4 Living longer in the community

This chapter considers the impact of the additional services available to clients through the Pilot on accommodation outcomes recorded during the evaluation.

4.1 Short-term accommodation outcomes

Accommodation status recorded at the end of the evaluation shows stability of residence for the majority of participants, despite reports of increasing age-related support needs. Between 14 June and 30 November 2004, only 13 of the 147 evaluation participants in 2004 (8.8%) ceased receiving services from projects, five of whom entered high level residential aged care (Table 4.1).

Table 4.1: Innovative Pool Disability Aged Care Interface Pilot, discharge outcomes current 30 November 2004

Status 30 Nov 2004	Number of clients	Per cent	Service episode median (days)	Range of ADL scores at entry (min–max)
Continuing client	134	91.2	190	0–20
Deceased	5	3.4	210	1–13
Residential aged care	5	3.4	266	3–20
Other[(a)]	3	2.0	186	10–12
Total[(b)]	**147**	**100.0**	**190**	**0–20**

(a) Includes one client who no longer needed assistance and two clients referred to other programs.

(b) Excluding 18 evaluation participants in the Cumberland Prospect project who commenced services after 30/11/04.

Those clients who entered residential aged care either registered very low ADL scores when they joined a project or experienced severe deterioration in ADL functioning after joining. Four of these clients recorded a baseline ADL score at or below the level at which an individual is likely to be able to remain in the community for the longer term (12 points). The fifth client entered a project with a high ADL score but experienced functional decline between the first and second assessments and at the time of the second assessment scored just 7 points on the Modified Barthel Index, reducing to 4 points at time of discharge.

Approximately 48% of evaluation participants who were still with their projects at the end of November 2004 had recorded an entry ADL score of 12 points or lower. For most older people, such a low level of self-care and mobility functioning is likely to result in residential aged care placement (failing the 24-hour presence of a committed primary carer), yet this high proportion of disability clients were able to be maintained at home. Thus, though low or rapidly declining ADL function was a common factor among clients who were transferred to residential aged care, other clients with similar ADL profiles were able to be maintained in place through the combination of usual care and additional support from Pilot services.

Individual client experiences appear to reflect risk factors in addition to functional decline, some of which may be situational. Four of the five discharges to residential aged care took place in projects in New South Wales, of which three clients were in the Far North Coast project. One of the larger disability service providers participating in this project provides

supported accommodation in privately leased homes. The physical environment of a home may not be conducive to ageing in place but it is not always possible to make minor modifications under leasing arrangements. Another factor found to impact on longer term community living is availability of a 24-hour staff roster. Pilot projects have helped to address gaps in daytime rosters but even this could be insufficient for a client who requires 24-hour supervision.

Staff in participating accommodation services expressed concern about their ability to maintain Pilot clients at home should the additional support be withdrawn because there is no other community-based alternative. Pilot services are addressing age-related needs in the target group which are not expected to resolve, indeed which are generally observed to increase over time.

4.2 Levels of additional support for ageing in place

In addition to case management, projects delivered between 0.1 and 37.3 additional hours of additional support per client per week, counting additional hours of personal assistance, domestic assistance, allied health care, nursing care, social support, leisure and recreation programs and living skills development (Table 4.2). These additional services were directly related to care plans developed jointly to address clients' identified age-related needs. A range of other types of assistance not recorded in hours are not included in these figures, for example, transport services, medication review, and referrals to health services such as geriatricians, general practitioners and dieticians. The extensive range of service types and levels of service delivered to clients reflects the variation in individual age-related needs within the target group.

Table 4.2: Innovative Pool Disability Aged Care Interface Pilot projects, summary statistics for additional support services per client per week during the evaluation, by project (hours)[(a)]

Project	Clients	Minimum	Median	Maximum	Mean
Far North Coast Disability and Aged Care Consortium, NSW	13	0.1	6.0	15.7	6.9
Central West People with a Disability, NSW	30	0.9	11.4	37.3	12.0
Northern Sydney Disability Aged Care Pilot, NSW	23	0.1	0.1	7.2	1.9
Flexible Aged Care Packages, SA	30	0.6	4.4	10.2	4.6
Disability and Ageing Lifestyle Project, SA	7	6.0	15.2	19.5	13.9
Disability Aged Care Service, WA	18	0.5	2.5	6.9	3.1
Cumberland Prospect Disability Aged Care Pilot, NSW	17	0.4	6.7	9.1	5.7
Subtotal	*136*	*0.1*	*4.9*	*37.3*	*6.4*
Ageing In Place[(b)], Tas	7	19.4	23.7	41.4	25.1
Total	**143**	**0.1**	**5.4**	**41.4**	**7.3**

(a) Includes services measured in time units: personal assistance, domestic assistance, allied health services, nursing care, social support, and leisure and recreation programs and living skills development. Excludes case management time, transport, food services, medication review and time involved in referring clients to other services.

(b) Ageing In Place is a fully integrated case management and service delivery model. These figures include disability support and ageing needs support.

Time spent on initial needs assessment varied between 1 and 27 hours per client, with a mean across the projects of 7.2 hours per client (Table 4.3). A number of factors influenced the time spent on initial needs assessment. Most clients had completed initial needs assessment before the start of the evaluation and some coordinators relied on recall to estimate the time spent on initial assessments, which meant that the same number of hours was recorded for every client. For example, initial needs assessment for all Ageing In Place clients was completed well in advance of project establishment at the time when Oakdale Services was surveying clients for ageing needs to develop a funding proposal. Other projects were able to report initial needs assessment time from file records. Actual time taken depends on the complexity of client needs, number of referrals made for further assessment and whether these other assessments involve lengthy follow-up by the project coordinator, and the quality of documentation flowing from disability service providers to project coordinators.

Case management from project coordinators is in addition to case management performed by disability services. Project coordinators kept records of the number of contacts with a client or with a client's disability service provider beyond the initial needs assessment for the purpose of care plan review and service adjustment. Table 4.4 gives an indicative number of contacts per client service episode, highlighting that ongoing case management is a feature of the additional support given to clients.

