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into Aged Care Quality and Safety

MODELS OF INTEGRATED CARE, HEALTH AND HOUSING

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The Royal Commission into Aged Care Quality and Safety was established by Letters Patent on 8 October 2018. Replacement Letters Patent were issued on 6 December 2018, and amended on 13 September 2019 and 25 June 2020.

The Honourable Tony Pagone QC and Ms Lynelle Briggs AO have been appointed as Royal Commissioners. They are required to provide a final report by 26 February 2021.

The Royal Commission releases consultation, research and background papers. This research paper has been prepared by the National Ageing Research Institute for the information of Commissioners and the public. The views expressed in this paper are not necessarily the views of the Commissioners.

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Models of Integrated Care, Health and Housing

Report prepared for the Royal Commission into Aged Care Quality and Safety

Models of Integrated Care, Health and Housing:

Report prepared for the Royal Commission into Aged Care Quality and Safety

National Ageing Research Institute Ltd.,

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Glossary

ACAS/ACAT – Aged care assessment service/team

ACFI – Aged Care Funding Instrument

CHS – Community health service

CHSP – Commonwealth home support programme

GP – General practitioner

HCP – Home care package

MOU – Memorandum of understanding

MPS – Multi-purpose service

NDIS – National Disability Insurance Scheme

PREM – Patient reported experience measure

PROM – Patient reported outcome measure

PHN – Primary Health Network

Executive Summary

To assist the Royal Commission into Aged Care Quality and Safety (established October 2018), this report provides an overview and analysis of integrated models of care for older people, as they relate to health care, social care, and housing or accommodation in Australia.

Background and method

Integrated care is a nebulous term that can mean different things to different people. Fundamentally it refers to strategies aimed at overcoming fragmentation between different services and sectors as a way of improving the health and wellbeing of clients, client satisfaction with services, and the efficiency and long-term sustainability of health and aged care systems. Proponents of integrated care posit that fragmentation causes system inefficiency, poorer health and well-being outcomes, and poorer experiences for clients and professionals. Proponents also consider better integration of care fundamental to providing person-centred care, where clients and carers are empowered to take the lead in the provision of their own care in accordance with their own needs and preferences. In addition to a focus on individual clients, integrated care also encompasses strategies for improving care for communities. Community-focused integrated care aims to addressing broader determinants of health and wellbeing, including the pathways of service access, service availability, and the webs of reciprocal support.

Our method for this study comprised three steps: First, a rapid review of scholarly literature reviews on integrated models of care for older people. Second, a desktop review of grey and academic literature, to identify and evaluate existing models and related policy. Third, we held consultations with key experts and providers of integrated care in Australia. This method does not provide an exhaustive list of all integrated models of care for older people in Australia. Rather, it facilitates a discussion and analysis of current practices and the potential for further innovations and developments.

Integrated person-centred care

When considering care for the individual, models need to be aligned with the level of the clients' needs, whether low level support needs, complex health needs, or socio-economic and cultural needs, as well as their capacity to independently manage those needs. Different models of integrated person-centred care therefore need to be considered on a continuum of needs, with each model appropriate for different levels and types of need. Findings from our rapid

review emphasised clinical models of integrated care. These are predominantly designed and implemented from a primary health perspective and aim towards integration with secondary health and social care. From our literature review and consultations, we found that care coordinators are better placed to lead such models than General Practitioners for older people living in the community. However, GP-led models may be effective at engaging residential aged care providers, and provide additional resources that improve aged care residents' access to GPs. Clinical integration models usually target people with very complex medical needs and a limited capacity for self-management, and do so through mechanisms like case management, comprehensive assessment, multidisciplinary teams, shared information systems, and disease-specific pathways. Among these models are examples that are appropriate for supporting people with advanced frailty and/or dementia, whether they are living in their own homes in the community, residential care, or in supported accommodation. For older people with less complex needs and greater capacity for self-management, clinically integrated models are likely unnecessary, and there are less intensive alternatives. Integrating community health care and home aged care can support people with moderate needs living at home by providing regular contact with a care coordinator, and flexible care that crosses the boundary between acute and aged care. In our consultations, service providers saw entry point care as a priority for older people first engaging with services, struggling with system navigation, and unsure of their needs or options. Employing social workers for short-term entry point care can support people to stabilise their situation and provides a point of contact should their circumstances later become challenging. Formal integration of services may not be needed where older people with low needs and a high capacity for self-management can easily access relevant advice and guidance on how and where to seek support.

Community-focused integrated care

In addition to models that wrap around the individual, integration must also be considered at the level of the community. Addressing the needs of a local community, rather than individual clients, help facilitate integration across sectors and disciplines by aligning services or professionals with a common purpose and shared goals. Community-focused integrated care works best when focused on health and wellbeing for a defined population, with governance and leadership of models at a local rather than system-wide level. Each community requires an approach to integration that is responsive and adaptive to their demographic, geographic, socio-economic and cultural profile. Practical ways of facilitating community-focused integrated care include community needs assessments, community consultations, community involvement in

governance, feedback and surveys, and support for volunteers. Through our consultations and desktop review, we learnt of several existing models that align with their communities' values, needs and capacities:

- **Aboriginal communities** value culturally safe, holistic, and intergenerational models of care. The four diverse Aboriginal Community Controlled Services we consulted with, are run by and for Aboriginal people and embed the cultural determinants of care at their core. Some examples provide clinical care, aged care and/or a broad range of other social services for older and younger people. In addition, each of these services has established relationships and partnerships that link to their community members to a range of external services.
- **Culturally specific service providers** are sometimes considered the de facto provider of aged care in their community. Many provide a service that integrates aged care, community welfare, advocacy and a range of cultural and social activities, with volunteer and donation support from a community bound together by their shared identity, beliefs and values, and/or history.
- **Multi-purpose services** fully integrate acute care, aged care, and often community health care services in regional, rural and remote areas. Their service plans are based on assessments of local population needs as well as community consultations. Some of these services have expanded their scope to support volunteerism and various health promotional activities.
- **Community health services** often provide home aged care along with health services, and have a social mission that targets social disadvantage in the community. They draw on multiple funding streams from Government but present an integrated and continuous provision of care to their clients.

Older people in Aboriginal, culturally and linguistic diverse communities or geographically remote locations may be familiar with a particular organisation and identify with its model of care. This close connection with and trust from communities, which these organisations work hard to maintain, helps facilitate the integration of their services. Most other Australians, by contrast, face a plurality of health and aged care providers in a competitive marketplace. We found that regional alliances between Commonwealth Primary Health Networks, State regional health authorities, and sometimes local government, offer one possible model for an integrated approach to community-focused integrated care. These alliances implement both clinical

integration programs and community-level health promotion initiatives and could collaborate with local providers of residential and home care to connect their clients with a range of services.

Integration of aged care and housing

Australia's aged care system assumes that aged care clients either have secure and appropriate housing or live in residential aged care. There is little support for low-income older renters who face insecure tenancy, cannot modify their homes, and are struggling to pay utilities. We suggest there are advantages to the Commonwealth recommitting itself to promoting and supporting alternative accommodation options for low-income older people in the aged care system. Retirement villages present one possible option. Residents of these facilities often enjoy a sense of community, as well as higher levels of support, compared to living at home. However, most retirement villages require full cost recovery, and residents must have sufficient assets to purchase the services. Moreover, while a lack of policy interest from Government has led to a proliferation of options catering to diverse preferences and needs, many retirement villages are built on urban fringes and are not conducive to ageing in place. Co-housing presents another option, which involves residents in the design and management of their own communities. These models encourage social connectedness, reciprocal care, and active engagement in community life for the older people residing in them. We suggest there is scope for Government to promote and support the development of these facilities, through co-design with older people, and consider how integrated person-centred care services could be co-located on-site.

Discussion and conclusion

Key findings of the study are summarized as follows:

Care integration works best when it is a bottom-up and community-focused process

Integrated care needs to be adaptive to their geographical, community, cultural and institutional contexts in order to succeed. Models that allow governance and planning to take place at a local community level are more effective at in this than top-down system-level mergers of large health, social care or welfare departments.

Formalised partnerships facilitate integrated care

An effective approach to integration in highly fragmented and complex health and social care environments is through alliance or partnership models. In Australia these are most often

agreements between Primary Health Networks and regional State health authorities, and sometimes local government. There is a need to explore any boundaries faced by aged care providers to entering partnerships, and it may be appropriate for Government to offer grants for providers to develop new models of care through partnerships with other services.

Integration initiatives need to be targeted at their client groups

Most research literature is focused on integrated care in a clinical sense, and assumes beneficiaries have complex medical needs and require frequent contact with medical professionals. Yet in our consultations, aged care providers identified the entry points to services as a priority for integration; when people are first encountering and navigating Australia's complex and fragmented aged care, healthcare, and social service systems. There is no one-size-fits all approach, and models designed for medical contexts may not be appropriate for many aged care users.

In the community, models work best as a complement to general practice, rather than GP-centred

We suggest that while GP-centred models of integrated care may be appropriate where people reside in residential care or have chronic illnesses, they are not best placed for coordinating the care of older people living at home in the community. These roles are better performed by skilled health or community service workers, such as nurses or social workers, who can regularly visit clients in their homes, address the environmental determinants of health and well-being, and actively engage with other relevant providers across the health, aged care and social service sectors.

The primary goal should be improving client experience and outcomes, rather than reducing costs to health and aged care systems

Integrated care programs are often justified as a way of reducing system costs, but evidence supporting this promise remains ambiguous. A "value-based" approach to performance and evaluation is recommended, that assesses how changes in the processes of care improve the value of services from the perspectives of older people, carers and service professionals.

Service integrated housing is the "third sector" of aged care and warrants policy and research attention

A growing number of older Australians are projected to need support with accessing age-appropriate housing in the future, but this is not addressed within current aged care policy.

There is scope for Government to recommit to supporting service integrated housing for older people, potentially by promoting or sponsoring co-housing developments and/or housing co-located with home care services.

Integrated workforces work well in regional and remote areas

Evidence suggests the Multi-purpose Services program model is successful at addressing acute care and aged care needs in regional and remote communities. A key lesson from these programs is that having a workforce that can cross the boundaries between hospital care and aged care not only supports the sustainability of those services, but also continuity of care for clients who transition between those services.

In conclusion, while the academic literature has a strong emphasis on clinical integration strategies in primary health, findings from the rapid review, desktop review and consultations suggest further attention can be given to:

- Supporting older people at the entry points to health, aged care and other services.
- Promoting community-level initiatives, which engender trust and reciprocity between community members and in local services.
- Exploring boundaries faced by aged care providers to entering alliance models.
- Exploring flexible options for integrating home care into housing options that still afford clients' choice.
- Ensuring transport and access for older people to existing and new services.
- Sustainable funding that affords community-based organisations scope to innovate and proactively support older people in the community.
- Rigorous governance that is in partnership with and/or includes community views.
- Committed leadership that is community not profit-oriented.
- An intergenerational life-course approach that integrates older people with their communities rather than siloed aged care.

Different models of integrated care are suited to different contexts and different target populations and goals. However, as a minimum, Commonwealth and State Governments should consider incorporating measurable performance indicators into their service contracts so that grass-roots organisations can demonstrate how they are trying to incorporate integrated care thinking into their service models and measure the impact of these changes.

1 Background and method

The Royal Commission into Aged Care Quality and Safety commissioned this report in order to better understand models of care that integrate aged care with (all or any aspects of) social care, health care, and housing or accommodation. This project supplements existing research undertaken for the Royal Commissioners that examined systems of long term care for older people and innovative models of aged care, seeking community based options for living [1, 2].

To assist the Commission in their work, we undertook this study comprising a systematic literature review, a desktop review and consultations with policy experts and integrated care providers. This report presents our findings across three themes: integrated person-centred care, community-focused integrated care, and integration of aged care and housing. We focus on describing practical real-world examples that illustrate what integrated care means in and around Australia's aged care sector, the potential benefits of these models for older people and services, and any limitations of these models or barriers to their implementation. The report concludes by presenting key findings and discussing their implications for integrated care models and innovative thinking in Australia's aged care sector.

1.1 *The need for integrated care*

As populations in countries such as Australia age, rates of chronic conditions such as dementia and diabetes as well as frailty and multi-morbidities increase. Consequently, our healthcare system is ever more focused on managing chronic conditions in older people [3, 4]. Older people with complex care needs come to rely on diverse forms of cross-sectoral support from General Practitioners (GPs), medical specialists, hospitals, pharmacists, allied health and community services [1, 3, 5]. Rising acuity and medical complexity of aged care users both in residential care and the community warrants examination of innovative models of care that can better integrate aged care with healthcare, social care, community services, and accommodation options.

Integrated care is a nebulous term that can mean different things to different people [6, 7]. Fundamentally it refers to strategies aimed at overcoming fragmentation between different services and sectors as a way of improving the health and wellbeing of clients, client satisfaction with services, and the efficiency and long-term sustainability of health and aged care systems [6]. Consequences of fragmentation can include service duplication, poor

communication between care providers, shifting of costs and responsibilities onto other providers, unmet needs, low satisfaction with care, client disempowerment, and greater likelihood of error [8]. From an integrated care perspective, ensuring quality and safety in an older person's care is not just a question of *what* kinds of care are delivered, but also *how* these different forms of care can be coordinated to be delivered in a cohesive, comprehensive, and empowering way [7, 9].

The World Health Organization's (WHO) Integrated Care for Older People (ICOPE) strategy recognises the importance of the forms of support that aged care services provide in enabling older people to live healthy and fulfilling lives [10-12]. It also underlines the importance of holistic care that supports not only physical health, but also social, emotional, mental, cultural, and economic wellbeing. The WHO strategy aims to refocus understandings of older age away from seeing it as a period of physical and cognitive decline which imposes demographic burdens on care systems, and instead towards appreciating older people as important participants in and contributors to communities, who need support to fulfil their potential [13]. Shifting older person's care away from disease-centric models is a way of breaking down ageist stereotypes and reducing insecurities around ageing.

Importantly, there is no one size fits all model for how to integrate care. It is widely accepted that a single model of integrated care for older people that is uniformly applied across healthcare, social care, and community service systems is not a realisable or effective goal [6, 14-17]. At the level of individual care, models need to be appropriate to the needs and capacities of the particular person. People with chronic illnesses and/or multi-morbidity are likely to have complex medical needs and require frequent contact with a range of professionals across healthcare and social care organizations. However, not everyone receiving aged care is in this situation. Some older people may benefit most from a skilled nurse who they can call upon to when needed, and who can flexibly deliver both acute care and personal care in their home. Other older people have a high capacity for self-management but benefit from better integration of the processes through which they are assessed, funded and given access to different services. At the population level, models of care need to be attuned to the needs, capacities, values, and local resources of particular communities. Contrasting our rapid review and consultations, we found dissonance in the way integrated care was understood in academic literature and in Australia's aged care sector, the former usually defining it as a clinical intervention from a primary health perspective [16, 18] and the latter placing emphasis on entry

point care, community connections, and addressing the social and cultural determinants of health.

1.2 *Integrated care in Australia*

Integrated care has become a popular policy goal in Australia over recent years, but changes in actual practice have tended to trail behind these policy intentions [4, 18, 19]. Initiatives are mainly focused on the interface between primary care and hospital care [18]. There are bilateral agreements between States and Commonwealth governments to support various integrated care initiatives. These include alliances between the Commonwealth's Primary Health Network (PHNs) and State regional health authorities, as well as the Health Care Homes initiative [20], announced in 2016, which aims at clinical integration for treatment of chronic diseases [21]. We have not attempted to survey all these initiatives in this report, focusing instead on those that most relate to the interface with aged care.

1.3 *Method*

This report focuses on the integration of care between aged care, healthcare, and/or community service sectors. It does not investigate initiatives targeted at healthcare integration more generally – such as initiatives targeted at chronic diseases, mental health or different age groups – unless these initiatives are relevant to aged care. Nor does it investigate innovative models of aged care, as was the subject of a previous study [1], unless those innovations involve integration.

The methods of this study included:

1. A rapid review of scholarly literature reviews that examined integration of aged care and healthcare for older people in the community, residential care, and other accommodation.
2. An environmental scan for practical real-world examples, through a search of:
    - Academic and grey literature.
    - Government departmental and other health or social service websites.
    - Websites of aged care providers.
    - Direct engagement with stakeholders across the relevant sectors.
3. Phone or video consultations with 12 experts and integrated care providers.

Our consultations were affected by the COVID-19 pandemic and the burdens that placed on healthcare and aged care services during 2020. Consequently, we were not able to consult with representatives for every model we sought. Rather, by combining a comprehensive review of the academic and grey literature in tandem with a case-study approach, we provide a diverse overview of current accomplishments and potential future developments vis-à-vis integration of aged care models in contemporary Australia.

We refer to “Aboriginal communities” rather than “Aboriginal and Torres Strait Islander communities” throughout this report, as the organisations we consulted are not Torres Strait Islander Community Controlled.

The following four chapters outline the main analysis of the study, which focus on integrated person-centred care, community-focused integrated care, and the integration of aged care and housing services. Individual case studies of providers as well as the rapid review are included as appendices.

