

# Wellness and Restorative Model of Care Project

## BACKGROUND PAPER

### The project

Following the HACC National Forum in February this year, UnitingCare Ageing NSW.ACT was asked to lead a project looking into the opportunities for implementing Wellness, Capacity Building and Restorative care approaches within the Northern Sydney HACC sector.

It is a 12 month project to be completed by June 2009. The pilot phase will be supported by a steering committee and be conducted in the new Berowra, Brooklyn and Galston centre based day care programs in conjunction with the social support programs offered by the Community Health Centres in those areas from October 08 to June 09.

An essential component of the pilot is consultation with social support, centre and day care Service Providers through a focus group and survey, to consider where Wellness, Capacity Building or Restorative Care approaches could be adopted and identify options to pilot and implement these approaches. An Advisory Group has been established to support this consultation.

Uniting Care issued invitations to the focus group for this discussion to be held on 9 September 2008.

A consultation has been held with the Hornsby Shire Seniors Advisory Committee.

Some consumers of centre based day care and social support programs and volunteers will be asked to contribute their input through a survey.

### Background Paper

This background paper draws primarily from a literature review prepared by the Australian Institute for Primary Care at the Victorian Department of Human Services : *The Active Service Model: a new paradigm for HACC: A conceptual and empirical review of recent Australian and international literature (1996-2007)* which is due for public release soon. It also draws on the presentations at *the HACC National Forum: Promoting Independence* held in February 2008 to explore the evidence base and implications of adopting Wellness, Capacity Building or Restorative Care approaches in HACC services. Information on the theory and evidence base of different approaches from Western Australia, Victoria and South Australia and from the UK and New Zealand were showcased and discussed. See <http://www.haccforum08.com.au/program.php>

### The Home and Community Care (HACC) Program

The HACC program, since its inception, has focused on assisting frail older people and people with a disability to remain living successfully in their communities and preventing premature admission to residential care through a broad range of services. Informal carers are also supported in their caring role through general and specifically targeted programs. Social support and centre based day care programs for frail older people are key services focused on supporting older people on a one-to-one and in a social group context. In NSW the Department of Ageing, Disability and Home Care has invested HACC funding in these service types based on an understanding of the importance of social as well as practical support and care for the individual, and respite care and support for carers.

The HACC program in NSW has explored a strength based approach and this has become embedded in case management practice in the Community Options program over the past decade. Local services such as social support Neighbour Aid programs have successfully served local communities and showed great creativity and responsiveness to the needs of their local residents. Some centre based day programs provide structured fitness and falls prevention sessions, nutrition education and many other health related activities on a regular basis.

There are, however, concerns that the HACC service system is fragmented and difficult to understand, that older people, and especially those from a Cultural And linguistically Diverse (CALD) Background, are not accessing services in a timely manner, that they and their family members are not receiving all the information they need to make decisions and plan effectively, and there is a general expectation that HACC services 'care for ' rather than 'partner with' people to assist them to regain their independence, adapt to their health and ability levels or learn new skills in older age. These concerns need to be addressed as the service system grows to meet the needs of a large population of older people with increasingly complex and chronic health issues in the coming years.

A new approach is being explored for the HACC Program across Australia that has a wellness, capacity building and restorative emphasis, called an active service model in Victoria and wellness approach in Western Australia. This is to address the concerns that the HACC program is perceived as currently leaning towards a 'dependency model', including activities, that are provided in a "standardised way to eligible clients, and often act to substitute in areas in which clients experience difficulties looking after themselves."(p.9) A cycle of dependency and learned helplessness can be established, and as the older person's confidence "decreases further they are offered more services, and this in turn further reduces their confidence" (p10). "Instead of providing largely passive services to 'support' and 'maintain' individuals at home, a wellness/active service model emphasises providing timely interventions that prioritise capacity building or restorative care, with the aim of maintaining and promoting a client's capacity to live as independently as possible."(p6)