Table 4.3: Innovative Pool Disability Aged Care Interface Pilot, summary statistics for time spent on initial needs assessment per client, by project

		Initial needs assessment time per client (hours)				
Project	**Number of records**	**Minimum**	**Median**	**Maximum**	**Mean**	**Standard deviation**
Far North Coast Disability and Aged Care Consortium, NSW	13	5.5	9.5	15.5	9.8	2.7
Central West People with a Disability, NSW	30	1.5	1.5	1.5	1.5	n.a.
Northern Sydney Disability Aged Care Pilot, NSW	22	12.0	17.5	27.0	20.2	5.2
Flexible Aged Care Packages, SA	31	1.0	1.0	1.0	1.0	n.a.
Disability and Ageing Lifestyle Project, SA	7	7.0	7.0	7.0	7.0	n.a.
Disability Aged Care Service, WA	18	6.0	9.0	9.0	8.8	0.7
Ageing In Place, Tas	7	4.0	4.0	4.0	4.0	n.a.
Cumberland Prospect Disability Aged Care Pilot, NSW	18	1.5	11.0	16.5	8.9	4.9
Total	**146**	**1.0**	**5.0**	**27.0**	**7.2**	**7.1**

n.a. Not applicable.

Table 4.4: Innovative Pool Disability Aged Care Interface Pilot, summary statistics for number of ongoing case management events (contacts) per client service episode, by project

		Case management contacts per client service episode				
Project	Number of records	Minimum	Median	Maximum	Mean	Standard deviation
Far North Coast Disability and Aged Care Consortium, NSW	13	11	17	26	17.6	4.9
Central West People with a Disability, NSW	30	2	5	9	5.8	1.7
Northern Sydney Disability Aged Care Pilot, NSW	22	17	42	48	38.6	8.1
Flexible Aged Care Packages, SA	18	0	1.5	3	1.6	0.8
Disability and Ageing Lifestyle Project, SA	6	2	2	2	2.0	. .
Disability Aged Care Service, WA	18	14	88	102	76.9	24.9
Ageing In Place, Tas	7	3	3	4	3.1	0.4
Cumberland Prospect Disability Aged Care Pilot, NSW	8	5	5	5	5.0	. .
Total	**123**	**0**	**7**	**102**	**22.6**	**28.0**

. . Not applicable.

4.3 Main findings

The evaluation coincided with a period of stability of residence for most Pilot participants. A link between receipt of pilot services and stability of residence is difficult to establish because of the observational nature of the evaluation and the diverse circumstances and support needs of clients. ACAT approval for high level residential care is not considered a reliable guide because for many clients ACAT assessment was initiated only because of the Disability Aged Care Interface Pilot.

Approximately 48% of evaluation participants who were still with their projects at the end of November 2004 had recorded an entry ADL score of 12 points or lower. For most older people, such a low level of self-care and mobility functioning is likely to result in residential aged care placement (failing the 24-hour presence of a committed primary carer), yet this high proportion of disability clients were able to be maintained at home. Thus, though low or rapidly declining ADL function was a common factor among clients who were transferred to residential aged care, other clients with similar ADL profiles were able to be maintained in place through the combination of usual care and additional support from Pilot services.

It is reasonable to conclude from the available evidence that around 7 hours of additional support per week, on average, has reduced pressure on disability support staff and improved the quality of life of Pilot participants and their household companions. Maximum levels of additional support during the reporting period ranged up to 37 hours per client per week. On this basis it could be concluded that a proportion of clients with high age-related

need were at risk of transfer to residential aged care but were able to be maintained at home with Pilot services.

Partners in the Pilot identified the following factors as presenting risks to remaining at home in the community for members of the target group:

- severe mobility limitation which would require, for example, the use of a lifter and the presence of two members of staff for transfers
- physical, cognitive and/or behavioural decline to the extent that extended periods of daytime supervision and assistance are required
- sleep disturbances, especially in group homes that do not have an overnight staff roster
- altered psychological and behavioural patterns that impact on other residents and staff
- physical home environments that cannot be suitably adapted for the use of aids and equipment.

Whether a level of additional support helps a client to remain at home for longer than would otherwise be possible therefore depends on the extent to which the specific risks for the individual can be reduced or compensated. These can encompass any or all of individual need characteristics, home physical environment, household routines and culture, for example, the ages and activity patterns of other residents, culture and philosophy of the disability service and the beliefs and practices of staff in the home, and family involvement. The process of comprehensive assessment involving project coordinators, disability support staff and ACAT has identified the risks that apply in a given situation and projects have clearly tailored interventions to individual needs. Some interventions are designed to mitigate immediate risk of transfer to residential aged care, for example, disability-specific 24-hour nursing care for multiple sclerosis clients, additional personal assistance, provision of mobility and continence aids, and physical maintenance programs. Other interventions produce immediate benefits to clients but their impact on rates of transfer to residential aged care can only be measured over the longer term if indeed 'measurement' is possible (increased social participation and self-directed leisure, for instance).

The Pilot has brought an awareness of ageing processes and age-appropriate interventions. According to project coordinators, staff in some supported accommodation services showed little prior knowledge in this area but the Pilot has provided on-the-job training and support tailored to the needs of individual clients. Skills transfer will potentially benefit not just Pilot participants but all clients in a household. We caution against any generalisation on capability for aged care assessment and intervention within disability services because it was also observed that in other cases resources rather than knowledge appears to have been the major impediment prior to the Pilot. In these circumstances, the Pilot has created a mechanism by which disability services are able to respond to observed changes that would otherwise be impossible due to boundaries between aged care and disability services, structural inflexibilities within the disability services sector, and funding constraints that seem to rule out local initiative.

We conclude that the Pilot has helped people with disabilities to live longer at home as they age in two ways: first, by fostering an awareness of age-related change through comprehensive assessment and second, by enabling aged care intervention. In all cases the source of referral has been the client's supported accommodation service, so that in a hypothetical mainstream service scenario the capability of staff working in supported accommodation services to identify clients with age-related needs would be critical. Staff selection, training and support, and documentation practices are fundamental in this regard. The Pilot top-up model is effective in helping clients stay at home as long as it delivers both

additional hours of support to clients and support for disability workers to acquire knowledge and apply workplace practices which support ageing clients.

5 Cost of Pilot services

This chapter contains an analysis of project income and expenditure in consideration of the third evaluation question on the cost of Pilot services. Project financial and occupancy reports for the quarters ending 30 September and 31 December 2004 are the source of material presented here.

5.1 Comparative cost of Pilot services

In the financial reporting period for the evaluation, flexible care subsidy payments totalling $2.13 million were reported by all projects with the exception of MS Changing Needs and Cumberland Prospect Disability Aged Care Pilot (Table 5.1; figures are subject to verification by the Department of Health and Ageing). MS Changing Needs did not report income. Cumberland Prospect reported financial results for the quarters ending 31 March and 30 June 2005 (Table 5.2). Projects derived most of their income from flexible care subsidy payments.