2 Integrated person-centred care

Key points:

- *Integrated person-centred care models need to align with the needs and capacities of the individual care recipient.*
- *For older people with advanced frailty or dementia, there are advantages to models that involve regular home visitations from a social worker or nurse.*
- *Community-focused integrated care is appropriate for people whose needs are not complex enough to warrant interdisciplinary teams.*
- *Entry point care is important for integrating aged care with other services, but not well supported by the current Government funding models.*
- *Many older people and/or their carers can manage much of their own care with the right kind of support from health and care professionals.*

Changes in consumer attitudes over recent decades have meant that older people are now more likely to expect a greater role in making decisions about how their health and lifestyle needs are being met by the professionals and services they engage with. Clinical integration refers to strategies that bring different medical, aged care, and other services together to coordinate their service delivery around the needs and preferences of an individual client. In healthcare sectors, clinical integration is seen as a way of achieving person-centred care [7, 8]. While in the aged care literature, person-centred care implies a critique of institutionalised depersonalisation [22], in the integrated care literature, person-centred care aims to reduce service fragmentation and increase client empowerment [23, 24]. In the integrated care literature, person-centeredness is also about empowering and supporting carers, especially as the structural burden of navigating fragmented services often falls to them [25, 26]. The goal is for each client, and carers, to be an active partner in the provision of care rather than passive recipients of treatments and services [27].

As there is no one-size fits all model of integrated care for older people [6, 15], the models discussed in this chapter are presented on a continuum of needs. They start with highly structured models that support people with complex health conditions and a low capacity for self-management, through to unstructured linkage between providers and within the wider community, which support people with mild needs who can manage their own health and wellbeing with only minor and irregular support. Integrated person-centred care generally aims

to transcend a narrow medical focus, and address the broader determinants of health and wellbeing [11, 12, 19]. Yet the structural and cultural inertia of healthcare systems can make this difficult. We consider this below.

2.1 *Primary health initiatives for complex medical care*

Our rapid review found that existing literature emphasises clinical integration programs for people with complex, multiple and/or long-term health conditions. These clients must engage with a range of different health, social care and other providers, and may have difficulties managing their own care. Models are usually designed and implemented by primary care, with their goal being a responsive and integrated primary care system [28-32]. This is posited to reduce duplication and wastage in other systems, such as hospitals and residential aged care, and improve clients' health, wellbeing and overall experience of care [3, 6, 8, 33]. These programs are often justified as a way of reducing costs, especially for hospital systems by way of reducing admissions and occupancy [6, 17, 34]. Our rapid review found that the evidence supporting this latter promise is ambiguous at best [35, 36]. These programs generally include some or all of the following components [7, 19]:

- Comprehensive geriatric assessments
- Care planning
- Care coordination/case management
- Multidisciplinary teams
- Shared information or record systems
- Disease-specific care pathways

Primary health clinical integration programs require the right kind of organisational contexts and connections within the community [7, 37]. Many international models are fully integrated, which means programs pool healthcare funding from different systems, and all purchasing is controlled within the model. Taking control over funding, eligibility, and record systems allows a fully integrated program to exist in parallel to other systems, circumventing system-level discordances, restrictions, and chains of command. This can be especially effective in closely tailoring a program to very complex needs clients [14, 15].

In Australia, clinical integration more often consists in coordination between Commonwealth primary and State secondary health systems, with different aspects of clinical care funded by respective systems [18]. These models are typically based on formal partnerships between Commonwealth Primary Health Networks (PHNs) and regional State health authorities, with

some also partnering with local government [8, 38]. We discuss partnership arrangements as forms of community-focused integrated care in section 3.6 of this report.

2.1.1 GP-centred models

Some models of clinical integration are led by GPs, with the responsibility of conducting comprehensive assessments, drawing together multidisciplinary teams, and signing off on expenditure resting with a GP or their practice nurse. The advantage of GP-led models is that many older people have well-established relationships with a GP, who they trust, and GPs have authority that allows them to pull in other providers through referrals and professional networks [39]. GPs are also in a good position to get a foot in the door with residential aged care providers, and clinical integration programs could provide resources that allow GPs to spend more time visiting residential aged care facilities. Professor Don Matheson, who leads the Health Alliance (See Section 8.5), a GP-led model in Brisbane North, supports a GP-centred model, but he described to us some problems that GPs face in this role:

> My experience as a doctor working with older people is you spend a good five minutes asking about the grandchildren and the dogs and things just to get people comfortable. Short consultations just don't work and so we need a system that incentivises the GP and the practice to spend quality time and actually engage in the complexity of the issues that older people are facing (…) people don't necessarily blurt it all out in the first few minutes of a consultation (…) The current system strongly rewards throughput and does not reward the sort of outcomes that we know we should be achieving.

There are other problems with GP-centred models. As Leutz argues, "The one who integrates calls the tune" [15]. In other words, there is a risk that the health professional leading clinical integration may emphasise the priorities and perspectives of their own discipline. Leutz notes that historically, clinical integration programs for older people have found it difficult to enrol the support of GPs, and those GPs that do enrol tend to be most willing to commission medical treatments and testing, and commission fewer other services such as social care or services that address social determinants of health [15]. Some studies have reported that aged care professionals feel side-lined or subordinated when medical professionals are dominant within multidisciplinary teams [40, 41]. GPs are also often under time constraints and serve a broad clientele, which can reduce their responsiveness to older clients with urgent needs and create bottlenecks in the process of connecting a client to other services [17, 42]. Moreover, small independent practices operating on fee-for-service can have varying degrees of commitment to integrated care programs, and do not have business models conducive to developing community level partnerships [8].

2.1.2 Coordinator-centred models

Professor Nicholas Goodwin (University of Newcastle, NSW) suggested to us that more funding for GPs for longer consultation times is unlikely to transform the way they work. He argues that the person in the integrating role needs to fully subscribe to the values of integrated care and see care coordination as their role specialisation and priority. He endorses models centred on care coordinators, who can regularly visit clients' homes and have the capacity to link up with other services without GP authorisation:

> You need to achieve… something called "advanced simplicity" whereby whoever is supporting and managing that patient in the home, we'll call them a care coordinator or a care navigator or case manager, whoever it is, has the authority to pull in the services that are required to support that person in real time, as immediately as possible… The GP is a part of that alliance and ecosystem and are supported… but it's almost working on behalf of the GP. So, the GP still feels in control but actually, the service runs separately to it.

Many clinical integration models either train nurses or social workers specifically for a care coordination role [17, 31, 43]. Distinct roles like this can support a flexible approach and helps break out of disciplinary thinking [44]. As the OPEN ARCH model shows (see box), having a care coordinator (which they call Enablement Officers) who works outside of general practice may broaden clinical integration programs beyond a medical focus, and better address non-medical social, physical and mental health needs. These workers do things GPs are unlikely to

Example: OPEN ARCH

The Older Persons Enablement and Rehabilitation for Complex Health Conditions (OPEN ARCH) program is the result of collaboration between Cairns and Hinterland Hospital and Health Service and Northern Queensland PHN to offer an integrated "whole of system" model of integrated care for older people in the community [45, 47]. The program employs Enablement Officers (EO) as named points of contact for each client, who drive the model and perform the bulk of integrating work. EOs work with a geriatrician to first assess the client in their home, examining both their health and lived environment. The EO and geriatrician then conduct periodic case conferences with the client's GP to collaboratively plan treatments and review medication. Both the geriatrician and EO share access to the client's records through a general practice IT system, implemented by the PHN. The EO has authority to engage with Aged Care Assessment Teams, home care providers, occupational therapists, allied health providers, meal services, transportation services, and other services to further coordinate care planning and ensure any apparent gaps in the client's care are addressed. The model is intended to complement, rather than compete with, the role of the GP. The project in its early stages and systemic evidence of its cost effectiveness and efficacy is yet to be published, but case study evidence suggests clients and professionals are responding well to the initiative and it is improving the capability of primary healthcare to meet the needs of older people in Northern Queensland [45].

do, such as organising clients' transport and negotiating home care responsibilities with aged care providers [45]. For much of this work, a care coordinator need not consult with doctors at all. [46]

2.1.3 Clinical integration for people with dementia

Our desktop review found a number of specialised integrated care programs and pathways directed at chronic diseases such as diabetes, cardio-pulmonary disease and cancer in Australia [18, 29, 48]. Some international models specifically target frailty in the community [49-52]. However, we found only a few examples of clinically integrated models of care that specifically supported people with dementia in the community. There is good evidence that changes to the built environment, diet, and lifestyle can improve the health and wellbeing of people with dementia [53]. Clinical integration programs centred on care coordinators who visit people's homes are a potential way of applying these changes. They may also support innovations into how people with dementia, their carers, and clinicians might tailor smart home technologies to support the safety and wellbeing of people with dementia in their own homes [54, 55].

2.2 *Integrated community health and aged care*

For people living in the community, who have mild-moderate health needs and require support with activities of daily living, it may be more appropriate to situate integrated care initiatives at the intersection between community health and home care. The advantage is that a skilled nurse can potentially provide acute care, social care, and care coordination in the home, without the need for higher-level agreements between primary and secondary health systems.

2.2.1 Nurse-led teams

Self-managed community nursing teams are one potential way of integrating care at the intersection of community health and social care. A prominent example is Buurtzorg (See Section 8.4), a Dutch non-profit. Buurtzorg consists of small teams of up to 10 to 12 qualified nurses, each working in an allocated "neighbourhood" and responsible for 50-60 clients [56]. Teams of nurses typically set up offices in a neighbourhood, then actively engage local communities and service providers in order to locate clients and build up their caseloads. The size of the team is important, as smaller teams are claimed to be more sensitive to local realities and able to get a more direct and detailed sense of the local community's needs [57]. The nurses offer home-based community health and aged care to their clients, including needs

assessments, care planning, acute care, personal care, support with medical or allied health appointments, and they maintain client records via an online system [56, 58]. In a typical day, a nurse might see three or four clients, doing things ranging from complex medical tasks, support with activities of daily living, to just sitting and having a chat. Buurtzorg care has a strong emphasis on improving clients' self-management, with the goal of clients being the drivers of their own health and welfare, with the nurse's role to enable this [57]. Buurtzorg devolves its governance and financial management to the teams. The model's founder, Jos de Blok, claims this improves cost effectiveness as it reduces fixed overheads and managerial waste. Studies have found Buurtzorg nurses spend about 40% less time on their clients compared to other Dutch home care providers [56, 59]. Proponents of the model claim this is because care is more individually tailored, self-management is more successful, and the needs of Buurtzorg clients are more effectively met [60]. There are calls to trial nurse-led teams in Australia [61-64], for both in-home aged care and disability care. Nurse-led teams may be well suited to CHSP type block-funding. However, policymakers would have to either reconsider the exclusion of medical expenditure and care coordination from CHSP or consider how budgets could be pooled with other healthcare funding streams, in order to fully realise the integrative potential of the model.

2.2.2 Home care providers

It is possible that integration of community health and aged care could centre on aged care providers. We consulted with Kylie Houlihan from Integrated Living (See Section 8.6), who outlined their "systems demonstrator": a plan to transition Integrated Living away from solely delivering in-home aged care towards a more holistic model of community health and aged care. In this model, Integrated Living would enter regional partnerships with PHNs. They would use PHN resources to screen the community and identify potential clients, then engage those clients earlier and more directly than current referral pathways allow. Much of the model would be managed digitally, though telehealth consultations, digital health monitoring, electronic health records, remote assessments, and online marketing. "Personal care managers" employed by Integrated Living would perform a care coordination role, coordinating multidisciplinary teams of primary and tertiary healthcare professionals and providing linkage to other providers. Through this, Integrated Living coordinates integration of general practice, specialists, allied health, and other in-home help while also providing personal care.

According to Ms Houlihan, there are system-level barriers to implementing this model. First, the model requires shared data custodianship over client information with clients having rights to their own data. She stated that there is a need for clarity about how this could happen given current privacy laws and data ownership. One way of realizing this is a national health care data system that, in her words, would "link a client's story across multiple providers". This aligns with recommendations by the Productivity Commission, who have suggested using My Health Record for this function [4, 8]. Second, Houlihan claims the current consumer-directed home care model is not conducive to innovation, as it is difficult for providers to enter commissioned partnerships with PHNs or other Government entities. A way of getting around this is to develop a parallel funding stream, such as a Commonwealth grant, that retains the same level of funding as would the Aged Care Funding Instrument (ACFI), but removes the provider from the home care marketplace and the associated packaging and funding restrictions. This, she argues, would afford Independent Living some flexibility to build up their model in coordination with PHNs, until a point at which they can then re-enter the competitive marketplace.

2.3 *Entry point care*

Not everyone in the health and aged care systems need continual contact with a care coordinator or case manager. Some people may need a burst of support as they enter or transition between services, but are able to self-manage once an equilibrium of care is reached [14, 15]. This is especially important when older people or their carers are unsure what they need, unaware of what is available, and confronting unfamiliar systems. In our consultations, many providers emphasised this. Uniting AgeWell assess all home care clients using the same instrument, regardless of package, to anticipate changing needs and provide continuity of care (See Section 8.12). Other providers reported employing social workers to provide such guidance and support. These workers were reportedly skilled at identifying needs and vulnerability in the community, and could assist older people with finding services, navigating My Aged Care, understanding their eligibilities, and completing applications. Jewish Care fund this activity through donations and therefore reserve it for Jewish community members. ACH Group provides some of these services at a fee (See Section 8.1). Merri Health (See Section 8.8), a Community Health Service in Melbourne, use a "key worker" model: a client's first clinical contact in the service becomes responsible for referring them to other services based on an assessment of their needs. This support is usually short term, and the need for it is reduced once

a client establishes their own routine of care. However, the worker can remain a point of contact for the client and/or carer should their situation become more challenging [15].

> When we talk about integration of care, it's how we can support a client across the range or the continuum of services that we have, and the aim is for the client not to necessarily know or understand which buckets of funding they're being supported in if they don't need to, but that their care needs are being met seamlessly. The only time that that becomes a problem is where you're not able to deliver a service, because it would be deemed as double dipping or they don't meet the eligibility, and then it does actually become problematic trying to explain how different buckets of money work and why they can and can't do something. (Lence Markovska, Merri Health)

In a submission to the Royal Commission, Wintringham, a Victorian provider of aged care and housing for older people at risk of homelessness, argue that this kind of activity should be block funded [65]. They argue that current consumer-directed care ties up case management with home care package eligibility, which is not available for entry point care. They suggest flexible discretionary funding is especially important for socially disadvantaged clients, whose living situations can be precarious and whose multiple eligibilities can be complex to negotiate.

2.4 *Integration through linkage*

Not all integration of care needs to occur through specific points of contact. Linkage refers to connections and relationships between health and social care professionals in the wider community [14, 15]. Care remains fragmented by different organisations and/or funding streams, but professionals work in cooperative and coordinated ways [66]. When linkage is strong, professionals understand where they sit within the whole care ecosystem, including what their respective roles and responsibilities are, and they are able to inform clients of their entitlements and options and link them with other services. Linkage may be supported by referral policies within organisations, through training, through professionals being familiar with their local service environment, and through having good relationships with the community [19, 67]. The National Health Service (NHS) in the United Kingdom, for example, has employed "link workers" in some jurisdictions, who visit clients homes and undertake "social prescribing" by guiding clients to socially and physically beneficial services like social groups, education, mental health services, exercise classes and gyms, and more [68, 69]. Community integration enables linkage, not just by professionals but also by community members. The Chief Executive Officer of a regional Multi-Purpose Service, who we spoke to in our consultations, illustrates this well:

> [Clients] come to us, pretty much. When they don't, their family bring them to us. When they don't, their neighbours or their friends or their co-workers or even strangers in the street will give us a call and say "there's an issue here, can you help?" and the answer is always "yes"… Nobody is afraid of ringing us and saying, "can you help with this?", and sometimes we can't, but we always know where and when and how to get somebody to a place where they can get help. (Lyndon Seys, Alpine Health)

Clients do not need to meet eligibility criteria or undergo assessment to benefit from linkage. Professionals may also be less constrained by program structures or inter-service agreements than in more formalised integrated care arrangements. This can potentially allow professionals discretion to refer clients to a broader range of services. Leutz argues that linkage provides appropriate integration for older people in the community who have relatively mild or emerging needs, and can mostly self-manage and self-advocate [14, 15]. If the professionals they engage with are taking the time and responsibility to consider their situation holistically and provide relevant guidance to other supports, then more formalised integration across the domains of care may be an unnecessary complication.

2.5 *Conclusion*

Integrated person-centred care needs to align with the needs and capacities of the individual care recipient and their carers. There is little point setting up complex interventions with multidisciplinary teams for people who do not need that intensity of medical support. Models centred on GPs may be appropriate for people with chronic illness, or for people residing in supported environments like residential care or assisted living. However, when older people face frailty or dementia, models that involve care coordinators or nurses regularly visiting their homes have advantages over models centred mainly on a medical practice. This allows regular assessment of the home environment and life circumstances, and supports social relationships between coordinators, clients and carers.

From our consultations, entry point care emerged as a major priority for aiding integration of the aged care system. Specifically, aged care service providers claimed that different eligibility and funding streams, within aged care and across other health or social services, are fragmented and clients often need in understanding and accessing different options. Services provide this support in various ways, but unless their clients are on HCPs and eligible for case management, it is not currently supported by the Commonwealth. It would be worth considering how Government could support this. Finally, it is important to point out that many older people manage much of their care on their own. When professionals are able and willing to provide

the right kind of advice about and linkage to other services, more structured models of integrating care may not be required.