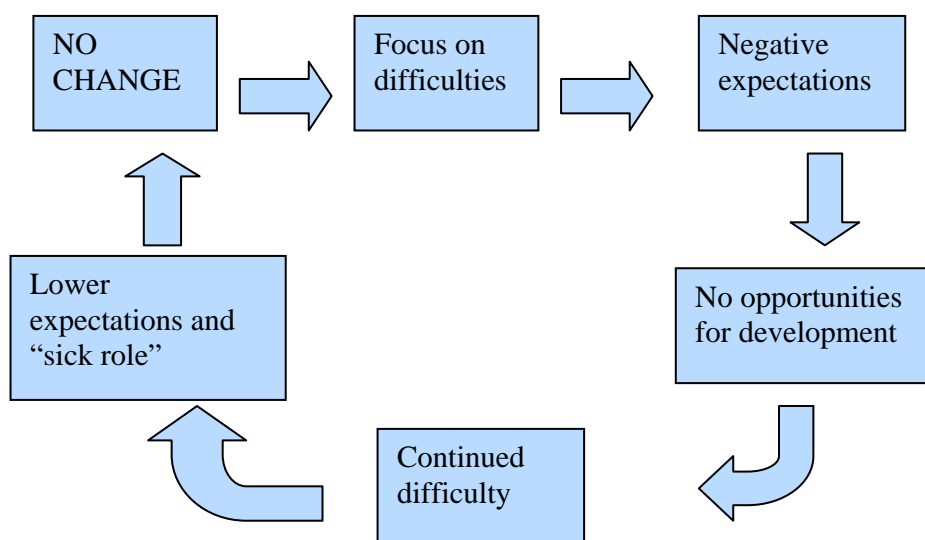


Figure1. The Illness/Dependency Cycle, adapted from Hillary O'Connell

"A key concept that has emerged in attempting to rethink how to address the needs and maximise the health and well being of our ageing population is that of 'successful ageing' (Browning & Kendig, 2003, 2004). This concept emphasises the roles of healthy life styles and daily routines, degree of social support, amount of exercise, and sense of autonomy and control in enabling older people to maintain their health and independence for as long as possible." (p.8)

### The New Approach

World Health Organization defines "active ageing as the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age.' (World Health Organization, 2002, p.12).The term 'wellness' has been used to emphasise a broader definition of 'health' than the traditional narrowly focused medical perspective, and include a focus on the absence of disease and disease-related disability (Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002). This shift to a wider perspective is consistent with the World Health

Organization's declaration that health should be considered as "a state of complete physical, mental, and social well being, and not merely the absence of disease and infirmity" (World Health Organization, 1986, p.1).

"This emerging concept has been developed based on the principles of successful ageing and the key components of the model include:

- 1) An emphasis on capacity building or restorative care to maintain or promote a client's capacity to live as independently as possible. The overall aim is to improve functional independence, quality of life and social participation.
- 2) An emphasis on a holistic 'person-centred' approach to care, which promotes clients' wellness and active participation in decisions about care.
- 3) Provision of more timely, flexible and targeted services that are capable of maximising the client's independence.

Key aspects include an holistic person-centred approach that focuses on each client as integrated person encompassing an individual's overall physical, mental, spiritual, and emotional well being and placing the person at the centre of their own care and considers the needs of the older person's carers' (Department of Human Services, 2003, p. 18). It marks a contrast to other more traditional models of service delivery that may be more focussed on service priorities such as tasks, routines, and time frames. Person-centred service provision is flexible, responsive and based on the individual goals of a particular client and carer in their own environment, rather than providing a standard program of care for all clients (National Ageing Research Institute, 2006).

Another key concept is the promotion of 'wellness', which refers to good physical and mental health, especially when maintained by proper diet, exercise, and other habits. The importance of promoting wellness, even in the context of chronic illness, is consistent with a growing body of evidence (Baker, 2006) demonstrating that continuing to undertake domestic activities (shopping, cooking and gardening) and exercise is very important for the overall fitness and psychological and social well being of older adults (Gill et al., 2002; van der Bij, 2002). Emphasis is encouraging wellness or independence cycles (in which positive expectations, opportunities for development, and positive experiences reward improvement).

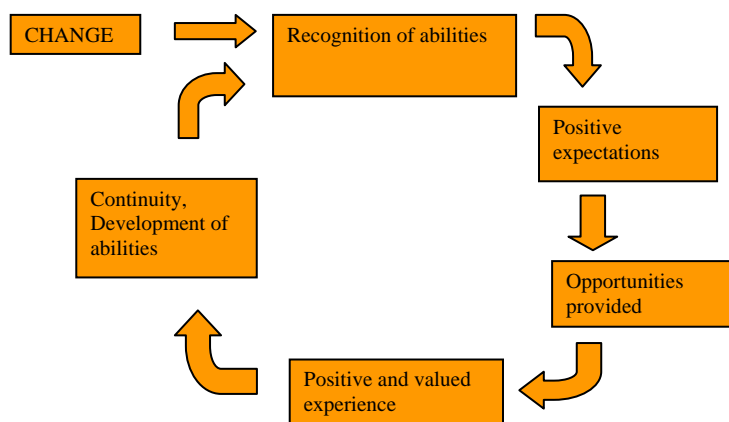


Figure 2. The Wellness/Independence Cycle adapted from Hillary O'Connell (community West, WA)