Flexible care subsidy payments ranged from $30.73 to $68.50 per place day (Table 5.3), being the prices paid by the Australian Government to deliver additional support to disability clients with age-related needs. There is currently no mainstream community care alternative to the Pilot 'top-up' model of aged care for these clients. Residential care basic subsidy for high level care as at 1 July 2004 was between $92.27 (RCS 3) and $121.16 (RCS 1) with minor variation for different state and territory locations. Additional Australian Government subsidy amounts are payable for residents with certain special nursing care needs.

People who enter high level residential aged care also contribute to the cost of their care in the form of basic daily care fees and, possibly, additional (means tested) daily care fees and accommodation charges (based on an assets test). Most people in the Disability Aged Care Interface Pilot receive the Disability Support Pension or Age Pension as their primary source of income. People in this situation would not normally pay additional daily care fees and accommodation charges for residential aged care (the basic daily care fee is set at 85% of the full pension). People living in disability-funded community accommodation also generally contribute to the cost of board and lodgings. Arrangements vary across and within the states and territories and depend on individual circumstances. Information provided to the AIHW indicates that a client in receipt of the Disability Support Pension would typically contribute up to 75% of the Pension towards the cost of board and lodging in a disability-funded accommodation service.

It is not strictly valid to compare levels of flexible care subsidy for Pilot services to residential aged care subsidy except from the point of view of Aged Care Program funding alone. Flexible care subsidy payments for Pilot clients are in addition to contributions from state governments for accommodation support services and any other specialist disability services that clients may be accessing at the same time as receiving Pilot services. Projects reported contributions made under the CSTDA for the provision of accommodation services to Pilot clients in the range $27 to $391 per client per day. Some of the figures supplied are known to be unreliable and it became clear that the evaluation would not be able to report average per client total funding levels.

Table 5.1: Innovative Pool Disability Aged Care Interface Pilot, income and expenditure, quarters ending 30 September and 31 December 2004, by project

	Income					Expenditure			
Project	Flexible care subsidy[(a)]	Other income[(b)]	Total new income	Funds carried forward	Total available funds	Services expenditure	Non-services expenditure	Total expenditure	Expenditure as a per cent of new income
FNCDAC, NSW									
September quarter	175,177	735	175,912	228,135	404,047	50,021	39,409	89,430	50.8
December quarter	116,785	742	117,527	330,461	447,988	36,703	53,191	89,894	76.5
Total	*291,962*	*1,477*	*293,439*	*558,596*	*852,035*	*86,724*	*92,600*	*179,324*	61.1
CWPDA, NSW									
September quarter	463,680	—	463,680	370,505	834,185	73,491	27,247	100,738	21.7
December quarter	226,800	—	226,800	733,447	960,247	91,555	41,769	133,324	58.8
Total	*690,480*	—	*690,480*	*1,103,952*	*1,794,432*	*165,046*	*69,016*	*234,062*	33.9
NSDACP, NSW									
September quarter	205,114	—	205,114	291,262	496,376	36,069	28,302	64,371	31.4
December quarter	405,769	—	405,769	291,262	697,031	92,419	45,563	137,982	34.0
Total	*610,883*	—	*610,883*	*582,524*	*1,193,407*	*128,488*	*73,865*	*202,353*	33.1
FACP, SA									
September quarter	149,833	3,961	153,794	295,667	449,461	62,251	49,575	111,826	72.7
December quarter	—	3,911	3,911	337,635	341,546	55,938	55,504	111,442	(b)
Total	*149,833*	*7,872*	*157,705*	*633,302*	*791,007*	*118,189*	*105,079*	*223,268*	141.6[(b)]
DALP, SA									
September quarter	—	—	—	29,985	29,985	10,212	–514	9,698	—
December quarter	55,314	—	55,314	—	55,314	18,277	–5,168	13,109	23.7
Total	*55,314*	—	*55,314*	*29,985*	*85,299*	*28,489*	*–5,682*	*22,807*	41.2

(continued)

Table 5.1 (continued): Innovative Pool Disability Aged Care Interface Pilot, income and expenditure, quarters ending 30 September and 31 December 2004, by project

	Income					Expenditure			
Project	Flexible care subsidy[(a)]	Other income[(b)]	Total new income	Funds carried forward	Total available funds	Services expenditure	Non-services expenditure	Total expenditure	Expenditure as a per cent of new income
DACS, WA									
September quarter	125,012	—	125,012	112,510	237,522	50,035	64,848	114,883	91.9
December quarter	125,013	—	125,013	122,639	247,652	56,169	57,586	113,755	91.0
Total	*250,025*	—	*250,025*	*235,149*	*485,174*	*106,204*	*122,434*	*228,638*	91.4
AIP, Tas									
September quarter	39,569	34,291	73,860	–8,674	65,186	31,310	21,783	53,093	71.9
December quarter	39,569	33,329	72,898	12,093	84,991	30,808	43,088	73,896	101.4
Total	*79,138*	*67,620*	*146,758*	*3,419*	*150,177*	*62,118*	*64,871*	*126,989*	86.5
Total excluding MS Changing Needs									
September quarter	1,158,385	38,987	1,197,372	1,319,390	2,516,762	313,389	230,650	544,039	57.6
December quarter	969,250	37,982	1,007,232	1,827,537	2,834,769	381,869	291,533	673,402	56.7
Total	*2,127,635*	*76,969*	*2,204,604*	*3,146,927*	*5,351,531*	*695,258*	*522,183*	*1,217,441*	*57.1*
MS Changing Needs, Vic									
September quarter	n.r.	n.r.	n.r.	—	—	109,171	—	109,171	n.a.
December quarter	n.r.	n.r.	n.r.	65,870	n.r.	109,171	—	109,171	n.a.
Total	*n.a.*	*n.a.*	*n.a.*	*65,870*	*n.a.*	*218,343*	—	*218,343*	*n.a.*

(a) Subject to verification by Department of Health and Ageing.

(b) Other income includes state government and auspice body grants (AIP only), client co-payments, and interest earned on project funds.

— Nil; n.r. Not reported; n.a. Not available.

Source: Project financial reports to AIHW.

Table 5.2: Cumberland Prospect Disability Aged Care Pilot, income and expenditure in quarters ending 31 March and 30 June 2005

	Income					Expenditure			
Project	Flexible care subsidy[(a)]	Other income	Total new income	Funds carried forward	Total available funds	Services expenditure	Non-services expenditure	Total expenditure	Expenditure as a per cent of new income
March quarter	44,859	—	44,859	—	44,859	34,057	10,802	44,859	100.0
June quarter	120,236	—	120,236	—	120,236	77,396	42,840	120,236	100.0
Total	**165,095**	**—**	**165,095**	**—**	**165,095**	**111,453**	**53,642**	**165,095**	**100.0**

(a) Subject to verification by Department of Health and Ageing.

