine. For someone living alone more coordinated visits and involvement would improve it.'

'Until my father deteriorates to the point where he needs a nursing home to administer the high care.'

Respondents who believed that the project was not a suitable care option for the client in the future commented:

'Mum's dementia slipped dramatically so family felt that mum required full-time assistance through hostel care.'

'If incontinence was an issue during day or night—no help would be to hand.'

'Due to onset of Alzheimer's it will become more and more difficult to leave this client unsupervised without staff for some hours.'

Respondents who were unsure about whether the client could be maintained on the project in the longer term commented:

'It could be if they were young enough and the charges don't go up.'

'Yes unless my mother's dementia worsens or/and [sic] she has a severe deterioration. Long live the Carer's Pilot Scheme.'

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