With emphasis on wellness and independence, this new approach may involve health promotion, improvement in activities of daily living, and social participation and applied to a range of different situations, eg, assisting a client to regain capacity for personal care following an acute episode such as a stroke, supporting someone whose independence has slowly diminished, because of frailty or a chronic condition, to regain a degree of functional

autonomy, self-confidence and connectedness with the community. It implies a coming together of a range of strategies and services to promote wellness and independence within the limitations imposed by disease or disability for each individual." (P 11)

The sorts of programs and therapies that might be undertaken can be provided by a range of staff, within a range of services such as:

- "Adequate support to re-learn or learn **alternative methods** to undertake a particular task (e.g., cooking classes)
- **Physiotherapy** to address an underlying issue that has led to restriction in mobility
- Connection and support to a range of capacity building options (e.g, local walking groups)
- The trial of different **equipment** (e.g., labour saving equipment such as new style cleaning gadgets),
- The provision of **environmental modifications** (e.g., grab bars and ramps), often facilitated by an occupational therapist
- Psychosocial education and support to assist individuals to cope and adopt **strategies** for the **self-management** of chronic illness
- Encouragement to participate in local **health promoting activities** and other activities to enhance health
- **Health education** about principles of healthy ageing, use of medications and illness / accident prevention strategies
- Reactivation and support to sustain **social networks**, via a short-term process of social rehabilitation that often involves significant volunteer input." (p12)

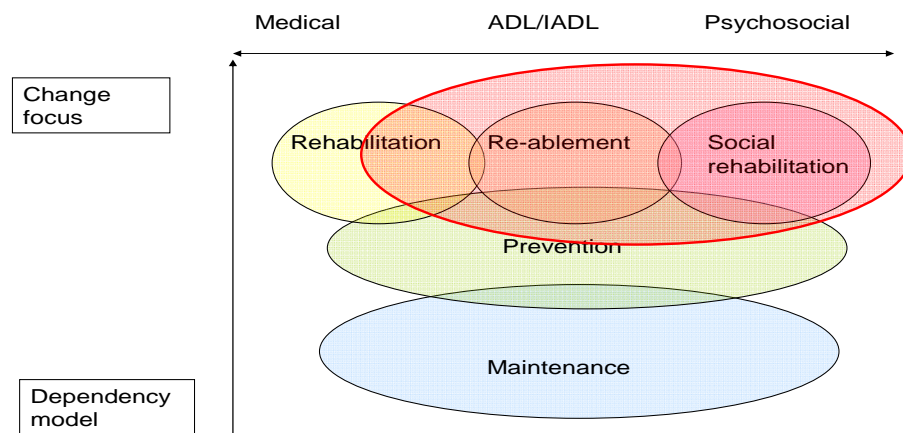


Figure 2 How the Wellness/Restorative care Approach compares with other approaches

### Implementing this approach in HACC Services

'A growing body of research literature has demonstrated it is often possible to rehabilitate or re-enable occupational and social functions in frail older adults with chronic illness (e.g., McWilliam et al., 2000). A variety of the specific elements of an wellness approach, such as exercise and balance programs, health promotion and programs

involving the provision of aides and equipment, have been trialled, with largely positive outcomes. The majority of studies have been trialled as separate programs—as single components outside of existing HACC type services (i.e., typically not undertaken by HACC staff)—and are not directly compared to “standard” services. Almost all the research and evaluation undertaken within HACC services has specifically investigated the effects of intensive, time-limited programs.

In Australia, while there is little peer reviewed published evidence about the efficacy of multi-component programs, a growing body of grey literature, including service evaluations and government reports, outlines the success of pilot programs that have been developed, including work undertaken within the Silver Chain service in Western Australia (Lewin et al., 2006), the Supported Independent Living Collaborative in Queensland (Matthews, 2004) and the recent implementation of four pilot programs within Victoria (e.g., Saxon, 2007)."

### 1. Three Key Examples of Programs Utilising a Wellness and Restorative Approach

"Among all of the relevant literature, the three programs that have received the most thorough attention as well as the most robust evaluations include the Silver Chain 'Home Independence Program' in Western Australia (Lewin et al., 2006), the 'Leicestershire Home Assessment and Re-enablement Team' in the UK (Kent et al., 2000) and the 'Restorative Home Care Agency' based in Connecticut, US (Tinetti et al., 2002). Each program involves the input of a multi-disciplinary team delivering multi-component interventions that are time limited in duration, and based within home and community care services. Both the WA and the UK programs have targeted relatively low dependency clients, who are referred at the point of entry to home care services. Following the completion of the program, clients, are then referred for ongoing "standard" HACC services if required. The US program was slightly different in that it targeted clients who were referred for a time-limited burst of Medicare covered home care post discharge from hospital, who may well have been at a higher level of dependency than those included in the other two programs."