Note: Project established in December 2004 with initial intake of clients continuing through to May 2005.

Source: Project financial reports for March and June 2005.

Table 5.3: Innovative Pool Disability Aged Care Interface Pilot, flexible care subsidy payments and client co-payments to projects per client service day

	Daily payments ($)	
	Flexible care subsidy	Client co-payment
Far North Coast Disability and Aged Care Consortium	63.47	—
Central West People with a Disability who are Ageing	63.00	—[(a)]
Northern Sydney Disability Aged Care Pilot	63.70	—
MS Changing Needs	60.32	—
Flexible Aged Care Packages	54.73	0.73[(b)]
Disability and Ageing Lifestyle Project	30.73	—
Disability Aged Care Service	68.50	—
Ageing In Place	61.94	—
Cumberland Prospect Disability Aged Care Pilot	60.00	—

(a) One CWPDA client is recorded as paying $29.63 per day for the project, whereas all other CWPDA clients did not pay a co-payment.

(b) From nil to $1.43 per day.

— Nil.

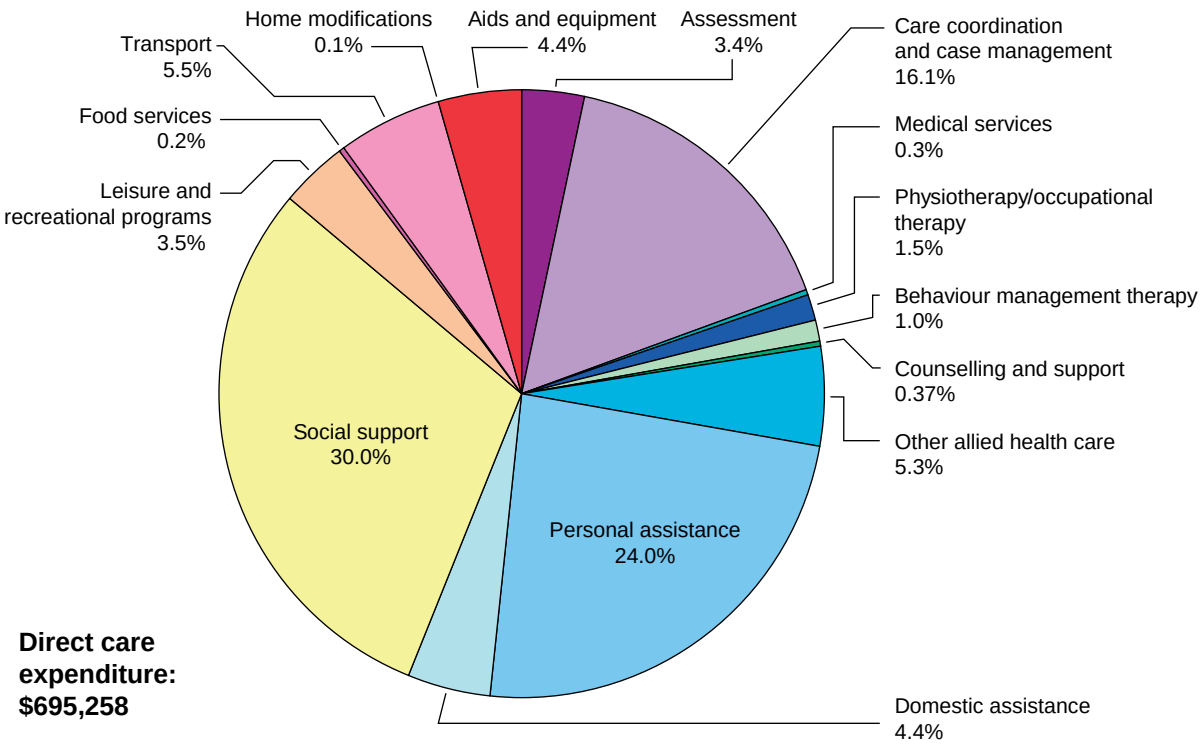
Source: Department of Health and Ageing (flexible care subsidy rates); evaluation database (client co-payment rates).

5.2 Expenditure patterns

Project expenditure reports detail expenditure on all activity covering evaluation participants and non-participating clients.

Projects reported spending between 33% and 100% of new income (new income excludes funds carried over from previous quarters) in the reporting period covered by evaluation (see expenditure as a per cent of new income, Tables 5.1 and 5.2). Department of Health and Ageing state offices monitored project occupancy and adjusted flexible care subsidy payments accordingly; some adjustments occurred within the reporting period and others occurred in earlier and later quarters. Projects that had filled all or almost all allocated places reported levels of total expenditure close to income received through flexible care subsidy. Expenditure lower than income was mostly associated with low occupancy and delays in establishing ongoing services while waiting for assessment processes to complete. Flexible care subsidy rates appear to align with total expenditure per client service day when occupancy is high.

Projects also reported a breakdown of expenditure by different categories of assistance to clients. MS Changing Needs and Cumberland Prospect Disability Aged Care Pilot are excluded from the overall breakdown of direct care expenditure shown in Figure 5.1. Across the remaining seven projects, over 75% of direct care expenditure was spent on a combination of social support (30.0%), personal assistance (24.0%), assessment and case management (19.5%), and allied health assessment and therapy (6.8%). The service expenditure profile changes over time as projects complete the bulk of assessments and establish care plans. Thus, the proportion of direct care expenditure on assessment and case management was influenced by the fact that some projects were still completing initial client intake.



Source: Appendix Table C1.

Figure 5.1: Innovative Pool Disability Aged Care Interface Pilot: total services expenditure by service type, all projects except MS Changing Needs and Cumberland Prospect Disability Aged Care Pilot, 1 July – 31 December 2004

A similar breakdown of services expenditure in each project can be seen in Figure 5.2. Three projects in New South Wales—Far North Coast Disability and Aged Care Consortium, Northern Sydney Disability Aged Care Pilot and Cumberland Prospect Disability Aged Care Pilot—show expenditure on client services focused mainly on providing additional personal assistance and allied health interventions. The expenditure profiles of the latter two are similar, reflecting the completion of initial needs and allied health assessments during the evaluation. Northern Sydney Disability Aged Care Pilot provided an update on project expenditure to June 2005, reflecting a stabilised expenditure profile for an established client group (see section 3.3 in Chapter 3).