3 Community-focused integrated care

Key points:

- *Community-focused integrated care is optimised when collaborating partners work towards shared goals of improving health and wellbeing for a defined population.*
- *Strategies that support community-focused integrated care include community needs assessments, community consultations, satisfaction surveys, and community governance.*
- *Community integration depends upon and in turn reinforces personal relationships, mutual trust and respect between collaborators and their community.*
- *Community-level health promotion that address the social and cultural determinants of health.*
- *Different communities have different capacities and needs, which must be reflected in models of care.*
- *Governance at a community, rather than system-wide level, allows greater community involvement, ownership and planning that is responsive and adaptive to local realities.*

This chapter discusses integrated care at a community or population level rather than an individual level. While individualised care may draw on community resources or services, care for the community is about building up and maintaining those resources and services as well as shaping the social, cultural and economic determinants of health [3, 8, 10, 12, 40, 70]. Personalised care does not target these structural factors, which also contribute to ill health and lack of access [7]. In this chapter, we explore what integrated care means across a range of different contexts by looking at different types of providers and the kinds of communities they service. The purpose of this approach is to emphasise that there are many types of communities in Australia, who have developed different models of care that align with their specific needs and capacities.

3.1 *Strategies for integrating care at the community level*

Integrated care needs a community-focus for three main reasons [44, 70]. First, having a community-focus is what gives participating partners and stakeholders a shared purpose and mutual goals. Second, community-focused integrated care has a more adaptive than prescriptive approach and is therefore better able to tailor care to local conditions and

community needs and preferences. Third, a community-focus is built upon, and in turn builds, relationships and trust, between professionals and within the community. Programs may adopt some or all of the following strategies to support a community-focus [12, 30, 70]:

- **Community needs assessments:** Including of health and other demographic data, service availability, and community values and preferences.
- **Consultations and focus groups with community members:** To ensure a model reflects the community's values and priorities and remains adaptive and accountable.
- **Community input into governance:** Including in working groups and boards of management.
- **Feedback and surveys:** Ensures the model is meeting community expectations.
- **Support for volunteers:** Increases community links and supports a workforce.

If communities feel involved in and represented by integrated care programs, they are more likely to refer their family or friends, volunteer time or resources, offer constructive feedback, and expect accountability [30, 70-72]. Relationships are valuable in and of themselves. When professionals are known and trusted by their communities, and have a better understanding of the local landscape they are in a better position to draw together diverse linkages when their clients need it [30, 70].

Community needs and capacities vary depending on geographical, demographic, socio-economic and cultural factors. For example, some areas are poorly connected to public transport, some have few local allied health providers, while some lack a hospital. Some areas have older populations and others may have large migrant populations. Care at the community level involves accounting for these local differences and remaining adaptive to changing community needs [6, 11, 17]. Devolution of leadership and planning to a regional or community level is more effective than comprehensive integration across whole States or Commonwealth systems because governance at this level is more adaptive and sensitive to regional realities [4, 8, 73]. Below we describe how different types of communities have organised and integrated care into their local practices.

3.2 *Aboriginal communities*

We consulted with four Aboriginal Community Controlled Services to learn how they approach integration. Each organisation offers a range of services to people across their life course and each of these organisations emphasise that members of their communities, including people

who identify as Elders, play a key role not only as recipients of care, but as decision makers in their governance structures. Booroongen Djugun, which translates from Dunghutti (Booroongen) and Gumbaynggir (Djugun) languages to "Sleeping on Home Ground", provides aged and disability services to mainly Aboriginal people in the Kempsey region of regional NSW (See Section 8.3). Established over 30 years ago, they co-designed their buildings with community Elders to reflect the community's spiritual beliefs and maintain connections with Country. Booroongen Djugan provides independent living, residential care, and aged and disability community services, they are also a Registered Training Organisation and pride themselves on employing a largely Aboriginal workforce. Booroongen Djugan's Aboriginal Support Sector Worker says having a largely Aboriginal workforce translates to provision of "care our way".

In remote Western Australia, Ngaanyatjarra Health Service, a comprehensive primary health, aged and disability care provider and Tjanpi Desert Weavers, a social enterprise and part of the NPY Women's Council, have collaborated to co-locate in two remote community settings (See Section 8.10). The collaboration enables Ngaanyatjarra women to earn an income through weaving as well as an opportunity to access a range of aged care and disability services from the same location. The model enables staff from each organisation to link the women with primary, allied and mental health services as well as visiting specialists. Weaving on-site provides an opportunity for women of all ages to come together to share knowledge and strengthen the cultural determinants of health.

Tharawal Aboriginal Corporation Aboriginal Medical Service is an Aboriginal Community Controlled Health Organisation in South Western Sydney (See Section 8.11). Their model includes primary health, community aged care, allied health, transportation, social and cultural programs. They have established strong partnerships with services such as Centrelink, the police, legal services, disability/NDIS, and housing providers that provide regular outreach services at Tharawal. Similar to Booroongen Djugan, Tharawal employs a large Aboriginal workforce, recognising the value that meaningful work and a regular income plays in promoting the well-being of staff and that this has an enormous ripple effect throughout their community.

Each of these examples works to break down boundaries between clinical care, aged care and social support to optimise opportunities for intergenerational, spiritual, cultural and social connections. These services aim to address their community's complex needs by creating and

maintaining conditions that optimise their member's access to holistic and seamless care in a culturally safe framework.

3.3 *Culturally and linguistically diverse communities*

Culturally specific providers have operated in Australia for generations. Their models have shaped and been shaped by their communities. Jewish Care has existed in Melbourne since 1848, and provides a wide range of aged care, disability, welfare and social services to the Jewish community (See Section 8.7). Hugh Cattermole, Chief Operating Officer of Jewish Care, reported to us that long-term trust from the community regulates how they function:

> It creates a sense of oversight… It keeps Jewish Care sharp with respect to our service delivery, whether it's activities, whether it's around food, cleanliness, that sort of thing too, and that's important. The Jewish community of Melbourne… give Jewish Care the licence to operate, but they hold us accountable to it.

In our work at the National Ageing Research Institute [74, 75], we also interviewed Chinese-speaking carers for people with dementia in Western Australia. Many reported that they first reached out to Chung Wah, a Chinese cultural and community organisation that has existed since 1909, to support them with in-home and respite aged care, system navigation, carer support groups, and with locating medical support.

These culturally and linguistically diverse organisations play an integrating role because they have evolved in symbiosis with each of their community's cultural, linguistic and socio-economic context. They also depend on social networks and trust within those communities to operate. Although, we can learn a lot from these examples, much of the broader Australian population lacks the shared cultural identity and community connectedness that supports the way these organisations integrate care.

3.4 *Rural and remote communities*

Rural and remote communities may lack the population density to economically sustain a diversity of services providers. One approach to addressing this is the Multi-Purpose Services (MPS) program; a Federal agreement that allows Commonwealth aged care and State healthcare funding to be pooled, so that a single provider can offer acute care, residential aged care, and community services in a flexible, sustainable, and economical way [76-78] (See Section 8.9). An advantage of full integration is MPS nurses can work across the boundaries of aged care, acute care, and community care, providing continuous care for high needs clients

[78-80]. Some MPSs are the largest employers in their area and play a major role in their local social and economic structures [78]. They are community-focused by design and generally highly valued by communities. Each MPS is set up through community consultation and are required to produce regular Service Delivery Plans that map out their activities based on an assessment of community needs. Their plans, however, can be quite broad, and some MPSs, such as Alpine Health (See Section 8.2) in Victoria, go beyond their traditional scope by attracting allied health providers to their areas, organizing local volunteers, and funding health promotion, social activities and support groups [78-80]:

> Integration of service delivery and workforce with community needs and expectations is our life. It is a driving principle of everything that we do, and it is fundamental to health and wellbeing in our communities… What we do as a business affects everybody, so we really care about what we do, so maintaining those relationships is key and we have a great reputation across our environment for that reason. We will bend over backwards to help people get what they need. And we won't care too much what the cost is, we worry about that after the event. (Lyndon Seys, Alpine Health)

In Victoria, MPSs are run by independent boards, which have more autonomy from regional State health authorities than in other Australian states. It has been argued that this independence gives Victorian MPSs flexibility to provide a broader range of services and engage in community activities beyond a medical and aged care focus [78, 80].

3.5 *Socially disadvantaged communities*

Community Health Services provide generalist primary health and community support services to their local communities, while also providing specialist services for specific and vulnerable population groups [81]. Inner city Community Health Services offer support for people affected by drugs and alcohol, homelessness, and mental health. In areas with refugee populations, they organise programs for refugee groups, as well as providing culturally appropriate and in-language support where needed. Services commonly provided include nursing and allied health, medical care, health promotion, chronic disease management, dental services, disability services, emergency support, family planning, refugee support, mental health services, drug and alcohol counselling, post-acute care, home and community care, community rehabilitation, as well as diverse activities initiated by and for local communities. Because of their generalist scope, Community Health Services must manage different funding and governance requirements behind the scenes, while offering continuous and coordinated care to their clientele. The Victorian Auditor General suggests that Victoria's Department of Health and Human Services could reduce this operational burden on Community Health

Services by improving the consistency of definitions across different application, funding and reporting requirements [81].

3.6 *Regional alliances and partnerships*

Health alliances have been promoted in recent years as a way of coordinating community level population health initiatives as well serving as platforms for clinical integration in Australia [4, 8, 29]. Alliances between Commonwealth Primary Health Networks (PHNs and State regional health authorities are the main organisational framework for doing this, and are aimed at integrating primary health, secondary health, and community care. The Productivity Commission endorses this approach, and highlights the need for regional governance that is grounded in relationships and responsive to community needs [4, 8]. The goal is that State health authorities and PHNs collaborate to tailor a regional model through which they can coordinate initiatives, share information, and co-commission services or projects from other organisations at a local level, including residential aged care providers and Community Health Services.

3.6.1 Alliances with local government

Two-way alliances have tended to reflect the remit of PHNs and State health departments and have therefore been platforms mainly for clinical integration rather than community-focused initiatives. A more community-focused model is potentially a three-way alliance that includes local councils as a primary partner. The Wollondilly Health Alliance in South Western Sydney is one such example (See Section 8.13). With support from volunteers, they undertake a range of health and lifestyle programs that extend beyond a narrow clinical focus. These activities include social meetups, community gardening, group exercise, walking groups, and programs for local older Aboriginal people [82, 83]. Their activities are targeted at addressing the social determinants of health, including social isolation among older people. They host various working groups, which allow input from community members. The role of the local council in this partnership strengthens the social and geographical focus of community. Vice versa, the resources and partnership of the PHN and Local Health District (LHD) help embed health policies and health planning into the council's day-to-day business.

3.7 *Commitment from partners, funders and policy makers*

A potential challenge to partnerships is conflicting priorities between major partners. Madison Jarrett, Project Officer for Wollondilly Health Alliance (See Section 8.13), said this was especially the case during critical periods – such as the bushfires or the COVID-19 pandemic – when Executive Committee members found it difficult to meet, creating blockages for initiatives that need Executive approval. Another obstacle she noted was variable commitment or capacity from other partners or collaborating agencies within working groups and individual projects. This is mainly a problem when collaborators do not attend key meetings or do not follow through on actions. Models of care based on partnerships can also face challenges when financial partners are reluctant to combine budgets or withdraw their contributions [30, 84]. Partnership success depends on commitment from participants, whether that involves a commitment of time, commitment to values, commitment of resources, or commitment to how the model is governed [29, 43, 44].

3.7.1 Issues with limited term funding

There can also be challenges with securing long-term sustainable funding commitments. Lungurra Ngoora is a well-regarded model of community care that was developed with and for people living with conditions associated with ageing, disability and mental health, along with their families, carers and service providers in one Aboriginal community in remote Western Australia [84, 85]. The model was developed and implemented during a National Health and Medical Research Council-funded study. According to evaluations of community members' and service providers' perspectives, the project delivered an improved, holistic and integrated community care service to the people of Looma Community, and the community supported continuation of the service beyond the conclusion of the pilot [86]. The research team noted some challenges with implementing new management and funding models and recommended these be addressed in consultation with all involved. Nonetheless, researchers concluded that the Lungurra Ngoora model offered a template for how all levels of Government might provide an integrated model of care for remote Aboriginal communities [84]. Government commitment to sustain implementation of the model ended once the pilot finished, and as the research team stated: “the major risk of limited term funding is the significant disappointment and disruption for communities and all those involved when programs cease” [84].

3.8 *Evaluation*

Another challenge is that integrating care typically costs money long before it saves money [15], and benefits can take many years to come to fruition [40, 87]. Also, when barriers to access and literacy are addressed, people can become more frequent users of the services they need [88]. This is difficult when a new initiative must prove its worth through evaluated trials or pilots that may only be supported for one or two years, and particularly so when there are expectations that the program can save on system expenditure. Systematic literature reviews have noted this and recommended longitudinal, population based studies as an alternative to clinical trials [36, 40]. Many suggest a value to clients or communities approach, using Patient Reported Outcome Measures (PROMs) or Patient Reported Experience Measures (PREMS), quality of life (QoL) instruments, or qualitative methods to evaluate models [35, 40, 87, 89-91]. These measures can serve as performance indicators that focus on the quality and experience of care, can be built into client record systems, and can provide oversight while allowing integrated care models to retain a flexible approach to resource allocation and self-governance [4, 8, 38, 78, 92].

3.9 *Conclusion*

Community-focused integrated care focuses on communities rather than individuals. This focus depends upon and in turn reinforces personal relationships, mutual trust and respect between service providers and their community. Aboriginal Community Controlled services, culturally specific services, and rural and remote services provide examples of what community-focused integrated care can look like. These services often offer much more than aged care as they tend to support communities over the life course in various ways. However, these services tend to support populations who already have strong social connections, familiarity with the service, and in some cases share a cultural identity that is representative of the service. These factors help strengthen and sustain those models. In contrast, much of the Australian population is likely to face a marketplace of competing health and aged care providers, whom they may have little prior identification or familiarity with. Alliances or partnerships are a potential means for offering community-focused integrated care to the wider community. However, these will likely require long-term commitment from collaborators and funding partners.

4 Integration of aged care and housing

Key points:

- *There will be growing demand for appropriate housing options for older people who use aged care services.*
- *The retirement village sector has expanded and diversified to meet growing demand but does not cater well to low income older people.*
- *Co-location with other housing, health, and community facilities may break down siloes around residential aged care.*
- *Co-housing is a promising way to involve older people in the creation and management of alternative housing options, and there is scope for Government to promote and financially support these initiatives.*
- *Combining co-housing with integrated person-centred care could offer an alternative to residential aged care for some people.*

Service integrated housing sits between community care and residential care and has been called "the third sector" of Australia's aged care ecosystem [93]. The term, "service integrated housing" encompasses a broad diversity of different housing and care models, including retirement villages, independent living, assisted living, and extra care housing [94, 95]. However, this sector has had relatively little attention from researchers or policy makers in Australia [93, 96]. What these models have in common is that the housing service, either directly or through external arrangements, supplies some form of support and care to residents in addition to providing housing. The types of support and care provided broadly fall into three categories: recreational and lifestyle, facilitation of independence, and health and personal care [93, 97]. For the purposes of this report, we primarily focus on how housing is integrated with other services, rather than the quality of the housing or the quality of aged care in housing models.

4.1 *The intersection of aged care and housing*

There has been little Government policy interest in the intersection between aged care and housing since the 1980s, when the Commonwealth ceased subsidising the development of hostels and independent living units (ILUs) [93, 98]. This shift broadly coincided with a policy realignment towards fostering a competitive home care marketplace, with a greater emphasis

on consumer control over the choice of provider [99, 100]. However, this shift has been premised on the assumption that home care clients have a stable and sustainable housing situation and can make informed decisions. There has been comparatively little consideration at a policy level of low-income aged care recipients who often have insecure tenure, are unable to modify their homes to suit their needs, and are struggling to afford utilities [101, 102].

In the future, fewer numbers of older Australians are projected to own their own homes [103, 104]. Concurrently, there is a growing shortfall of affordable housing or social housing that can accommodate them [105-108]. The existing stock of subsidised independent living units has gradually declined over time, as providers struggle to run and maintain them [106, 109]. There are calls for a national housing strategy that would support either State or private investment in affordable supportive accommodation for older renters [101, 102, 110-112].

Aged care and housing policy could also be better integrated by assessing housing needs as part of aged care assessments[102]. This would allow a more consistent and accurate understanding of how aged care and housing needs intersect at an individual and community level.

There is very little research into how housing and aged care are integrated as different services in Australia. Reports by Australian Housing and Urban Research Institute (AHURI) in 2010 and 2011 found that housing providers generally integrated aged care into their service by offering home care options to their residents, either themselves or through external home care providers [93]. At the time, divisions between the home care, residential care, and older independent living unit funding streams placed siloes around different aged care options and prevented the provider from being able to transition clients seamlessly between streams [103]. The Commonwealth aged care assessment process was a perceived barrier, as clients were required to go through an external aged care assessment to change arrangements. This contrasts with international aged care systems, such as in New Zealand, where the provider can manage clients' transitions between streams. Providers interviewed by AHURI argued that Australia's approach made it difficult to provide a continuous and integrated service [103]. The AHURI studies were conducted prior to reforms that favour consumer-directed home care, and which have transferred control of funding from the provider to the recipient [113, 114]. There is need for research investigating current arrangements across the non-profit and for-profit sectors.