## 2. Outcomes from implementation of the new approach

### 2.1 Clinical

i) **Functional status** "An older adult's capacity to undertake activities of daily living impacts directly on their overall quality of life and capacity to remain integrated into normal community life. Either improvement or maintenance of functional status is clearly a fundamental objective of a wellness approach. There is now a relatively robust body of evidence that indicates it is possible to either prevent deterioration or directly improve the functional status of frail older adults, including those with significant chronic illness (e.g., stroke; Trialists, 2003). A range of physical, occupational and health-based interventions that constitute components of an ASM have been associated with such improvements. Those that have been specifically demonstrated to have a positive impact on functional status in randomised controlled trials include the provision of aids and equipment and environmental interventions (Gitlin, Corcoran, Winter, Boyce, & Hauck, 2001; Mann, Ottenbacher, Fraas, Tomita, & Granger, 1999; Stark, 2004), occupational therapy intervention based on activities of daily living (Logan et al., 2004; Steultjens et al., 2004; Walker et al., 2004) and the provision of physical therapy, including strength and balance training (Gill et al., 2002)."

ii) **Quality of life** "can be broadly conceptualised as a global assessment of well being. Assessed quality of life can be based on judgments about a wide range of factors including an individual's health, family relations, friendships, occupation and finance as well as sexual activity and leisure time. Most people would agree that many of the chronic illnesses associated with ageing, such as stroke, diabetes, osteoarthritis and dementia, constitute a major challenge to an individual's quality of life across a number of these dimensions. Programs utilising a wellness approach, with their potential capacity to enhance functional and social independence, are likely to have a positive impact on quality of life for clients. However, to date, the focus of the majority of

intervention studies has been on improvement of basic functional status and measurement of ongoing use of services rather than the broader effects of interventions on clients' lives, including their well being and social status. There are only a few studies, albeit with generally positive findings, that have directly investigated the impact of programs utilising a wellness approach directly on clients' quality of life.

**iii) Mortality** If programs utilising a wellness approach have a beneficial effect on functional and health status of older adults, they may also have the potential to prolong life span. To date there have been relatively few attempts to measure the extent to which more active programs may impact on mortality, perhaps due to the fact that the majority of evaluations have involved relatively high functioning participants and small sample sizes, and have occurred within 12 months of program implementation. Nevertheless, there is some limited evidence based on a larger intervention trial and meta analysis, that more active or preventative approaches may indeed have a tendency to reduce mortality rates in intervention participants.

## 2.2 Use of Services

**i) Use of community services** One of the key objectives is 'to attempt to provide more timely, flexible and targeted services that are capable of preventing further exacerbation of dependency'. Therefore, an important side effect of programs utilising a wellness approach may be to reduce the use of ongoing services. There is now a strong body of evidence that suggests that time limited multi-component interventions appear to result in a reduction in the ongoing use of HACC services in comparison to what would have been anticipated with the provision of "usual" HACC services, at least in the short term.

**ii) Admission to residential care** Another important and cost effective outcome that may result from more active intervention programs is a delay in the need for residential care. To date, however, only a few evaluations of multi-component programs have attempted to investigate the relationship between programs that utilise a wellness approach and admission to residential care.

**iii) Hospital admissions** To date very few studies have investigated the extent to which programs utilising a wellness approach may reduce the number of hospital admissions, either in the short or longer term. The exception is the evaluation of the restorative home care agency (one of the three key examples) undertaken by Tinetti et al. (2002) in which restorative care was associated with a significantly reduced likelihood of visiting an emergency department during the duration of the intervention (approximately two months). No studies have investigated the extent to which programs utilising more active service approaches reduce hospitalisations in the longer term.

## 2.3 Carers

**Caregiver burden** Ideally, the use of a wellness approach would result in increased independence for the client and a subsequent decrease in burden for the caregiver. However, it has been suggested that this approach might be more labour intensive for caregivers at least in the short term, particularly while clients are re-learning how to undertake certain tasks. Nevertheless, the limited evidence to date has displayed either positive or benign impacts on caregivers."