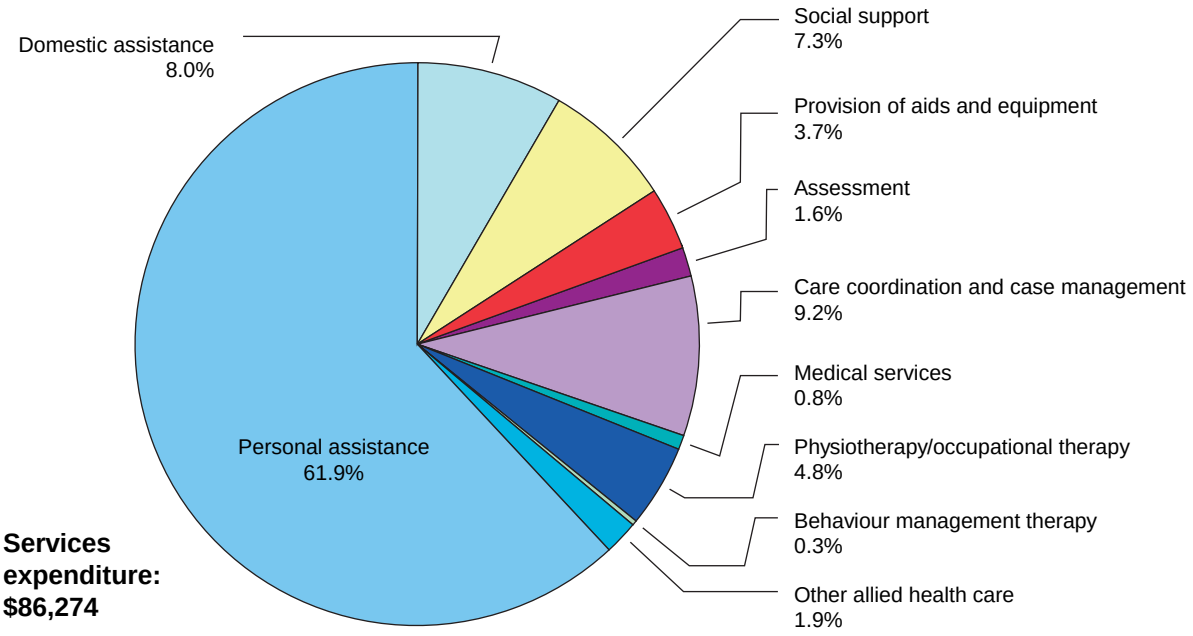
Central West People with a Disability who are Ageing (New South Wales), and the two projects in South Australia, Flexible Aged Care Packages and Disability and Ageing Lifestyle Project, recorded service expenditure profiles that more closely resemble each other than those of other projects. During the evaluation these projects directed a relatively high proportion of service expenditure to social support, recreation and leisure and associated transport costs. Subsequently, Central West People with a Disability who are Ageing reported delivering higher amounts of personal assistance to clients during 2005, which is likely to have altered that project's service expenditure profile.

Disability Aged Care Service (DACS) in Perth is a primarily therapeutic service, channelling most service expenditure into personal assistance, allied health and physical maintenance

and life skills development programs. Following allied health assessments, DACS develops individual care plans that aim to maintain fine and gross motor skills, and stimulate conversation and cognitive and sensory function. These programs are developed with and monitored by allied health professionals contracted to Senses Foundation for DACS.

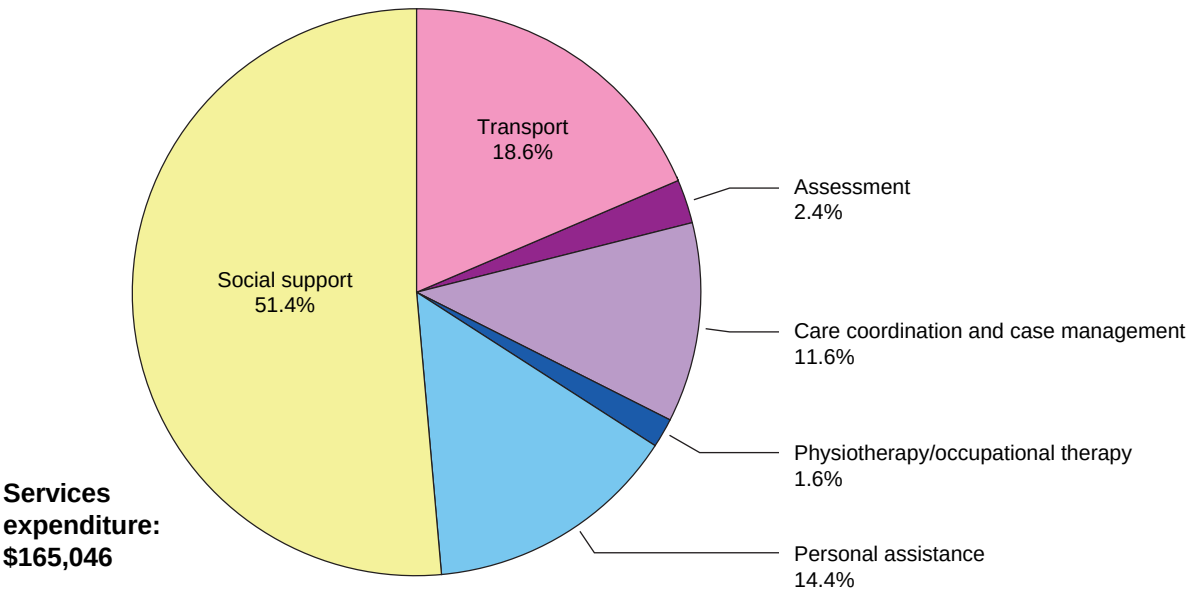
Ageing In Place, Tasmania, shows a mixed service expenditure profile covering personal assistance, behaviour management and social interventions. The project was designed to extend daytime supervision and care for clients from the 66 hours per week available through disability funding to 96 hours per week. This extension of hours to cover the period 9.00 am to 3.00 pm has provided scope to engage clients in day programs in the local community and activities tailored to individual hobbies and interests. Additional capacity for personal assistance through the Pilot and seen in the AIP services expenditure profile allows clients who have made or are in the retirement transition to depart from the usual household morning routine.