Older people who own their own home have assets to downsize or choose alternative housing options. Retirement villages are the most prominent example and will be discussed below. Co-

housing offers another potential housing option, which is novel in Australia. Both options tend to cater well to people with assets, but we consider how they could apply for people with insecure tenancy or limited assets. We also explore the potential for integrating housing models with other services, including aged care and healthcare.

4.2 *Retirement villages*

The market of service integrated housing options has greatly expanded over recent years through independent developments of retirement communities and similar models by private companies and non-profits. An AHURI report argues the "hands off" policy approach by Government has likely facilitated diversification and innovation in the sector [93]. Retirement villages offer a wide range of care options catering to various needs and preferences, including on-site medical support and personal care [115]. These may be offered by the housing service or through an external provider and may be (fully or in part) subsided through Commonwealth packaging or paid for privately. The models and funding arrangements vary widely [115].

4.2.1 Benefits of retirement villages

Moving from the family home to a retirement village can improve quality of life [116]. Studies have found residents enjoy the social connections, the availability of recreation and lifestyle options, the ready access to health and care services, and the pleasant environment that facilities

Example: The Retirement Village Care Pilot

The Retirement Village Care Pilot, funded by the Commonwealth from 2002-2004, trialled service integration of on-site aged care at retirement village developments. The pilot introduced Commonwealth packages, equivalent to community care packages, for people living in a number of retirement communities [97]. Participants qualified through aged care assessments and had a broad diversity of care needs. Accounting for diverse needs, care hours delivered to participants were about equivalent to what they would have received if living in their own home in the community. The trial found several advantages of the program in comparison to community care in the home. Foremost, by co-locating with resident accommodation, care staff were able to offer a more comprehensive and flexible service. The evaluation pointed to advantages of short visits to clients throughout the day for check-ins, medication support, and assistance with daily living tasks, which supported relationships and gave reassurance to residents. Second, the scheme facilitated coordination of care. Nursing and allied health staff were available on site, or partnering providers were able to attend the site for multiple appointments at a time. This allowed services to address the continuum of a client's needs responsively and flexibly, rather than being constrained by package requirements. The pilot suggests that service-integrated housing with care staff on site can deliver a higher level of care at a lower cost compared to community care in the home.

may offer [117-120]. Retirement community residents are more likely to have complex health and care needs than older people in the community, and some older people make the move to have better support [121]. Many retirement villages provide 24 hour on-site nursing [93, 122]. Residents may potentially provide forms of "symbiotic care" to one another, such as emotional support or support with instrumental activities of daily living like transportation, shopping or finances, although existing research into this is limited [94]. The Retirement Village Care Pilot (See box) demonstrates the advantages of having home care staff located on-site at retirement villages. Clinical integration initiatives, such as The Health Alliance, also coordinate with housing providers to target clusters of clients with complex health needs living in retirement villages (See Section 8.5).

4.2.2 Issues with retirement villages

Moving into a retirement village usually requires full cost recovery for the provider, and consequently a high capital cost of entry, often paid for by residents selling their former home [100, 118]. Few are available as rentals for low-income older people [102]. Yet this group could benefit from retirement village living, especially if they lack family carer support or currently reside in inappropriate homes [100, 102, 120]. Most new developments are on the fringes of metropolitan areas, where land is most available and affordable. This may not be conducive to ageing in place as it concentrates older people into clusters, while potentially dislocating them from former neighbourhoods [93, 107].

Studies have found that retirement village communities can exclude or marginalise some residents, and economic, gender, cultural and health status divisions can segregate a village [123-125]. Residents in retirement villages can also face financial stress and may feel they have lost control of their living situation [107]. Rising general fees, exit fees, and concerns over the resale value of units means residents may feel trapped there and unable to pursue other options. There can be ambiguity around dispute resolution between residents and retirement village providers. These factors have led to calls for mandatory staff training and regulatory reform of the sector [118, 126], as well as specialised legal and financial advocacy for people purchasing service integrated housing or considering it [100, 107].

4.3 *Opportunities for co-locating residential care, housing and healthcare*

Around a third of retirement villages in Australia are co-located with residential aged care facilities [115]. This is intended to allow continuity of care and ease transitions into residential

care. Whether co-location achieves this is unclear. One study found that older people in a retirement village with an adjacent residential facility experienced anxiety about the transition, and associated the latter with functional decline, dependency and lower quality care [127]. Another United States study found that some residents who transition from residential care to co-located independent living units chose to move back as they found independence required more self-management than suited them [128]. Different accommodation options on-site may allow greater choice, making it possible for residents to try options out and thereby come to a better understanding of what they need.

4.3.1 Integrating residential aged care with the community

"Aged care precincts" are another way of collocating services with residential aged care. Some private or non-profit providers offer both retirement living and residential care on site, while providing further space for retailers, community facilities, allied health providers and general practitioners. These facilities are also available to the wider public for use. This approach originated in the Netherlands as a way of integrating residential aged care into the community [129]. Jewish Care are currently building three of these precincts in Melbourne, with a specific focus on encouraging the inclusion of residents in Jewish community life [130]. TLC Healthcare, a for-profit provider in Melbourne, have also developed "integrated care facilities". These have residential aged care, GPs and other allied health on site, all employed and trained by TLC. They also have recreational facilities and retail spaces, which are publicly available. TLC claim that integrating general practice and allied health allows holistic 24-hour care for residents. They also claim their model overcomes problems arranging visits from GPs or other health professionals, and is more financially viable than providing residential care alone [131].

4.4 *Co-housing for older people*

More common in Europe than Australia, co-housing is a way for older people to live together in environments designed to meet their age-specific needs within communities that offer mutual care and support [132-134]. These communities differ from retirement villages in two key respects: first, at least some of the residents are involved in the initial planning, design and development. Second, residents themselves, usually through consensus or direct democracy, manage their communities. Co-housing communities can vary widely in design and size, but they usually involve private units alongside communal spaces. The latter are designed to encourage social contact and chance interactions between residents. Communities may also

schedule regular meals and recreational activities to maintain their social connectedness. Co-housing communities are not communal economies, as residents retain their financial independence [135].

4.4.1 Benefits of co-housing

There can be many benefits to older people joining a co-housing community [132-135]. For those who own a home, they offer a relatively affordable way to downsize to a secure age-appropriate dwelling, with potentially lower maintenance costs, and cheaper utilities. Co-housing can also allow older people to retain financial and social independence, and foster friendships and connections in ways that traditional housing arrangements may not. Residents can have more control over who joins their community than other service integrated housing communities, and a commitment to participate in community life and support each other can be a condition of entry. They provide opportunities for residents to learn new skills and undertake new activities and initiatives, including running the community itself. They can keep people socially active and engaged and help avoid isolation and loneliness. They can also prompt older people to be proactive in planning for future changes in their physical, social and housing needs [135, 136].

4.4.2 Co-housing in Australia

A report by the Institute of Sustainable Futures has explored the possibility of co-housing as a form of supportive accommodation for older people in Australia, and comes to the following conclusions [135]: Co-housing projects require a great deal of initiative and planning from founders, and it may take years to bring together investors and complete the build; Australia's conservative lending institutions are not likely to enable groups of older people to take out mortgages for experimentation with new housing models; For these reasons, co-housing initiatives in Australia are more likely to succeed if supported by Government grants or through collaborations with developers; developers or housing associations also have the planning, development and management expertise that can help avoid some of the pitfalls of the early stages and support co-housing communities during establishment.

Critics have suggested that co-housing communities are a privilege of affluent, well-educated retirees, and do not address housing disadvantage [134]. However, some international co-housing communities have blended privately owned and rental units, with low income residents drawing on Government housing support [133]. There are different ways of achieving this in

Australia, including Commonwealth Rent Assistance or collaboration with State government housing authorities [135]. In our analysis, it would also be possible for the Commonwealth to renew its commitment to service integrated housing as a third pillar of the aged care system, through capital support for co-housing developments with aged care services available on site. Capital support could also help development of co-housing in areas close to urban amenities and local communities and therefore conducive to ageing in place.

4.5 *Conclusion*

Commonwealth aged care policy is predicated on the assumption that people are either in stable homes or in residential aged care. These policies do not account for those whose accommodation is unsatisfactory or unstable. In responding to the project brief, we investigated alternative models of housing for older people in Australia that do not fit this assumption.

The issue of supplying appropriate housing is complex and runs parallel to the issue of integrating care. We suggest a fuller investigation of how current housing policies and options intersect with the aged care system is needed.

These caveats notwithstanding, there may be scope for innovations that more fully combine housing and care. For example, it is worth considering whether the Commonwealth should recommit itself to supporting living arrangements between the poles of residential aged care and living at home. The case of the Retirement Village Care Pilot demonstrates the economies of scale and the flexibility of care that comes with integrating a dedicated team of nursing and attendant staff into a housing community.

The main justification for the current policy emphasis on home care is that older people want to live at home, close to their family and friends, and with control over their environment. These preferences are not incommensurate with downsizing in later life, for which there are several economic, environmental, and health and wellbeing benefits. Unfortunately, current home care policy does not fully align with living, ageing, and dying in place [115, 137]. More financial support for and promotion of alternatives like co-housing from Government could begin to bring these benefits to wider attention and shift preferences and perceptions among the ageing boomer generation [135]. Alternative housing communities would ideally be in locations desirable to older people and designed in ways that allow people to age in place for longer [137]. Combining this with integrated person-centred care that supports people in these

communities who have complex needs may be a viable and more appealing alternative to residential aged care in some cases.

5 Discussion and conclusion

The rapid review, desktop review, and consultations utilised in this project have provided insights into the aims and scope of integration between healthcare, aged care and housing sectors, and potential models for its realisation. Key findings are presented as follows:

Care integration works best when it is a bottom-up and community-focused process

Integrated care needs to be adaptive to their geographical, community, cultural and institutional contexts in order to succeed [17, 32, 138-140]. Top-down system-level mergers of large health, social care or welfare departments typically fail to enact the shift in values that is required on the front line, may increase rather than decrease administrative complexity, and can be met with various points of resistance on the ground [15, 40, 42, 73]. The implication of this is that there is no one-size-fits-all approach for an integrated model of care. Models need to be tailored in a way that reflects both program goals and the social and cultural environment they are operating in.

Many services, such as culturally specific providers, MPSs, community health services, are already doing this in various ways. In consultations, we learnt that these organisations take very seriously the communities they service, and direct resources into assessing what communities need or want, build local partnerships, and support volunteers who complement their work. They improve people's awareness of providers in their area, as well as knowledge of where to go for support, and undertake health promotion in a range of ways. These organisations described themselves as the first line of support in helping older people navigate health and aged care systems and explore their care options. Some employ social workers to do this, which is not fully supported by Government.

Formalised partnerships facilitate integrated care

An effective approach to integration in highly fragmented and complex health and social care environments is through alliance or partnership models [30, 38, 43, 141]. In Australia, these tend to be based on agreements between PHNs and regional State health authorities, and sometimes local government, to pool resources and share governance over regional initiatives [4, 8, 38]. In our desktop review and consultations, we saw anecdotal evidence that these models succeed in supporting innovations in clinical and community integration for older people living in the community [45, 82, 83, 142]. However, partnerships with residential aged care providers are still in their early stages. There is need to explore the boundaries faced by

aged care providers to entering partnerships. It may be appropriate to support providers who allocated resources to designing a model and engaging with potential partners, to implement their initiatives. This might involve Commonwealth grants.

Integration initiatives need to be targeted at their client groups

In our literature review, we found a broad consensus around what integrated care for older people meant in a clinical sense, with the most common aspects being a comprehensive assessment process, multidisciplinary teams, care coordination, and shared record systems. These approaches have emerged from primary and secondary health contexts, targeted at people with complex health needs and/or chronic disease, who are likely to be juggling multiple points of contact across healthcare systems [10, 11, 34]. These clients clearly benefit from better integration of healthcare, including pathway programs for specific diseases. However, this level of care is not suitable for everyone. In our consultations, we found that generalist providers emphasised the importance of integrated entry point care. This might involve relatively short-term, sometimes informal, support in navigating health and aged care systems, contacting aged care assessment teams, identifying local health services, participating in community health and social activities, locating support groups, or having a chat. Transportation is an important service that many services provide for older people. Where generalist providers are active facilitators of community services and activities, their relationships with older people in their communities are reciprocal, and favours are often returned through crucial contributions as community volunteers.

In the community, models work best as a complement to general practice, rather than GP-centred

While GPs play an indispensable role in communities, and are often trusted by older people, our findings suggest they are not always best placed to lead integrated care initiatives [17, 42]. This is due to being independent practitioners, with fee-per-service funding and short consultations, as well as the disciplinary demands of general practice itself and a lack of consensus among GPs on the value of integrated care [8]. Evidence suggests that integrated care for older people in the community works best when led by skilled health or community service workers, such as nurses or social workers. These workers can regularly visit client's homes, consult with GPs, and have authority and resources to pull in external providers and services when clients need them [40, 59, 61, 143]. They are also well positioned to build the community-level partnerships and relationships that integrated care depends upon. Nurse-led

teams are a potential approach that warrants trialling in Australia [56, 58]. The OPEN ARCH model that is currently being trialled in Queensland also shows initial promise [45]. Nonetheless, GP-centred models may work well if clients have environmental support, such as residential care.

The primary goal should be improving client experience and outcomes, rather than reducing costs to health and aged care systems

Integrated care programs are often justified as a way of reducing costs, but evidence supporting this promise is ambiguous at best [35, 36]. This is partly limited by the nature of existing studies, many of which have involved trials or pilots that evaluate only the start-up phase of what would need to be a long-term re-orientation in the cultures and habits of health and aged care services, that may take years before they influence health outcomes [40, 87]. Also, when barriers to access and literacy are addressed, people can become more frequent users of the services they need [88]. A "value-based" approach to evaluation, utilising quality of life and service experience measures, could better assess how changes in the processes of care may lead to improvements in the value of services from the perspectives of older people, carers and care professionals [35, 40, 87, 89-91].

Service integrated housing is the "third sector" of aged care and warrants policy and research attention

Most people prefer to remain living in their homes rather than residential aged care, and the expansion of the Commonwealth's home care provision supports this. However, some older people's needs fall somewhere between these two alternatives, especially where they lack family carers, or their current housing situation is unsustainable, but their condition is not acute enough to make residential care appropriate. There is a broad range of service integrated housing options that fill various niches, but the sector as a whole has remained relatively untouched by policy makers or researchers since the 1980s [93]. One potential problem is that many retirement villages tend to be private developer-led initiatives and situated where land is available rather than where residents would be able to maintain their community contacts.

Allowing flexibility for home care to be integrated into housing options is a logical and simple way of offering personal care in these contexts. There is some evidence to suggest that on-site home care services afford flexible care that overcomes some of the logistical problems and costs of visiting people in their homes [97]. We also found that health alliances saw older people in retirement living as among their target populations. By promoting or supporting co-

housing through grants or incentive schemes, the Commonwealth could recommit itself to the "third sector" of aged care, and potentially combine these initiatives with person-centred care programs.

Integrated workforces work well in regional and remote areas

Our review of the MPS program suggests integrated services are successful models for addressing acute care and aged care needs in regional and remote communities [78, 80]. In some cases, these integrated providers were the largest employers in their area and regarded as fundamental to local social infrastructure. One of the key lessons of these programs is that having a workforce that can cross the boundaries between hospital care and aged care not only supports the sustainability of those services, but also continuity of care for clients who transition between those services. Some have also extended into offering home care. This kind of service integration creates a multi-skilled and flexible workforce, with a higher proportion of trained nurses than typical residential aged care facilities.

5.1 *Conclusion*

This report has presented findings and analysis from a rapid review, desktop review, and consultations on integrated models of care, health and housing. In academic literature, we found a strong emphasis on clinical integration strategies, which generally had a primary health focus. While our analysis suggests that these strategies can afford benefits to older people who are experiencing chronic disease, frailty, and multi-morbidity, there is also a need to look beyond the clinical level at:

- Supporting older people at the entry points to health, aged care and other services.
- Promoting community-level initiatives, which engender trust and reciprocity between community members and in local services.
- Exploring boundaries faced by aged care providers to entering alliance models.
- Exploring flexible options for integrating home care into housing options that still afford clients' choice.
- Ensuring transport and access for older people to existing and new services.
- Sustainable funding that affords community-based organisations scope to innovate and proactively support older people in the community.
- Rigorous governance that is in partnership with and/or includes community views.
- Committed leadership that is community not profit-oriented.

- An intergenerational life-course approach that integrates older people with their communities rather than siloed aged care.

These factors play a role in shifting broader perceptions of ageing away from deficit and decline, to better supporting the valuable contributions older people make to contemporary Australian society. Different models of integrated care are suited to different contexts and different target populations and goals. However, as a minimum, Commonwealth and State Governments should consider incorporating measurable performance indicators into their service contracts so that grass-roots organisations can demonstrate how they are trying to incorporate integrated care thinking into their service models and measure the impact of these changes.

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7 Appendix - Consultation participants

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8 Appendix - Case studies

8.1 *ACH Group*

Services:	Residential care, home care, respite, disability care, community care and social activities
Approach to integration:	Community development linking clients with community resources and activities.
Key lessons:	Community development work provides linkage and supports reablement. Individualised funding does not support their community development work

This case study is based on a consultation conducted 12th May 2020 with Ivy Diegmann, General Manager Service Delivery, ACH Group, and on information provided at the ACH Group's website: https://achgroup.org.au/

The ACH Group is an Adelaide-based not-for-profit organisation that began in 1952 as Aged Cottage Homes with the purpose of providing housing for veterans and war widows. ACH has a history of engaging early with innovative models of aged care such as Community Options (now Commonwealth Home Support Program), Nursing Home Options Program (Home Care Packages), Hospital Substitution Programs (Transition Care), and consumer-directed care.