### Opportunities for Change

The 3 key examples of multi-component programs implemented within HACC services with highly successful outcomes shared some important components. A multidisciplinary team comprised of a combination of allied health staff and home care staff was involved with each program. Each appeared to involve a relatively comprehensive assessment (face to face and in the person's home) with a combination of interventions incorporating both functional

and social goals, and each was time-limited in duration. Each of the components appears to contribute to the success of the program. Nevertheless, at this stage it remains difficult to be more specific about which component of a wellness type program may be integral to achieving positive outcomes. Questions remain about the most appropriate assessment approach, the best staff mix for such services and whether it is necessary to offer a “time-limited” program which is separate from existing HACC services or if it is possible to integrate the approach more broadly into standard HACC services.

**1. Assessment** The WA model has emphasised a need to develop assessment protocols focused on determining client strengths and not only on the weaknesses or symptoms that the client experiences (O’Connell, 2006). The WA team are in the process of developing and trialing new assessment tools to be utilised throughout the HACC system for this purpose. Nevertheless, there has yet to be any research that specifically investigates the usefulness of new strength-based assessment tools. There is some research-based evidence, however, which suggests that the breadth of an assessment may have important implications for outcomes.

**2. Staff and Service Mix** It is currently difficult to specifically identify the most appropriate staff mix or interventions. A variety of services, encompassing different mixes of staff disciplines, different intervention components, and different target client groups have been shown to demonstrate positive outcomes. There is also evidence for the effectiveness of a variety of individual components of an active service model on outcomes, ranging from befriending services through aids and equipment to physical therapy, suggesting that each factor may have an important role to play in the success of multi-component programs. No research project has, as yet, attempted to compare the effectiveness of one type of service and or intervention directly with another, although there are currently plans in England to compare the effectiveness of different types of re-ablement teams, particularly in relation to the extent to which the involvement of occupational therapists may be integral to outcomes.

**3. Management and Service Structure** While the question as to whether or not programs are most effective if they exist as separate entities from “standard” HACC services remains uncertain, some evidence exists to suggest, that regardless of the structure adopted, in order to be successful, programs that may be moving towards more of a wellness approach may require substantial staff re-education and re-structuring as well as active support from management. According to Gerald Pilkington from the Department of Health, UK, those re-ablement programs which have been most successful across England have involved substantial efforts to re-train care staff with new skills and a new model of practice as well as considerable re-organisation of the service (i.e., better structures to facilitate communication between allied health and home care staff) to support staff to implement the program. Those programs that have simply re-named services and have not involved re-training and re-structure have not been successful.”

## **Social Support and Centre Based Day Care Programs**

If we take the wellness and restorative approach key components of promoting a client’s capacity to live as independently as possible, by aiming to improve functional independence, quality of life and social participation within a holistic ‘person-centred’ approach which promotes clients’ wellness and active participation in decisions about care and provision of more timely, flexible and targeted support. How could this be expressed in Social Support and Centre Based Day Care Programs?

Some considerations could include ‘re-framing’ the way services initiate contact with older people and their families who are potential service users, the language we use, the service objectives we develop, assessment practices, a greater emphasis on co-ordinating effectively with primary health care and health education professionals and services, individual and participatory care planning and goal setting, staff and volunteers spending more time as facilitators, educators, and mentors than providers of assistance, focus on preventing people becoming socially

isolated and care outcomes could be assessed in terms of the older person's perception of their quality of life improvement.

## **Appendix Some Definitions:**

### **Active Ageing**

The process of optimizing the opportunities for physical, mental and social well-being throughout the life course, in order to extend healthy life expectancy, productivity and quality of life in older age.

### **Successful Ageing**

This concept emphasises the roles of healthy life styles and daily routines, degree of social support, amount of exercise, and sense of autonomy and control in enabling older people to maintain their health and independence for as long as possible.

### **Health**

The ever-changing process of achieving individual potential in the physical, social, emotional, mental and spiritual and environmental dimensions.

### **Healthy Ageing**

The ability to continue to function mentally, physically, socially and economically as the body slows down its processes.

### **Re-ablement**

Re-ablement refers to intensive and time limited interventions for people with poor physical and/or mental health to help them accommodate their illness by learning or re-learning the skills necessary to manage their illness and to maximally participate in everyday activities.

### **Self-Management of Chronic Disease**

The individual's ability to manage the symptoms, treatment, physical and psychosocial consequences and life style changes inherent in living with a chronic condition.

### **Social Rehabilitation**

Social rehabilitation focuses on restoring confidence and skills lost through illness, injury, bereavement or other trauma or loss, by learning or re-learning the skills necessary for social interaction and activities.

## Wellness

Wellness refers to a state of optimal physical and mental health, especially when maintained by proper diet, exercise, and other habits. It can also be considered from an ecological viewpoint as something that is dependent on the dynamic relationship between people and quality of their physical and social environment.