Far North Coast Disability and Aged Care Consortium



Services expenditure: $86,274

Central West People with a Disability who are Ageing

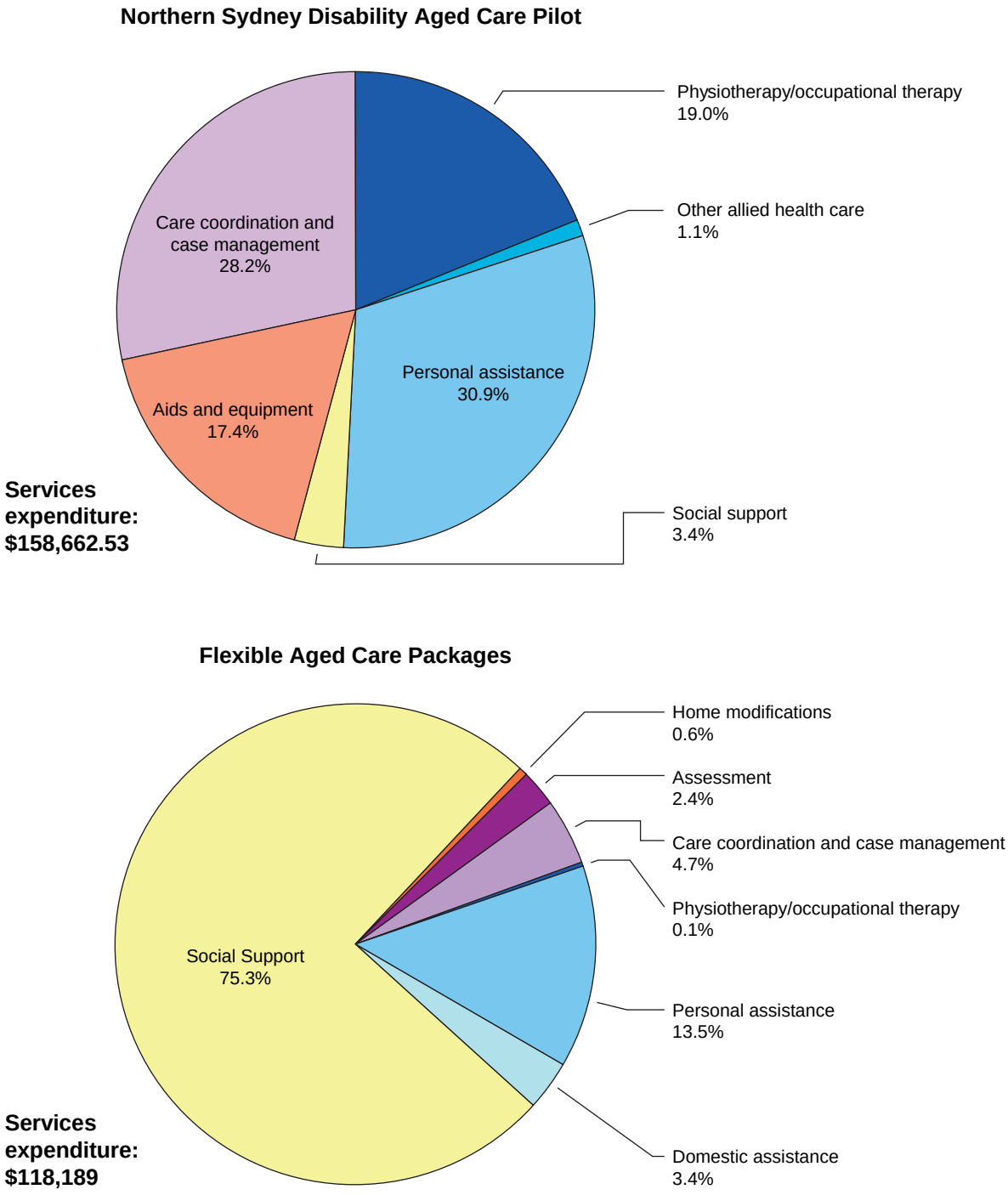


Services expenditure: $165,046

Source: Appendix Tables C2 and C3.

Figure 5.2: Innovative Pool Disability Aged Care Interface Pilot, services expenditure by service type, by project, 1 July – 31 December 2004

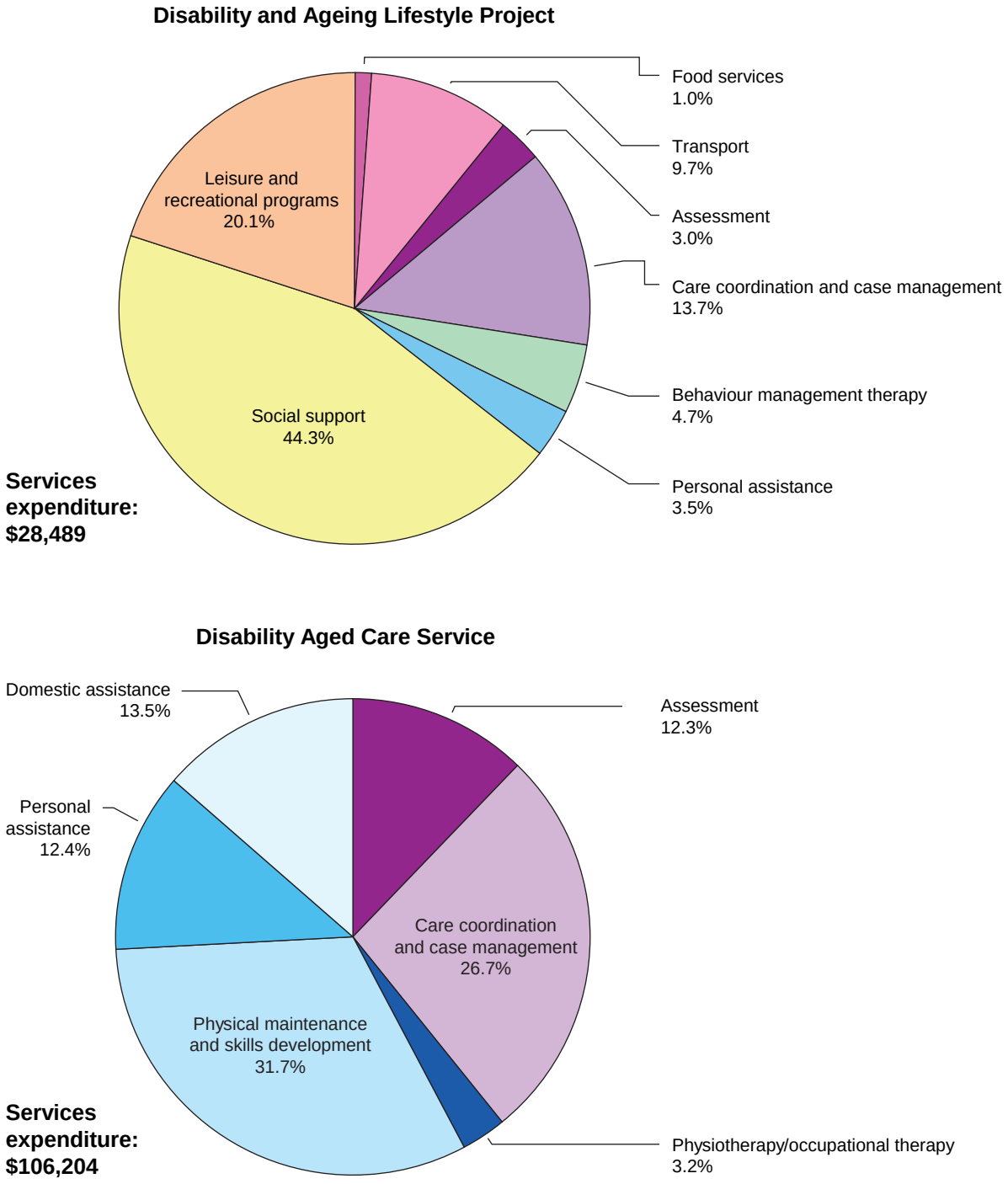
(continued)



Source: Appendix Tables C4a–b, C5.