ACH provides home support, social, recreational, nursing and allied health services across Metropolitan Adelaide, Gawler and the Fleurieu Peninsula. They also operate eight residential aged care facilities and three retirement villages in these areas, plus two retirement villages in the outer eastern suburbs of Melbourne. ACH work with clients' GPs and the acute sector but they do not deliver medical services.

The ACH Group's strategic direction is to transition from being a 'traditional provider of aged care services to a promoter of Good Lives.' The Good Life platform's guiding principles were derived from consultations with the organisation's clients and staff, the broader community, and researchers from the University of South Australia. The six core principles are: honouring the uniqueness of the individual; client-based decision-making and control; a sense of optimism; belonging through relationships and social roles; contribution and participation in life interests; optimising health.

Care delivery – the current ACH model

New aged care clients typically access ACH through the My Aged Care system with Commonwealth Home Support Programme (CHSP) eligibility, and the majority of CHSP clients progress over time to Home Care Packages (HCP). The ACH Group also services

approximately 100 younger clients with NDIS funding for neurological conditions such as younger onset dementia, for the reason that these clients normally have limited options beyond early entry to residential aged care.

Clients with HCPs have dedicated care advisors who work with them to create individualised care plans covering cognitive, social, recreational and physical needs. Clients with lower-level CHSP funding are serviced by a team of staff administering the 'light touch program.' CHSP and privately-funded clients can choose to purchase additional advisory services through ACH's Aged Care Navigation Service.

ACH offers a full range of home and community services including shopping, cleaning, meals, home and garden maintenance, personal care, transport, social outings, exercise and recreational programs. They also provide carer support including respite and dementia-specific support.

Connected Communities – the strategic vision

The Connected Communities model aims to expand beyond traditional aged care service boundaries by directly linking clients with mainstream local community resources, thereby enabling older people to maintain or create new social roles, relationships and experiences that are embedded in the broader community rather than aged care-specific environments. For example, a pilot Connected Communities project in the Onkaparinga region is working with local restaurants to offer hosted meals at earlier sitting times for older people who would otherwise not eat out by themselves. ACH currently applies this partnership approach with their NDIS clients, for example arranging for those who are interested in playing golf to have lessons with professional instructors at a golf club, rather than simulate the experience at a day care centre. These experiences also further the programmatic goal of 'reablement' which aims to improve clients' functional abilities.

In this way ACH is fostering integration at the neighbourhood and community level by engaging local partners according to the interests and needs of their clients, as well as the interests of mainstream suppliers, thereby cross-cutting traditional sectoral boundaries.

A challenge for the Connected Communities approach is how to fund community development work. Current funding at the individual level does not allow for capacity building in communities, or for developing new models of service delivery that take time to become cost-effective.

8.2 *Alpine Health*

Services:	Residential care, home care, acute care, community health, disability care, community programs, health promotion, volunteer network, more.
Approach to integration:	Full integration of residential aged care and acute care. Single service delivery of home care, community health. Coordination and linkage with other services.
Key lessons:	Community level governance allows for an innovative, broad ranging and flexible service. Alpine Health are well integrated and trusted in their local area. Continuity across a client's home care and residential care funding could support innovation in the sector.

This case study is based on a consultation conducted 3rd June 2020 with Lyndon Seys, CEO of Alpine Health, as well as information provided at the Alpine Health website (https://www.alpinehealth.org.au/) and information provided by Mr Seys to the Royal Commission (EXHIBIT 12-16 - WIT.0604.0001.0001, Mudgee Hearing, 5 November 2019).

Alpine Health is the primary provider of health and aged care services across the Alpine Shire in Northern Victoria, encompassing the regional towns of Bright, Myrtleford, and Mount Beauty. They also offer aged care packages to home-based clients further afield, such as the neighbouring Indigo Shire. As an MPS and the largest employer in Alpine Shire, Alpine Health considers itself fundamental to both local industry and community. We spoke to Mr Seys, Chief Executive Officer of Alpine Health, who emphasised the importance of a single flexible workforce and the embeddedness of Alpine Health in the local community as important integrating factors in their model of care:

> Integration of service delivery and workforce with community needs and expectations is our life. It is a driving principle of everything that we do, and it is fundamental to health and wellbeing in our communities… What we do as a business affects everybody, so we really care about what we do, so maintaining those relationships is key and we have a great reputation across our environment for that reason, we will bend over backwards to help people get what they need. And we won't care too much what the cost is, we worry about that after the event.

MPSs began as a way of giving regional and rural health services some financial security in the context of economic rationalisation reforms during the 1990s. However, the flexibility of the model, both in terms of funding and governance, has provided a platform for further initiative and innovative at a local level. In Victoria in particular, State health governance operates through health service boards, which are more numerous and more community-

focused than the much larger Health Districts of other states. This smaller scale governance gives affords greater independence to MPSs from State-level bureaucracy, which affords them space to tailoring their activities around the needs of their communities:

> The beauty of [local governance] is that it sustains local ownership or the feeling of local ownership of your health service if you live there, and that enables the health service. We've built on this to establish strong relationships with those communities and their involvement in our business. So we can identify very clearly with their needs, and we can work our planning and build our services accordingly.

Alpine Health has a whole of life course orientation, and aims to fulfil the healthcare needs of their whole population, from providing antenatal and post-natal care to community aged care, residential aged care and palliative care. As an MPS, Alpine Health spans both acute care and aged care services. They offer a full range of Commonwealth supported aged care options; encompassing CHSPs, HCPs, as well as the low care and high care residential aged care places supported through the MPS flexible funding scheme. They also offer disability support to younger NDIS clients. The advantage of containing all of these services within a single organisation is that staff are able to work across the boundaries of different programs, providing a familiar face and continuity of care if clients transition between services as their needs change. Alpine Health is also a Registered Training Organisation, and is able to train a workforce skilled and flexible in delivering care across the breadth of the organisation.

As a home care provider, Alpine Health offers case management as funded through the ACFI, with the case manager functioning as the single names point of contact for clients who have HCPs to support them in managing their package. They also employ care coordinators, who able to bring together whichever external agencies are needed to meet a client's needs. Care coordinators also manage people's transitions between in-home aged care and residential aged care, ensuring there is continuity across the programs. Older people with chronic disease are the predominant users of Alpine Health's hospital services, so transitions into and out of hospital care are managed by Allied Health's care coordinators who also organise case conferencing which can include external GPs, allied health providers and specialists.

Under Mr Seys's direction, Alpine Health has set up three Community Health and Advisory Groups Bright, Myrtleford, and Mount Beauty, which serve as the peak bodies for organizing volunteers in their communities. Consequently, in addition to Alpine Health's 420 paid staff, there are has around 380 volunteers who offer various forms of support and social activities in

the community, particularly for older people. These include a range of health and social support groups, men's sheds, and community gardens. This work has fostered community networks and trust in Alpine Health, and they are now seen as the de facto sources of health and social support by members of the community.

> [Clients] come to us, pretty much. When they don't, their family bring them to us. When they don't, their neighbours or their friends or their co-workers or even strangers in the street will give us a call and say "there's an issue here, can you help?" and the answer is always "yes"… Nobody is afraid of ringing us and saying, "can you help with this?", and sometimes we can't, but we always know where and when and how to get somebody to a place where they can get help. That's the beauty of full-service integration, I reckon.

Alpine Health receives block funding from both the Victorian government and the Commonwealth to support its hospital and aged care services, as part of the MPS program. This supports the sustainability of the organisation by offering a consistent stream of revenue, which can be flexibly deployed where it is needed. However, the MPS funding is not sufficient to support Alpine Health's ambitions as a provider of holistic care that is responsive to community needs, and it raises additional funds through other Government grants, community donations, as well as their training operations. As with other MPSs, they do not receive capital grants from the Commonwealth, which is a problem when old residential aged care infrastructure is not adequate to supporting the increasing acuity of aged care residents, in particular the increasing number of people living with dementia in their service.

Being a small, generalist provider with strong geographical connections to the community supports a model of integration that is responsive to community needs, and able to draw on local networks to support older people in the community and support the organisation's operation. This is difficult to replicate in metropolitan areas where health and aged care providers are more specialized and competitive. However, Mr Seys suggested that a shift in the sense of purpose for that aged care providers could be influenced by connecting packaged home care funding to residential aged care funding in such a way that residential aged care clients enter into the service through packaged care. This would focus providers on developing long-term positive relationships with clients and maintaining them across their care journey. It would also encourage the creation of a skilled and flexible workforce who are trained to work

across programs, with clients who have a wide diversity of needs, whether in community or institutional care contexts.

8.3 *Booroongen Djugun Ltd*

Services:	Residential care, home care, disability care, transportation, training, community programs, and more.
Approach to integration:	Aboriginal Community Controlled service. Coordination and linkage with other services.
Key lessons:	Booroongen Djugun was initiated and established by a community for their community. Booroongen Djugun has an RTO on-site, with many graduates taking up roles in their aged and disability services Booroongen Djugun has established partnerships with a wide variety of other organisations, providing links for their community to relevant services.

This case study is based on telephone-conference consultations conducted with the Aboriginal Sector Support Development Officer, Booroongen Djugan Ltd on 20th May 2020 and Debbie Urquhart, Director of Care, on 27th May 2020.

Booroongen Djugun Ltd is an Aboriginal Community Controlled Aged Care provider, based on Dunghutti land in Kempsey, about 50 kilometres North West of Port Macquarie in regional NSW. The organisation was conceived when Gary Morris and Val March, along with other health and welfare workers, recognised a gap in services for their community back in 1989. The name **Booroongen Djugun** comes from Dunghutti (Booroongen) and Gumbaynggir (Djugun) traditional Aboriginal Languages meaning **"Sleeping on Home Ground"**. Today the organisation includes a college that is a Registered Training Organisation that provides training for Aboriginal people, a 60 bed residential aged care facility, independent living units, and a range of community based services for Elders and people living with a disability. The majority of Booroongen Djugun's clients are Aboriginal people, although non-Aboriginal people are eligible and do access their services.

The community-based care services are accessed through My Aged Care, the Regional Assessment Service or NDIS. The services include entry level home support through the CHSP, HCPs, ComPacks and respite for people with disabilities and Elders. ComPacks is a State funded short term case management services for developed to facilitate safe and early discharge of eligible patients from hospital by providing access to a short term package of care designed to help them gain confidence and prevent re-admission to hospital. Booroongen Djugun's community team includes care coordinators and support workers as well as ability linkers for people living with a disability and a Senior Care Coordinator to link community members to NDIS. The Senior Care Coordinator provides extensive advocacy and case management to ensure people living with disabilities get the required assistance they need to

live inclusive and independent lives. The role involves regular contact with clients, often on a daily basis and far exceeds the funding received to deliver the service.

Booroongen Djugun also has an Aboriginal Sector Support Development Officer (ASSDO), who supports 70 CHSP providers across 400 kilometres and 8 local government areas in the region. In her role, the ASSDO assists CHSP providers to better understand how they can shape their services to identify and respond to the needs of Aboriginal people in their area. This role has also been vital in bringing representatives from the Aged Care Assessment Service (ACAS) and Regional Assessment Service for My Aged Care to speak with Elders and their families at Booroongen Djugun's Elder's groups.

Booroongen Djugun's provision of transport, for Elders and those with chronic health issues to access specialist clinics and a large range of allied health services that are often located some 50 kilometres away in Port Macquarie, is central to ensuring their wrap around model of care. The nature of integrating care in this regional setting is time and resource intensive, with support workers often spending up to a day accompanying Elders to and from their appointments. The team of 20 Aboriginal support workers who provide the transport also play a valuable role in caring for people's social, emotional and cultural wellbeing. Providing transport provides an opportunity for relationships to form between staff and their clients. The ASSDO emphasises that transport needs to be recognised and resourced as a vital way for staff to identify and respond to the clinical, social, emotional and cultural wellbeing of their community members. Providing transport for older people to spend time with their family members is also viewed by Booroongen Djugan as an essential but somewhat under-recognised resource.

The 60-bed residential care unit is funded through Commonwealth aged care programs and supplemented by homeless viability grant. Approximately 50% of residents are under the age of 65 and the majority of residents are Aboriginal people. The idea for the design of the aged care facility came from the views and opinions held by the Elders. For the Elders, the totems of fire, water, earth, and sun were seen as having strong ties to traditional life. To meet their needs, extensive consultation took place at a grass roots level. The participatory process led to the development of buildings that reflect the spiritual feelings connected with the traditions and customs of the local Aboriginal community. The facility overlooks mountains, is close to a river and is often visited by local wildlife, including Kangaroos.

Debbie Urquhart, the Director Care for the residential care unit, is concerned that in its current iteration, the ACFI does not capture the amount of time required to support the client's healing and social and emotional wellbeing needs. This is an ongoing challenge, particularly for a facility that sees many people's physical wellbeing improve rather than decline on entry to care. Ms Urquhart explains that many people in this community are experiencing ongoing trauma as they are members of the Stolen Generation and they have experienced ongoing structural violence and disadvantage throughout their lives. Ms Urquhart stresses that she and her team "prioritise the time it takes to build relationships of trust, but this is simply not reflected as 'care' in the ACFI".

Booroongen Djugun Community College is a co-located Registered Training Organisation and a striking feature of this integrated model. Many of the College's students complete their placements within the community and residential aged care service programs on-site and stay on as staff, or are employed at other organisations. Many students return to Booroongen Djugan to take up roles at a later date. The organisation places great emphasise on promoting cultural safety as a priority and employing a largely Aboriginal workforce is evidence of the organisation's connection with and obligation to community they service. The Aboriginal Sector Support Development Officer emphasises that having Aboriginal staff is so important to "provide care our way".

Booroongen Djugun has established partnerships with a wide variety of organisations that has resulted in regular visits to their organisation from local GPs, Geriatricians and a Mental Health team. Referrals are facilitated through relationships, Memorandum of Understanding (MOU) and referral pathway systems. Regular meetings also occur through established local area networks. The organisation also runs Elders' day programs from their facility, hosts major celebrations such as NAIDOC week and the Elder's Olympics day. The annual Elders Olympics Day, which was established 20 years ago, is a highlight on their community's calendar and a chance for old and young to meet up with communities from around the State. Booroongen Djugun also partner with local schools to regularly visit their aged care facility, and they played a key role in organising an intergenerational day with Kempsey Shire and Taronga Zoo in Sydney, during Senior's Week celebrations.

The ASSDO says these partnerships are all underpinned through relationships, and enabled through technology and informatics and she advocates for more investment to support, maintain, and grow these IT systems as they are key to integrating care across the region.

Booroongen Djugun was initiated and established by a community for their community. Their integrated or wrap around model of care is reflected in the deep knowledge of the Country and its Lore, on which they are situated. Great consideration was given to the architectural design of their building to facilitate the spiritual care of residents and those frequenting Elders groups onsite. Their model is built on and maintained by strong relationships and understanding of their community's needs. Booroongen Djugun's investment in training and employing a largely Aboriginal workforce reinforces their priority of promoting healing through culturally safe care and identifies and responds to the clinical, social and cultural determinants of health.

8.4 *Buurtzorg*

Services:	Home care, community health.
Approach to integration:	Nurse-led teams integrating in-home acute and personal care.
Key lessons:	Nurse-led teams may simplify bureaucracy, reduce operational overheads and improve workforce morale. Small, neighbourhood based teams support familiar and trust with local people and local services. Clients benefit from continual in-home contact with qualified nurse, who can provide flexible care and enlist other services when required.

The Buurtzorg model is as much a philosophy about organisation as it is a model of integrated home care. Buurtzorg began in the Netherlands in 2006, as a non-profit provider of community nursing and home care. The model has since been extended to other countries, including the Sweden, United States of America, United Kingdom and Japan, and there have been various calls to implement it in Australia. Buurtzorg means "neighbourhood care" in Dutch, and the central principle is that when community nurses organize home care themselves, at a small-scale in as close proximity to their clients as possible, the outcome is better care for clients, happier staff, and better financial management [143].

The organisation's founder, Jos de Blok, has been a vocal critic of what he sees as increasing managerialism in health and social care in the Netherlands since the 1990s. The emergence of Buurtzorg is best understood in that context [56, 58, 59, 143]. Central to the Buurtzorg model is a rejection of organisational hierarchies and bureaucracy. Administratively complex, top-heavy organisations are less responsive to clients' and community needs and tend to prioritise cost management and administration over delivering care in a genuinely person-centred way [58]. Managerialism, according to de Blok, also affects staff morale, as it ties qualified nurses up in administrative tasks that take time away from the work they would rather be doing – building relationships with their clients, and helping them to live happy and safe lives in their own homes.

Buurtzorg consists of small teams of up to 10 to 12 qualified nurses, each working in an allocated "neighbourhood" and responsible for 50-60 clients [56]. Teams of nurses typically set up a physical presence in a neighbourhood, then begin actively engaging local residents and service providers in order to locate clients and build up their caseloads. The size of the team is important, as smaller teams are more sensitive to local realities and able to get a more direct and detailed sense of the local community's needs [57]. The nurses offer a full spectrum of

community nursing and home-care services to their clients, including needs assessments, care planning, acute care and personal care, support with medical or allied health appointments, and maintaining documentation via their internal ICT system [56, 58]. In a typical day, a nurse might see three or four of their clients, doing things ranging from complex medical tasks to just sitting and having a chat. The type of care Buurtzorg nurses deliver has a strong focus on self-management, with the goal of clients being the drivers of their own health and welfare, with the nurse there to support them [57]. Overall, Buurtzorg nurses spend about 40% less time on their patients compared to other Dutch providers, but it is argued that the flexibility to tailor individualized care means the needs of Buurtzorg clients are more effectively met [60].