Figure 5.2 (continued): Innovative Pool Disability Aged Care Interface Pilot, services expenditure by service type, by project, 1 July – 31 December 2004

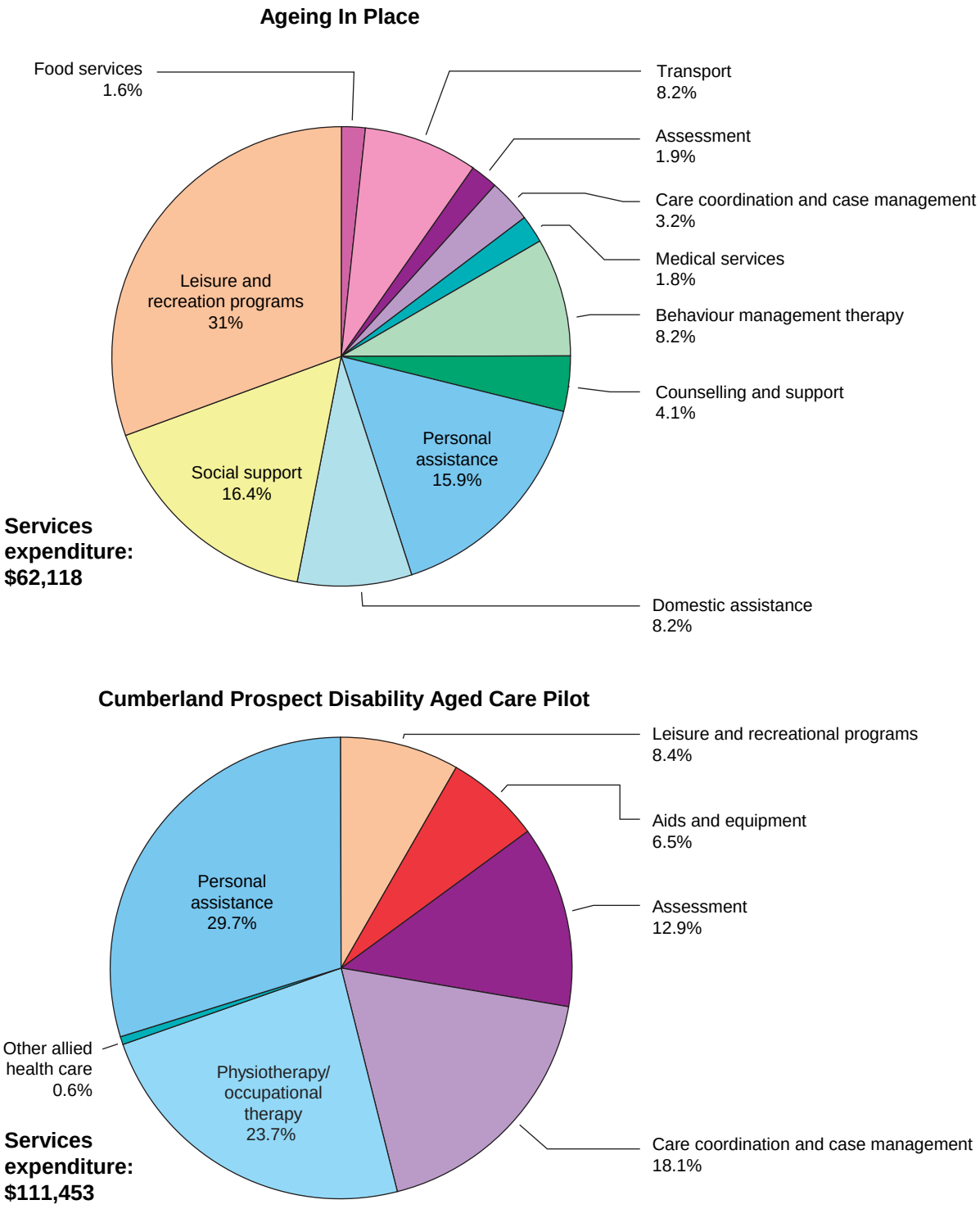
(continued)



Source: Appendix Tables C6–C7.

Figure 5.2 (continued): Innovative Pool Disability Aged Care Interface Pilot, services expenditure by service type, by project, 1 July – 31 December 2004

(continued)



Source: Appendix Tables C8–C9 (figures reported for the Cumberland Prospect Aged Care Pilot refer to the March and June 2005 financial quarters).

Figure 5.2 (continued): Innovative Pool Disability Aged Care Interface Pilot, services expenditure by service type, by project, 1 July – 31 December 2004

Provision of aids and equipment features in the service profiles of three projects in New South Wales and assessments of Ageing In Place (Tasmania) clients also led to the purchase of aids by the disability service provider, Oakdale Services (Table 5.4). Between these projects a total of $13,781 of project funds and an additional $4,813 of external funds were spent on aids and equipment for Pilot clients. Unspecified aids or equipment were purchased for 18 clients; seven clients received mobility aids. Access to funding for aids and equipment was cited by several project coordinators and disability service providers as a key benefit of the Pilot for individual clients. Expenditure on aids and equipment from project funds and other expenditure categories is shown in Appendix Table C1.