Importantly, there is no one model for what a Buurtzorg team looks like. As teams are self-organizing and self-managing, they have discretion over how funding is spent and how they choose to operate. This allows flexibility in responding to what people in their neighbourhoods need, what is already available to them, and how the teams can adapt their activities. Teams typically work closely with local GPs, allied health providers, community and volunteer services, or local councils in order to ensure continuity of care for their clients and improve referral pathways. They can also become advocates for improving access to services and overcoming service gaps in their local area [143]. It is also possible for different Buurtzorg teams to work collaboratively alongside each other in overlapping areas, yet have different specialisations or foci, such as dementia care [56].

An important departure from mainstream models of home care in the Netherlands is how nursing is costed within the Buurtzorg model [56, 58]. Activities are costed on the basis of time spent with clients, rather than the type of activity performed. In mainstream home care, activity-based funding means that the qualification and remuneration of staff must align with the tasks they are performing. Consequently, older people are likely to see a range of different nurses and care attendants coming and going to attend to the full range of their needs. Buurtzorg, by contrast, funds nurse's time with clients based on an average hourly rate. The information system does not require them to input the type of task they were doing, just the amount of time they are spending with a client. This allows nurses full discretion to provide clients with the care they need, rather than what the nurse has been costed to do. It also supports better relationships and better continuity of care, as it reduces the rotation of different care professionals through the older person's home [56, 143].

One of the biggest claims made about the Buurtzorg model is that is has superior economic and resource efficiency. The teams all operate with a shared ICT system that manages patient records, provides self-evaluation and client satisfaction tools, offers digital training and promotes idea sharing between teams. The ICT system also includes the costing and budgeting tools, which decreases the need for financial administration. Self-governing teams reduces fixed overheads and the need for an executive layer of the organisation. Moreover, the model is designed to encourage entrepreneurialism among nurse teams: when they must collectively decide how care is delivered and funded for their local clientele, they feel a greater responsibility and ownership over managing the reputation and financial status of their team [58].

It is difficult to assess how well Buurtzorg stands up to its promises, especially outside of the Netherlands. An evaluation by the Commonwealth Fund found that that Buurtzorg is cost effective in that it delivered more efficient care (by hours), with greater client and staff satisfaction. However, these savings averaged out the cost of clients' access to other health and aged care services where factored in [56]. A recent trial of the model for older people in the United Kingdom National Health Sservice system found that clients were generally very satisfied with the model. Particularly, they appreciated close relationships they were able to form with proactive and highly trained nursing staff, who had the time, resources and competence to deliver care organized around meeting their needs [56, 59]. The model ranks very well for staff satisfaction and morale, and nurses report that the model affords them greater pride in their work, and more ownership over the care process. This fits with the philosophy that trusting care professionals is the most effective way of motivating them to do their well [144]. The self-management philosophy has become inspiration for restructuring workforces in other industries [58].

A major barrier to the model is scepticism that nurses can self-manage, especially within larger bureaucracies. In particular, there is limited scope within the model for administrators to quantify costs of care per unit and compare it to other models [59]. However, proponents of Buurtzorg argue this is by design, and fine-grained costing conflicts with principles of flexibility and autonomy [58, 143].

The Nurses Professional Association of Queensland has advocated the introduction of Buurtzorg teams in the Australian context, in order to address problems with the current home

care package system. They claim that would produce significantly lower overheads, and could lead to a $4.5bn annual saving on health and aged care costs for government in Australia [61].

Nonetheless, the Buurzorg model is probably best suited to delivering care to older people living in the community when they have high-level and complex health and aged care needs. This might mean frailty, comorbidities or dementia. These older people, in particular, would benefit from the frequent contact and strong relationships with skilled nurses who are attuned to any changes in their health status and personal situation.

The Buurtzorg model is likely a less efficient allocation of resources when older people do not need clinically skilled nurses, and just require low-level personal support. However, the idea of self-managed community-based teams may still nonetheless offer inspiration for how these types of home care could be reimagined.

8.5 *The Health Alliance*

Services:	Primary health, secondary health.
Approach to integration:	Alliance between PHN and regional State health service.
Key lessons:	The model is a GP-centred clinical integration program across primary and secondary health, with programs targeted to older people. The Health Alliance is engaging with residential aged care providers and retirement villages. Capitation or bundled funding would better enable both episodic and longitudinal care.

This case study is based on a consultation with Professor Don Matheson, General Manager of the Health Alliance, conducted 11th May 2020, and on information provided at the Health Alliance's website: https://www.healthalliance.org.au/

The Health Alliance was created in 2017 as a collaboration between the Brisbane North Primary Health Network and Metro North Hospital & Health Service (MNHHS), covering the North Brisbane and Moreton Bay region. Its overall aim is to address 'healthcare problems that transcend the mandate of any one organisation or part of the health sector, and that can't be fixed by existing approaches.'[1]

The Health Alliance currently focuses on three populations: people with complex health and social needs who frequently present to emergency departments; children in the Caboolture area; and older people in The Prince Charles Hospital catchment, primarily Chermside and surrounding suburbs.

In its work with older people – called the Ageing Well Initiative - the Alliance has chosen to concentrate on those aged 75 and above, and 50+ for Aboriginal and Torres Strait Islander people. These age criteria were selected as proxy for frailty when health and social care needs become more complex, and where an integrated and person-centred system response may produce better outcomes than business-as-usual. There are approximately 23,000 people living in the catchment area who meet the age criteria.

[1] The Health Alliance, 2019. *Submission to the Royal Commission into Aged Care Quality and Safety, on behalf of the Older Person Core Group. https://www.healthalliance.org.au/page/our-work/older-people.* Accessed on 11/06/2020.

The Ageing Well Initiative is supported by local stakeholders comprising Metro North HHS, Brisbane North PHN, Residential Aged Care Facilities, Queensland Ambulance Service, Indigenous service providers, non-government service providers, and general practice. The Initiative is also informed by consultations with aged care services clients and carers, including residents of a local retirement village.

The Initiative aims to expand healthcare beyond its predominant focus on disease states to a holistic approach that recognises the multiple dimensions of frailty and takes the perspective of the older person. The key features of their model are:

- Person-centred services focusing on what matters most to the older person, their family and carers.
- Envisaging a 'health journey' that encompasses mental, social, emotional and spiritual wellbeing as well as physical.
- Capacity-building and empowerment of older people and the community to guide their own care.
- Recognition of diversity and development of culturally appropriate services.

The Ageing Well Initiative's care model

General practice clinics are at the centre of the Alliance's integrated care model and are the primary point of engagement, to include referrals coming from hospital emergency and outpatient departments. A core strategy of this model is to build relationships between GPs and specialists, and between GPs and hospitals and residential aged care facilities.

The older person's care is built around an initial comprehensive health assessment conducted by the GP and the development of a care plan. The GP will engage other professionals as needed, such as geriatricians, allied health, and nurse navigators, to implement the care plan according to the client's needs and wishes. This care team is to be facilitated be mechanisms such as a 'Virtual Huddle' (where team members can meet virtually to discuss progress and challenges), and GP direct referral to Hospital in the Home, avoiding unnecessary hospitalisation.

The Health Alliance is especially interested in engaging residents of aged care facilities, and to this end is working with local residential care facilities to 'support a community of practice with geriatricians, GPs and residential care medical nursing staff.' The geriatricians involved are supporting the group of GPs servicing a particular aged care facility, through both visits to the facility and virtual consultations and assessments. These mechanism help build the

relationships between the members of the care team, and as a consequence, improve the quality of care.

While the Alliance posits that GPs are best positioned to construct and oversee care planning, they recognise that current funding arrangements create a time-poor environment for this type of work. The Health Alliance's General Manager, Professor Don Matheson, notes that the current funding system incentivises throughput and short consultations, whereas GPs need far longer consultations to perform a comprehensive assessment:

> *My experience as a doctor working with older people is you spend a good five minutes asking about the grandchildren and the dogs and things just to get people comfortable. Short consultations just don't work and so we need a system that incentivises the GP and the practice to spend quality time and actually engage in the complexity of the issues that older people are facing (…) people don't necessarily blurt it all out in the first few minutes of a consultation (…) The current system strongly rewards throughput and does not reward the sort of outcomes that we know we should be achieving.*

The Alliance in its submission to the Royal Commission proposed that health and wellbeing funding be shifted 'from discrete silos focusing on volumes of services towards outcomes that matter most to older people.'[2] Professor Matheson suggests that this may take the form of capitation or bundled payments to enable services to address longitudinal care as opposed to episodic care, and should not increase system costs due to more effective use of system resources through a pro-active approach to health care that prevents avoidable hospitalisations.

The Alliance also recognises that while GPs may be in a good position to identify a person's social needs, they may not have sufficient knowledge of local community infrastructure to meet those needs. Under the banner of "Social Prescribing" they intend working with GPs to build their knowledge of local resources, and with community organisations to respond. This approach will help address prevention opportunities for older people, especially nutrition, physical activity and social connection

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[2] The Health Alliance, 2019. *Submission to the Royal Commission into Aged Care Quality and Safety, on behalf of the Older Person Core Group*. https://www.healthalliance.org.au/page/our-work/older-people. Accessed on 11/06/2020.

A further element of the integrated care model - navigation of the healthcare system by or on behalf of the older person - is yet to be resolved. The ideal and ultimate situation under the Ageing Well care model is for the older person or their carer to be empowered to do this themselves, but in the interim, this role defaults to the GP or the practice nurse where they exist. Hospitals currently have nurse navigators, however they tend to work from a specialist perspective, such as diabetes nurse navigator.

One area where the Ageing Well Initiative has come to a standstill is on shared client records between primary and secondary care. The Alliance developed a platform for sharing care information on activity and plans but they have been unable to sustain the funding for it. Negotiations with Federal and State bodies around innovative funding arrangements for the Ageing Well Initiative were initiated during 2019 but have not progressed.

On the positive side, the Alliance's platform of a virtual hub comprising the GP and relevant specialists, allied health and nurse navigators was given a boost by Covid-19 precautionary measures. Instantaneously, GPs and older people were able to consult with geriatricians without sending the person to outpatients. This has provided proof-of-concept for 'virtual huddle' teamwork at the core of the integrated care model.

8.6 *Integrated Living*

Services:	Home care, community health, respite.
Approach to integration:	Proposing a partnership with PHNs to run a community based integrated care model.
Key lessons:	Clients entering the Commonwealth Home Support Programme are supported for entry point care. Integrated Living want to redefine their approach to offer both home care and coordinated community health, supported by an ICT system. They argue that individualised home care packages do not enable them to innovate, and they suggest a parallel funding source to develop an alternative model.

This case study is based on a video-conference interview held with Kylie Houlihan, Chief Health Transformation and Research Officer of Integrated Living on 1st June 2020.

Home care providers are well situated to be potential drivers of care integration in the community, but current policy and funding arrangement present barriers to realize this. We consulted with Integrated Living, a non-profit provider of in-home community aged and healthcare who operate across regional and remote New South Wales, Queensland, Victoria and Tasmania. Integrated Living market themselves as offering an integrated approach to care, and we interviewed Kylie Houlihan, Chief Health Transformation and Research Officer at Integrated Living, to ascertain what they meant by this and how they were delivering it. Ms Houlihan instead used the opportunity to introduce their "systems demonstrator", which is in the process of planning and development. This model aims to transition Integrated Living away from being a traditional provider of in-home aged care into a "contemporary community healthcare provider". It envisions them working with PHNs to overcome boundaries between primary health, tertiary health and aged care. We describe Ms Houlihan's vision for the model here, as well as some current funding and regulatory barriers to its realisation.

Currently, Integrated Living operates as a traditional aged care provider of in-home care. They offer a catalogue of different services, which address particular needs and preferences, such as palliative care, physiotherapy, and dementia care. Their clients are mostly referred to them via ACAS, and they have clients on both CHSPs and HCPs, with some clients also paying privately. The goal of the systems demonstrator is to envisage how they can transition out of this traditional arrangement and instead seek out commissioning partnerships with PHNs to adopt a more multidisciplinary team-based approach to older person care. This alternative model would experiment with using electronic health records and partnerships with other

providers to implement what Ms Houlihan calls “population health management”, where the model is able to identify potential clients in the community, and engage them earlier and more directly than current referral pathways allow.

Integrated living has physical premises in several large regional centres, offering a range of healthcare, lifestyle and recreational services. However, the long-term vision is to transition the organisation towards a primarily virtual presence. This possible due to recent technological developments in remote healthcare consultation, digital health monitoring, electronic health records, remote assessments, and online marketing. It is especially beneficial for older people in rural and remote areas, who may be geographically and socially isolated from regional centres. While in-person attendant home care would still be central to the model, the implementation of a digital platform would facilitate integration with primary health, specialists, and other providers, as well as allowing monitoring for changes clients’ health status.

A major issue facing providers like Integrated Living is that people who enter the service under CHSP funding are not supported for case management by the Commonwealth. Consequently, some providers offer assist with coordination at a loss to themselves because they see it as necessary to supporting their clients’ wellbeing. Current funding arrangements thus create a “perverse incentive” to get CHSP clients onto HCPs whenever possible and secure case management funding. A more flexible model would involve what Ms Houlihan describes as a “personal health management” approach. Here a provider might offer short-term care coordination for people who would benefit from support with accessing preventative health, lifestyle advice, system literacy and navigation, social connections and basic personal care. If an older person’s needs become more acute or complex, the provider would be able to increase the level of management accordingly, and provide them with a qualified health professional as their named “personal health manager” who has a strong understanding of the complexity of their health needs and their living situation.

The model would be based upon a partnership between PHNs and the community healthcare provider, with the potential for input from State healthcare systems or other third-party providers of allied health and community care. This would require aged care and primary health funding to be pooled into a capitated fund, which is then allocated out based on the individual client’s needs. Providers would work in multidisciplinary teams to develop shared case plans and with shared client data. The home care provider would be act in a coordinating role,

organizing care planning meetings, maintaining links between providers, while also providing personal care and social support for the client. Teams would include GPs, specialists, as well as other providers of allied health or community services, but a "personal health manager" would bring these professionals together and ensure their goal are mutually coordinated around the needs and preferences of the client. The emphasis of the model is on developing common vision and shared responsibility, which crosses professional and departmental boundaries:

> It's not about referral anymore. Referral doesn't exist in the new system. It's about engagement. So, once you refer a client, you transfer responsibility and risk and the client is moved.

The model would avoid adopting a pathways approach – where a client might select between a diabetes program, a dementia program, a pulmonary program. Ms Houlihan argues that offering specific pathways leads us away from flexible person-centred care towards protocol-driven processes, which define a person's care around their disease and may therefore not address their needs in a holistic way. She argues that while medical specialists have an important role to play, from an aged care perspective, the needs of older people do not vary enough to require specialized pathways. By minimizing assumptions about how disease will affect an older person's life, the team is able to better tailor care plans and goals towards enabling the client to live the life they want.

When asked what would support the realisation of this model, Ms Houlihan made three main points. First, there is need for further research that uses health economics modelling to conduct system simulations of these kinds of models. This research can begin to locate potential bottlenecks in the service and possible financial or resource inefficiencies. The development of integrated care for older people is at its infancy in Australia, and more evidence would fast track the design and implementation of models. Second, the model requires shared data custodianship over client information with clients having rights to their own data. There needs to be an investigation of how this happen given current privacy laws and data ownership. One way of realizing this is a national health care data system that can "link a client's story across multiple providers". Third, current aged care funding arrangements present a barrier to these models by encouraging competition between providers within a "quasi-marketplace" and preventing providers from entering into commissioned partnerships with PHNs or other government funded entities. A way of getting around this is to develop a parallel funding stream that retains the same level of funding as would be available through the ACFI, but allows isolates participating providers from the competitive market place and allows them to explore options for pooled funding and shared governance with other partners.

We all have to be willing to remove the artificial barriers, remove the artificial barb wire, whatever it looks like depending on where you are, we have to let go of our individual needs [as providers], we have to create a shared value set, and we have to create a new organisation… that is structured around the coming together of PHNs, hospital and house services, aged care services, and the client and their families.

8.7 *Jewish Care Victoria*

Services:	Residential care, home care, disability care, supporting volunteers, and other community and welfare services.
Approach to integration:	A culturally specific provider that provides a range of services under one organisation.
Key lessons:	Jewish Care fund social workers and others to provide entry-point care for members of the Jewish community. Being highly integrated into the community means increases accountability. Co-locating residential care and supported housing with home care, health providers, and retail and community spaces may break down siloes around age care.

This interview is based on a video-conference interview held with Hugh Cattermole, Chief Operating Officer of Jewish Care on 25th May 2020.

Founded in 1848, Jewish Care Victoria (Jewish Care) has supported the wellbeing of Melbourne's Jewish community for several generations. This is a relatively small community mainly concentrated in a handful of suburbs in inner South Eastern Melbourne. While a substantive portion of what Jewish Care does is provide aged care, it is not just an aged care provider. It is an organisation that offers a broad range of services that cater to needs across the whole life course of its community members in a manner that is ethno-specifically sensitive considerate of the circumstances and history of the Jewish community. The strong sense of community connectedness and responsibility, as well as the whole of life orientation, are both fundamental to how Jewish Care envisages itself delivering an "integrated model of care". We consulted Hugh Cattermole, Chief Operating Officer of Jewish Care. He described both the strong sense of community integration Jewish Care enjoys, and their person-centred, "wrap-around", approach to care and supports.

Having existed in Melbourne for over 170 years, Jewish Care is highly integrated with the Jewish Community. The organisation offers a wide range of community and wellbeing services that cater to people across their full life course. This means that a family often will have multiple points of engagement with the organisation, whether they are utilizing child focussed disability services, aged care and Holocaust Survivor services, other disability supports, employment support, financial aid, low-interest loans, pro-bono legal services, subsidized housing or other community and welfare services. There is a strong sense that Jewish Care exists as the trusted provider of such services within the community, something that is fundamental to both their social vision and their business model. Mr Cattermole described this

trust as “the community’s license to operate”, and suggested that it was strongly regulative of how they function:

> It creates a sense of oversight… It keeps Jewish Care sharp with respect to our service delivery, whether it's activities, whether it's around food, cleanliness, that sort of thing too, and that’s important. The Jewish community of Melbourne… give Jewish Care the licence to operate, but they hold us accountable to it.

An advantage of deep community integration is the large amount of support Jewish Care receives from it’s circa 350 registered volunteers. Part of this is motivated by the Jewish concept of Tzedakah, which places an ethical obligation to perform charity and acts of goodwill at the centre of spiritual life. Much of what volunteers do is social in nature, including community visitations and running activities or games. Volunteers also coordinate transportation for older people to attend appointments or activities, whether those are run by Jewish Care. For people receiving aged care services, the network of volunteers augments activities that are funded through Commonwealth programs. This is evident in Jewish Care’s residential aged care facilities, which Mr Cattermole describes as much busier places than typical aged care facilities, full of volunteers and visitors. He also describes the role of volunteers as crucial to the organisations success in identifying and responding to the needs of older people in the Jewish Community:

> Time and effort and sweat are more important than money, because you know a lot of what we really want and need to support people is time. It’s a set of hands to go and sit and have a cup of tea with someone. That’s the sort of thing that makes someone’s day. And having those eyes and ears in someone’s house or in someone’s life is critical.

These unfunded volunteers are an important part of being able to deliver “wrap-around care”. Jewish Care offers a full spectrum of aged care services. In addition to residential aged care and a strategic intent to invest in retirement living Jewish Care also supports a large proportion of the community with home or community care funded services. These are funded through the CHSP or HCP schemes as well as internationally funded Holocaust Survivor Supports given Melbourne, Victoria is purportedly home to the home to one of the largest per capita Holocaust Survivor communities in the world. Being a single provider of all these services affords continuity of care throughout later life and avoids some of the burden of an Elder or their families having to navigate different aged care funding schemes and providers. There are

also strong linkages with other providers, especially local Jewish GPs who tend to be very familiar to Jewish Care and service many its aged care clients.

Jewish Care also employs its own care coordinators and social workers who are front-line workers trained to identify needs and vulnerability in their community. If one of these workers identifies that an Elder in the community has possible unmet needs, they will often speak with family members and will support that person in accessing supports from Jewish Care or other providers, including navigating the My Aged Care or other application processes. When an Elder has serious unmet needs, care coordinators or social workers will often provide "a burst of support" in order to establish an equilibrium of care in the Elder's life. This might involve referrals to health or aged care assessments, organizing financial aid or subsidized housing, or helping them explore other care options. Apart from people receiving HCPs, the Government does not fund this care coordination. Hence, while Jewish Care offers its aged care packages to anybody, its unfunded support is primarily sustained through donations from the Jewish community, and therefore members of that community are given exclusive preference.

Before the end of 2020 Jewish Care will complete construction and commissioning of three "Senior Living and Community Precincts" spanning the community's geographic base. The precincts will incorporate residential aged care, as well as a synagogue, community and commercial spaces, gallery, gymnasium and educational facilities. The idea of the precinct is to build a hub that the Jewish Community may use for a variety of reasons, but which at the same time, supports inclusion of aged care residents in community activities and breaks down physical and cultural boundaries around residential aged care. By doing this, the precinct attempts to reduce some of the stigma and anxiety older people may have towards receiving aged care. The precincts are designed to offer tiers of amenity within the same building providing maintenance of wider connections. They allow Elders to reside in a small home that is of an amenity they can afford, but then allows them to share in the wider environment beyond their front doors with a broad section of the Jewish community, as they did before they moved into the precinct. Jewish Care has also developed and implemented a contemporary Elder-led model of support called Hand-in-Hand. The model seeks to empower Elders to lead their lives and move away from the traditional, task oriented and structured models of support that have become entrenched in aged care environments.

The precincts will act as a hub and spoke base for home care services, and include space for other providers, such as dental, podiatry, allied health and medical services in varying

capacities to deliver sessional supports to users of the precincts or the general community. This is intended to support continuity of care, as older people utilizing these services can remain engaged with them regardless of the kinds of aged care services they receive:

> The idea is to create that continuum of care from someone who is truly home based - what you might call the young old - then you might have the middle old moving into the retirement village and requiring slightly more supports; and then you have the old old in the nursing home proper environment.

The Jewish Care model is an inspiring example of how both community and person-centred integration can occur through an organisation that is able to flexibly combine Government funded aged care services with deep community networks, volunteering, and charitable funding. A limitation on the transferability of this model into other contexts is that the most integrated components of the model do revolve around a shared Jewish identity and membership of Melbourne's relatively close-knit Jewish community. As Mr Cattermole puts it:

> With only 55,000 to 60,000 members of the community, 75% of whom live within 8 kilometres of each other you know in that, it's very concentrated, you know everybody knows everybody, and everybody knows everybody's business.

It is important to emphasise that the history of Jewish Care is also forms part of the history of Melbourne's Jewish community, and that therefore community networks facilitate, rather than being facilitated by, the organisation's model. This illustrates a possible barrier to scaling up or replicating community integration for populations who do not already share a sense of identity with and ownership over the model.

8.8 *Merri Health*

Services:	Primary and community health, disability support, mental health, community care, home care (sub-contracted).
Approach to integration:	A community health service that provides a wide range of services under one model, especially for vulnerable or socially disadvantaged members of the community.
Key lessons:	Community members' involvement in the Board of Management supports responsiveness and adaptation to community needs and values. Merri Health provide entry point care through a funded Access and Support service. The service focuses on integrating care from the client's perspective, while managing divisions between funding and eligibility requirements behind the scenes.

This case study is based on a consultation conducted 22nd May 2020 with Lence Markovska, Manager Aged Care, Merri Health, and on information provided at their website: https://www.merrihealth.org.au/

Merri Health has existed as a community health service for people of all ages since its establishment in 1975 as the Brunswick Community Health Centre. The agency provides a full range of primary health services including dentists and a geriatrician (historically GPs also but not at present), social support programs, and specific support services for older people, carers, people with disabilities, lesbian, gay, bisexual, transgender, intersex, queer and asexual (LGBTIQA), mental health, chronic conditions and dementia. They do not directly provide home and personal care services, which are sub-contracted. Merri Health operates multiple sites in the northern suburbs of Melbourne, and one site in Wangaratta.

Merri Health is managed by a Board of Directors elected by Members, who must be aged 18 years or over and 'live, work or study in the community where Merri Health provides services.' By its Constitution, the purpose of Merri Health is to 'improve the health and wellness of people in need, in particular people who suffer sickness, disability, helplessness, disadvantage or poverty, through the provision of benevolent, charitable and not-for-profit community based services in Australia that relieve their needs.'[3]

In keeping with this broad remit, Merri Health provides aged care services to people 65 years and older (50 years for Aboriginal and Torres Strait Islander people) that may be free,

[3] Constitution of Merri Community Health Services Limited, adopted 23 October 2017. https://www.merrihealth.org.au/about/governance/constitution/ Accessed 17/06/2020.

subsidised or full cost recovery, and funded from diverse sources according to the needs of the client and their eligibility for support packages. They provide services to people living in the community including retirement villages, but not to people living in residential aged care facilities.

Merri Health is funded for an Access and Support position which provides short-term support for people who have difficulty finding out or applying for services, due to their diversity.

The position works with clients who have difficulty navigating eligibility and assessment requirements for package funding or have been referred to their agency outside of the My Aged Care portal. The Access and Support person will also identify any services outside of the My Aged Care system that may benefit the client. Merri Health's Manager for Aged Care, Ms Markovska, believes that this Access and Support position is a vital system component that should be funded into the future.

Merri Health's integrated care model

Merri Health formulates integrated care from a client needs perspective:

> *When we talk about integration of care, it's how we can support a client across the range or the continuum of services that we have, and the aim is for the client not to necessarily know or understand which buckets of funding they're being supported in if they don't need to, but that their care needs are being met seamlessly. The only time that that becomes a problem is where you're not able to deliver a service, because it would be deemed as double dipping or they don't meet the eligibility, and then it does actually become problematic trying to explain how different buckets of money work and why they can and can't do something.*

Clients with Home Care Packages are assigned a Care Advisor, typically a social worker, who in collaboration with the client develops a goal-oriented care plan based on their assessed needs. Clients who are not in receipt of a HCP may receive limited de facto care coordination under the agency's 'Key worker' model, with a client's first Merri Health clinical contact referring them to other services according to needs identified in their assessment.

Beyond allied health, social support, recreation and exercise, home and personal care, Merri Health also offers specialised support via their Specialist Memory and Dementia Service, Rapid Reablement program, condition-specific educational services, mental health and wellbeing program, and respite services for clients and carers.

Merri Health works with local hospitals via the HARP (Hospital Admission Risk Program) and Transition Care programs.

Merri Health is in the process of transitioning to a single client record system. CHSP funded programs and HCP services currently sit on different databases.

The primary barrier to providing coordinated care that Merri Health encounters is delay in service provision due to funding shortfall. Under CHSP funding their capacity to service is capped well below demand for their services, resulting in wait times that the agency would like to reduce. With HCPs, the lengthy wait times for package allocation often mean that a client's needs have changed since their assessment for packaged care. The potential negative outcomes from this funding gap may be unnecessary hospital admissions or premature admission to residential care, particularly where there are mental health concerns. Merri Health tries within its means to support clients as their needs change.

Merri Health would like to see more flexible, streamlined funding for aged care services: funding that can be cross-purposed to meet community needs. For example, if there is an increase in demand for a particular service and reduced demand for another, they are able to re-allocate resources while remaining accountable for total volume of service outputs.

8.9 *Multi-Purpose Services Program*

Services:	Residential care, acute care, community health, and various other services (depending on the organisation).
Approach to integration:	Full integration of residential care, acute care and sometimes community health, through pooling of Commonwealth and State funding.
Key lessons:	Fully integrating residential care and acute care is cost effective for regional, rural and remote areas that cannot financially sustain a plurality of services. Community involvement in the establishment and governance of MPSs supports their sense of ownership and trust in the service. Integration of acute care and aged care facilitates a flexible and skilled workforce who can provide continuous care across health and aged care domains.

The MPS Program was introduced in 1993, to address health disparities between communities in rural or remote areas [76, 77]. The MPS Program constitutes an "integrated" model in the sense that it pools State health care and Commonwealth aged care funding within a single entity and single governance structure. The primary purpose of the MPS model is to address gaps in acute care and aged care services in rural or remote areas. Communities are only eligible for a new MPS service where there is a demonstrated need meet criteria set out in the *Aged Care Act 1997*. Many MPS services began through mergers of existing hospital, aged care and community health services.

MPS services had its impetus in the early 1990s, when faced with rising costs, state health systems were shifting towards more variable, activity-based funding models that would have been unsustainable on a small scale in rural and remote communities. The economic rationale of the MPS model is to improve efficiency and reduce operational costs by pooling funding, sharing governance, and often sharing staff and infrastructure across the boundaries of acute care, aged care, primary health and community care. By doing this, State and Commonwealth governments are able to combine services that would have been unsustainable as discrete entities into one single, more generalized, service. A key advantage of this model is that it allows MPS services the flexibility to adjust their services and redirect funds according to changing community and patient needs [79]. MPS services benefit from the relatively stable budgeting that the pooling model affords, as it allows consistency in meeting fixed overheads despite the small scale of their operations and variability in community needs [78].

Community and governance

Each MPS is funded through an agreement between State and Commonwealth governments, and where relevant service providers, based on an agreed set of standardized Terms and

Conditions. Some MPSs involve third parties, such as community health services in tripartite arrangements [78]. Many MPS services are also engaged in MOU-based partnerships with other providers such as allied health, home care and residential aged care. MPS programs must produce a Service Delivery Plan, which specifies program activities based on community needs. The Service Delivery Plans are also a main mechanism through which MPS evaluate their performance [78].

While governance structures of all MPSs involves committees of community representatives, there is state-to-state variation in how independently governed MPS programs are. In most states, MPS fall under state government health departments, and are accountable to regional health authorities. In Victoria, MPS are governed by independent Boards of Management which have sole authority and accountability over all aspects of the MPS [78, 80]. It has been argued that more independence from state government has meant Victorian MPSs tend to be more community-driven, more innovative and flexible, and able to sustain a range of service that extend beyond the traditional scope of health and aged care, which would otherwise be unsustainable in their communities [78-80].

The establishment of an MPS is supposed to be a community-driven process, occurring through consultation with local service providers and residents [145]. However, some communities have historically been resistant to the establishment of an MPS in their area, especially when it was perceived that State governments were scaling back commitment to providing acute care by imposing mergers between hospitals and other local services [78, 145]. In some cases, planning and establishment of MPSs has been a persuasive rather than consultative and community-driven process [76, 77, 145]. Nonetheless, where MPSs have been established for some time they are often highly valued by their communities and the integrated model is seen as a unique asset to their towns [78]. Community members attach importance to the MPS in providing access local hospital care and allowing them to age in their hometown, whether in residential or home care. The presence of an MPS can also attract people to move or return to a town, to either have access to MPS services or for employment opportunities [78].

Integrated care

MPS is a model of system integration in the sense that it is designed to overcome boundaries between state-based hospital, and Commonwealth funded aged care and primary health systems. MPS programs are not subject to the same financial and departmental siloing that mainstream services are, and the administrative simplicity of model reduces operational costs

[78]. Working from a single Service Delivery Plan coordinates the services across program boundaries, and can also be used to identify need for allied health and other community services [79]. The pooled MPS funding model allows staff and resources to be allocated in a flexible way, as well as engagement of external providers where required.

However, there is variation in how integrated care is at a clinical level. Where aged care and hospital services are co-located, MPS nursing staff are often required to be multi-skilled and able to work across the boundaries of acute, emergency and aged care as needed [76, 79, 80]. This results in a higher proportion of nurses compared to mainstream aged care facilities, who are trained and experienced in a richer nursing skillset [78]. It also affords a degree of clinical integration for aged care residents, as facility nurses are able to perform both acute and aged care duties in residents rooms, without having to transfer to different facilities [78, 79]. However, where aged care and hospital services are not co-located, it is much more difficult the program to take advantage of this flexibility [76]. Clinical integration may also depend on organisational culture. While some MPS services operate in a highly collaborative way, for others, distinct organisational divisions and identities between acute and aged care continue to exist within the MPS model [146].

MPS services offer a range of aged care services. All MPS are required to deliver residential aged care under the *Aged Care Act 1997;* however, are allocated flexible aged care places for this purpose. This arrangement means Commonwealth aged care funding can be pooled and is allocated by place rather than by funding individual users based on individual care needs through the Commonwealth's ACFI. Currently, funding differs depending on whether places are defined as high care or low care, which may not reflect the increasing acuity of aged care residents [78, 80]. Some MPS programs also deliver home care packages under the Commonwealth funded HCP Program, which are subject to approval through an aged care assessment and subject to mainstream arrangements, including allocation through the My Aged Care National Prioritisation system

Advantages of the MPS model

The MPS model has key advantages for rural and remote communities. Combining aged care and health care into one entity allows greater economies of scope and scale [76-78]. MPS is a single, administratively simple, model that allows sharing of staff, infrastructure and other costs across service boundaries. This is a more sustainable allocation of funding and workforce than maintaining separate services in areas of small population size and density [76-78, 80].

MPS programs are able to achieve a degree of community integration [78, 79]. Part of this is result of their geographic location, where an MPS might be the sole presence of primary, secondary health and aged care in a town. Service Delivery Plans also facilitate community integration by avoiding top-down programming from State or Commonwealth health departments, and allowing community input into how MPS programs define and expand their activities [79]. Many MPS programs also support a wider range of services than just acute and aged care, and have partnered with third party GPs, allied health providers and other community and welfare initiatives to offer services that would otherwise be unsustainable in their areas [76, 78, 80].

Limitations of the MPS model

A recent review of the MPS Program on behalf of the Commonwealth suggested there is a lack of clarity in how pooled funding was being spent under the current MPS agreement arrangements [78]. Specifically, it is difficult for the Commonwealth to evaluate how effectively the funding allocated to each MPS is meeting the Commonwealth's aged care objectives. Moreover, current arrangements incentivise MPS programs to lobby the Commonwealth for more aged care places as a way of expanding their budgets, but these additional places do not necessarily flow on to an increase in aged care service provision or occupancy.