Table 5.4: Innovative Pool Disability Aged Care Interface Pilot, number of clients receiving aids and equipment and expenditure on aids and equipment, by aid/equipment type and project

	Project funding		External funding		Total	
Aids and equipment	**Clients**	**Dollars**	**Clients**	**Dollars**	**Clients**	**Dollars**
Mobility aids						
CPDAC, NSW	4	996	—	—	4	996
FNCDAC, NSW	2	745	—	—	2	745
NSDACP, NSW	1	1,041	—	—	1	1,041
Total mobility aids	*7*	*2,782*	—	—	*7*	*2,782*
Hearing aids						
AIP, Tas	—	—	2	32	2	32
Total hearing aids	—	—	*2*	*32*	*2*	*32*
Continence aids						
AIP, Tas	—	—	2	343	2	343
CPDAC, NSW	2	1,074	—	—	2	1,074
Total continence aids	*2*	*1,074*	*2*	*343*	*4*	*1,417*
Home modifications						
AIP, Tas	—	—	1	66	1	66
FNCDAC, NSW	1	765	—	—	1	765
Total home modifications	*1*	*765*	*1*	*66*	*2*	*831*
Other aids						
AIP, TAS	—	—	3	4,372	3	4,372
CPDAC, NSW	5	4,636	—	—	5	4,636
FNCDAC, NSW	5	1,990	—	—	5	1,990
NSDACP, NSW	5	2,534	—	—	5	2,534
Total other aids	*15*	*9,160*	*3*	*4,372*	*18*	*13,532*
Total aids and equipment expenditure		**13,781**		**4,813**		**18,594**

— Nil.

5.3 Main findings

Flexible care subsidy payments to Disability Aged Care Interface Pilot projects ranging between $30.73 to $68.50 per place day are at a somewhat higher rate than CACP subsidy but substantially lower than basic daily care subsidy for high level residential care (basic daily care subsidy does not necessarily fully cover the cost of care, however). Cost comparisons need to factor in the significant contributions of state governments towards the cost of maintaining people with disabilities in the community.

Currently no community care mainstream equivalent or alternative to the 'top-up' model of Pilot service is available to the target group. The cost of service delivery as reflected in project total expenditure observed during the evaluation reflects projects at different levels of maturity, some still completing initial needs assessment and further specialised assessments and others with most clients established in their care plans. It appears that once a project is established total expenditure closely approximates income from flexible care subsidy. Occupancy monitoring has meant that adjustments were made during, before and after the evaluation reporting period and these would invalidate estimates and comparisons of expenditure per client service day from data supplied for the evaluation.

Expenditure and service profiles support the broad separation of projects into distinct categories, being mainly social care intervention or mainly therapeutic intervention. Within these categories some or most clients received higher levels of personal assistance through the Pilot and some projects delivered a range of services spanning both categories of assistance. This separation can also be seen by considering the distribution of weekly hours per client on personal assistance and specific allied health care interventions[10] combined, depicted in Figure 5.3. Projects that have channelled higher proportions of expenditure into social interventions have nevertheless delivered high hours of additional personal assistance to small numbers of clients. Thus, the social care and therapeutic focuses are not mutually exclusive but are driven by the needs of the client group at the time.

10 Physiotherapy, occupational therapy, social work, psychological assessment and counselling, podiatry, dietetics and alternative therapies.

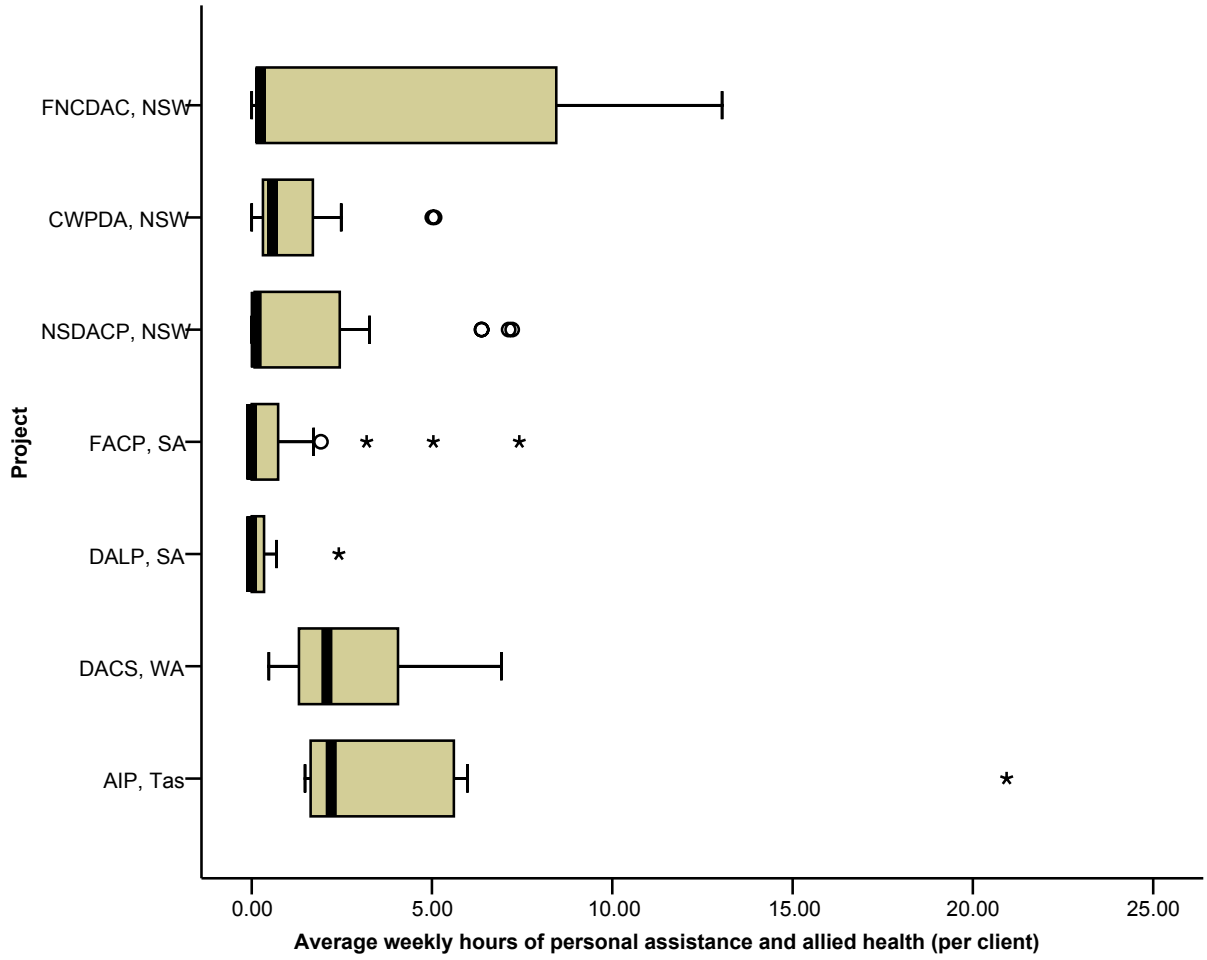


Figure 5.3: Innovative Pool Disability Aged Care Interface Pilot, distribution of average weekly hours per client for personal assistance and allied health care, by project