While daily care fees are broadly comparable to mainstream aged care providers, MPS residential aged care clients do not require ACAT assessment and are not required to pay any additional income tested care contribution [78]. This can mean a lack of competitive neutrality between MPS programs and mainstream aged care providers in an area, putting some residents in mainstream aged care facilities at a disadvantage. Moreover, the current distinction between high care and low care beds is an artefact of past policy, and does not well reflect the profile of current aged care residents [78]. The MPS Program review report suggests these limitations could be addressed by bringing MPS in line with ACFI requirements, and by funding through a combination of fixed place allocation and occupancy.

The Commonwealth does not provide capital investment for MPS infrastructure, which is either dependent on State investment and therefore subject to varying degrees of commitment, or dependent on local fundraising and philanthropy [78, 80]. Many MPS facilities started life as hospitals, and are not regarded as "homelike" environments by staff or aged care residents [78]. Moreover, nurses are often accustomed to providing acute care and may prioritise medical

needs over meeting the psychosocial needs of residents [147]. There can also be ambiguity over the allocation of roles and tasks when staff are required to work in a flexible, multi-skilled way [147]. MPS staff report that they struggle to meet needs of people with dementia, due to a lack of specific training, skills and infrastructure [78].

Since 1 July 2019, MPS services have been required to meet the Aged Care Quality Standards. The Australian Safety and Quality Commission (the Commission) has developed an aged care module to be included with the National Safety and Quality Standards (NSQS) Version 2 for Multi-Purpose Services to enable them to meet both the NSQS and the Aged Care Quality Standards accreditation requirements for their service.

8.10 *Ngaanyatjarra Health Service & Tjanpi Desert Weavers*

Services:	Ngaanyatjarra Health Service: Aboriginal Community Controlled Health Service (primary health, aged care, specialist care, allied health, disability support, and more.) Tjanpi Desert Weavers: An Aboriginal Community Controlled social enterprise working with Aboriginal women of all ages in the remote Central and Western deserts to create contemporary fibre art.
Approach to integration:	An MOU based partnership to share facilities and spaces.
Key lessons:	Both Ngaanyatjarra and Tjanpi have a deep understanding of the local context in which they provide services and face similar challenges with delivering services across a large geographical area, in ever changing contexts. Staff on the ground see each other and the women regularly and care planning happens in-situ through iterative and ongoing conversations and relationships. The partnership helps aims to increase local women's access to a range of relevant service providers, and provides a hub for the wider community, and celebrates the cultural determinants of health.

This case study is based on a telephone-conference consultation conducted with Dianna Isgar, Community Care Coordinator, Ngaanyatjarra Health Service and Michelle Young, Manager Tjanpi Desert Weavers, on 13th May 2020

Ngaanyatjarra Health Service (Ngaanyatjarra) is an Aboriginal Community Controlled Health Service governed by a Board of Directors, most of whom are from the communities it services. Ngaanyatjarra provides care to people living in throughout the Ngaanyatjarra Lands in remote Western Australia, near the Northern Territory and South Australian borders. They have 11 community Primary Health Care Centres, eight of these are permanently staffed by experienced Remote Area Nurses, Aboriginal Health Workers and allied health staff while the remaining three are visited by health staff from nearby communities. Ngaanyatjarra hosts visiting specialists and offers a range of maternal, child and chronic disease management programs as well as other public health programs. It also has one Residential Aged Care Facility and Community Aged Care and Disability services funded by a range of State and Commonwealth programs.

Tjanpi Desert Weavers (Tjanpi) is a social enterprise that works with women in the remote Central and Western deserts (tri-State border) who earn an income from contemporary fibre art. Tjanpi is part of the NPY Women's Council, which is led by women's law, authority and culture to deliver health, social and cultural services for all Anangu (people of Country). Tjanpi represents over 400 Anangu/Yarnangu women artists from 26 remote communities on the NPY Lands (approximately 350,000 square kilometres). Tjanpi's Creative Development Officers (CDO) regularly traverse this area to visit each community. On these trips, CDOs purchase

artworks from artists, supply art materials, hold skills development workshops, and facilitate grass-collecting. While out collecting grass, women are also able to spend time on Country and maintain their culture through gathering food, hunting, performing inma (cultural song and dance), and teaching their children and grandchildren. Tjanpi values the knowledge and strength that older people bring to the weaving practice and wish to support those receiving aged care in community and residential care settings.

Several staff members of both organisations have worked in collaboration for many years to respond to the wellbeing requirements of women engaged with each of their services. In 2019 Dianna Isgar, the Community Care Coordinator at Ngaanyatjarra Health Service, identified an opportunity to formalise the partnership via an MOU. Ms Isgar recognised that most of the older people receiving support through Ngaanyatjarra's funded aged care programs, which includes community specific funding through CHSP, HCP, HACC and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC) program, and one residential care facility funded by NATSIFAC, were avid painters and/or weavers. The partnership provides an opportunity for Tjanpi, whose business model is based on an outreach service to multiple remote communities, across a large geographic footprint, to co-locate in the buildings where Ngaanyatjarra Health provides their community care programs in two communities.

To enable the partnership, Michelle Young, Manager of Tjanpi Desert Weavers, secured some non-recurrent state government funding to support the expansion, recruitment, training and ongoing development of the local satellite Tjanpi arts workers. In addition, Tjanpi has received philanthropic funding to support the Creative Development Officer to provide creative development to an increasing number of weavers. Having access to the shared premises, resourced by Ngaanyatjarra, has been fundamental to enabling this type of model. In fact, the arrangement to co-locate has met Tjanpi's objective to increase the employment of local arts workers to provide a more regular weaving service to communities on the Lands. It also relieves some of the pressure from Tjanpi who receive no funding from aged care, health or disability care programs, but play a significant role in not only providing direct care for older women, as well as helping them to navigate access to funded care options. Tjanpi's business model promotes opportunities for older and younger women to connect to celebrate the vibrancy of Country, culture and family. Co-locating themselves at Ngaanyatjarra's community office, not only enables relationships with the women to be built by Tjanpi and Ngaanyatjarra staff, but enables the staff to identify and work together to increase the women's

access to a range of medical, aged care, disability, youth, primary, allied and mental health services in a more timely and less confronting manner. In the short term, this arrangement has also enabled Tjanpi to scale up its local workforce through these 'satellite' office hubs. It is hoped that this partnership will help to maintain the sustainability of Tjanpi as a viable social enterprise for local women throughout the Lands.

In this new partnership, staff on the ground see each other and the women regularly and care planning happens in-situ through iterative and ongoing conversations and relationships. Through these relationships staff can work with the women to increase their access to the relevant service providers. Another major benefit with Ngaanyatjarra and Tjanpi co-locating is that art centres tend to be a community hub, so a range of people from the community pop in and out of the office throughout the day.

Both Ms Young and Ms Isgar recognise that while the collaboration is in its infancy, these types of partnerships are essential due to large geographic region their organisations service. They are interested in solidifying their partnership in the initial two communities and will consider ways to extend the partnership into more communities. Ms Young is also keen to solidify and to upscale but is cautious as this initial trial has shown that it will require intensive input from Tjanpi to recruit, train and provide ongoing support to local staff, which requires resources. Tjanpi would also like all aged care providers to consider partnering with them to continue to support older women weavers when they transition to live in residential aged care. Ms Isgar strongly agrees with this sentiment and sees opportunities of bringing Tjanpi into the aged care facility as well as bringing residents out of the facility to the community office to access weaving in a less formal setting.

It has emerged through co-location that the centres could do with some further investments to improve the comfort for the weavers who tend to spend large parts of the day there. This could be the provision of age appropriate seating, shade cloths outside of the office and tea and coffee making facilities.

Both Ngaanyatjarra and Tjanpi value the roles older people play in their communities. Both organisations embrace holistic ways of conceptualising health and wellbeing and this integrated model of care has mutual benefits. It is worthwhile noting that both Ngaanyatjarra and Tjanpi have a deep understanding of the local context in which they provide services and face similar challenges with delivering services across a large geographical area, in ever changing contexts. As Ms Isgar says, "partnerships like this are vital, they provide social

engagement, activity and day care and it's these types of things that help older people stay on Country". This example of integration demonstrates the value of supporting and resourcing locally led initiatives that do not silo health, aged and cultural care needs of their community members. It places the utmost value on relationships and points to a strong case for initiatives that link people, across their lifespan, with a range of health and wellbeing services. This collaboration promotes belonging and provides opportunities for individuals to reveal potential health and aged care concerns in a trauma informed, strengths based and culturally safe framework.

8.11 *Tharawal Aboriginal Corporation Aboriginal Medical Service*

Services:	Aboriginal Community Controlled Health Service providing primary health, general practice, allied health, community aged care, health promotion, mental health support, disability support, support for Stolen Generations, training, and cultural and social activities.
Approach to integration:	A holistic integrated model that offers intergenerational culturally safe care within one service.
Key lessons:	Tharawal's model of integrated care enables community members to address any health, wellbeing and/or aged care needs in a trauma informed, strengths based and culturally safe framework. Tharawal has developed strong partnerships with a range of other services, including Centrelink, the police, legal services, disability/NDIS, and housing providers Tharawal employs a large Aboriginal workforce recognising the role that meaningful work, a regular income and job satisfaction plays in promoting not only the wellbeing of staff, but the entire community.

This case study is based on a telephone-conference consultation held with Darryl Wright, CEO, Tharawal Aboriginal Corporation Aboriginal Medical Service and Rebekah Markna, Acting Manager, Social and Emotional Wellbeing Unit, Tharawal Aboriginal Corporation Aboriginal Medical Service on 7th May 2020.

Tharawal Aboriginal Corporation Aboriginal Medical Service (TACAMS) is an Aboriginal Community Controlled Health Organisation (ACCHO) and governed medical service that is located on the lands of the Dharawal people, in the suburb of Airds, in the Macarthur region of South Western Sydney. It was started by Elders in the locality in the early 1980s and has grown to provide a holistic integrated model of care in the years that followed. Tharawal conceptualises health and wellbeing well beyond the bio-medical model. Taking a life course approach to care, they place great emphasise on the social and emotional aspects of wellbeing and by promoting opportunities for intergenerational connection.

Today, the services provided by Tharawal include antenatal, post-natal, early childhood, intensive family support programs, care for youth and care for Elders. They run primary health care, chronic health and preventative health programs, community aged care, and mental health care programs on-site and receive funding from a range of Commonwealth and State sources. The service also provides the Bringing Them Home program to support and trace family of the Stolen Generations. The service has 800 members many of whom are clients of the service and at present they have approximately 5000 active registered patients. Tharawal has a commitment to its community and embeds a culture of trauma informed care and creative thinking to drive innovation and community wellbeing. Tharawal employs a large Aboriginal workforce

recognising the role that meaningful work, a regular income and job satisfaction plays in promoting not only the wellbeing of staff, but the entire community.

Community members come to Tharawal to access a range of services including GPs, the only mental health nurse practitioner in NSW, as well as a range of allied health clinicians including speech therapists, social workers, psychologists, dietitians, dentists, optometrists, podiatrists, a diabetic nurse educator and an exercise physiologist.

In addition, people come to engage with cooking classes held in the community kitchen, to spend time in the community garden, and many partake in the fruit and vegetable box delivery program. Importantly, Tharawal provides transport to Elders to a range of their appointments, they host aqua exercise classes at a local pool, hold line dancing classes, and participate in an Elders Olympics with other Aboriginal controlled organisations located throughout NSW. Tharawal has a plan to set up a barista training program for young people, so clients can have a coffee and a yarn when they visit the service. All of these programs foster the development of relationships, belonging and trust.

Over the years, Tharawal has extended their approach to integrated care through developing partnerships with a wide range of services. These partnerships have ensured better access to appropriate care for its community and many provide outreach sessions for Tharawal's community on-site. Partnerships include Centrelink, the police, legal services, disability/NDIS, and housing providers. The provision of these outreach services to Tharawal promotes opportunities for relationships and trust to develop and increases access to these services for their community members. An added benefit for Tharawal, is the two-way exchange of knowledge and skills, as Tharawal wishes to upskill mainstream providers' ability to work with their community with culturally sensitivity.

Referrals are made internally and externally through established relationships and referral pathway systems. Systems such as these have assisted Tharawal transition many of its face to face services to online during COVID-19 restrictions and they have continued to run many programs through telehealth, Zoom and by using Facebook to connect with the community and deliver up to date health promoting messages. This has worked well as many Elders live with their children and grandchildren who are on social media.

Tharawal has continued to grow through good governance, cultural safety and by listening to and responding to its community's priorities. Tharawal places emphasis on creating a comfortable safe space for their community members and prioritises relationships at all times.

Tharawal have been visited and endorsed by Sir Michael Marmot, who is a professor of Epidemiology at University College London, Director of the University College London Institute of Health Equity, and Past President of the World Medical Association. Tharawal has engaged in several research studies with universities from around the country and this has led them to develop on-site nutrition programs and become a housing provider themselves. Tharawal is continually approached by universities and organisations who want to partner with them and as Darryl Wright, Tharawal's Chief Executive Officer says, "when you are doing the right thing people want to be part of you".

Tharawal invests and maintains good relationships with their funders, clients and workforce, which encourages all parties to connect and stay connected with their vision. Tharawal's model of integrated care enables community members to address any health, wellbeing and/or aged care needs in a trauma informed, strengths based and culturally safe framework. Tharawal has plans to build independent living units for Elders and those living with chronic illness and a residential aged care facility on-site, to enable the continuity of care and connection with community as people age and their care needs increase.

8.12 *Uniting AgeWell*

Services:	Residential care, home care, respite care.
Approach to integration:	Assessing all home care clients through a single instrument, and using a single record system, to support continuity across services. Connecting home care with other allied health and mental health support.
Key lessons:	Uniting AgeWell is already implementing integrated person-centred care strategies, such as comprehensive aged care assessment, care planning and a single client record, across different programs within its model. Integrated aged care may be delivered better under a more nuanced funding model with allocation based on individual needs, similar to NDIS funding.

This case study is based on a consultation conducted 21st May 2020 with Fonda Voukelatos, General Manger, Strategy & Business Development, Uniting AgeWell, and on information provided at their website: https://www.unitingagewell.org/

Uniting AgeWell is an organisation of the Uniting Church in Australia that provides community and residential services for older people in Victoria and Tasmania. Across the two states the agency has 20 residential aged care facilities accommodating approximately 1700 people, 500 independent living units, and about 8000 clients receiving home-based community care.

Uniting AgeWell's Identity Statement prioritises customer experience and quality of life through the lens of Christian faith: 'Our approach is holistic. We see each individual person as having needs related not only to their physical health, but also to their emotional and spiritual wellbeing.'[4] Their Strategic Plan outlines how this is to be achieved through active partnership with their customers in planning and delivery of services, continuous monitoring and feedback, and ongoing investment in staff, system resources, and research. During 2009-2011 the agency piloted a model of consumer-directed community aged care that was to inform the Commonwealth's subsequent roll-out of consumer-directed home care packages. Since 2015, Uniting AgeWell has been developing consumer-directed care approaches for residential aged care via action research initiatives and formal University grant relationships.

[4] Uniting AgeWell Identity Statement, June 2017. Accessed on 18/06/20 from https://unitingagewell.org/uploads/Publications/UA_Identity_Statement_Jun-2017_WEB.pdf

Uniting AgeWell is currently working with university partners on projects addressing assistive technologies, intervention programs for people with dementia in residential care, consumer-directed care in residential facilities, and a quality of life tool for older people living at home.

For home-based services, clients typically reach Uniting AgeWell via the My Aged Care portal following assessment by a Regional Assessment Service or ACAS. People who contact the agency directly are supported to undertake the assessment process or otherwise assisted to determine their needs and referred appropriately. Uniting AgeWell offers personal care, home and garden maintenance, shopping and transport, nursing and allied health services, respite and carer support, and exercise and recreational programs.

The integrated care model

Uniting AgeWell has taken the unusual step of adopting a common assessment tool for CHSP and home care package clients, under the logic that many will progress over time from CHSP to higher level funding. Accordingly, their CHSP and home care package teams have been integrated to enable continuous service from the client's perspective.

The assessment process begins with understanding what a day in the client's life looks like and their needs, wants and aspirations. The client and client advisor then develop a goal directed care plan. The client advisors for home care packages are all allied health professionals.

A variation of this model is applied in residential aged care, with an initial assessment and planning phase conducted over eight weeks in conjunction with the older person and their family or carer. In Victoria, the care planning process is coordinated by social workers.

In recognition of the relationship between resilience and mental health, Uniting AgeWell is currently implementing a mental health strategy for home care clients, facility residents, and families and carers by employing nurses with relevant training and experience. The agency's next focus is likely to be oral health in home care, and resolving how to optimise that while dental care remains outside funding guidelines for home care packages.

Uniting AgeWell has a single client record system for home care, and is halfway through implementing a separate single client record for residential aged care.

The agency's General Manager for Strategy & Business Development, Fonda Voukelatos, believes that integrated aged care may be delivered better under a more nuanced funding model with allocation based on individual needs, similar to NDIS funding. The legislation governing

aged care should similarly be reviewed to shift from a deficits-based approach to funding of services to encompass a more holistic, strengths-based or wellness perspective.

8.13 *Wollondilly Health Alliance*

Services:	Primary health, secondary health, community health promotion and accessibility programs.
Approach to integration:	Alliance between PHN, a regional State health service and a local government.
Key lessons:	By collaborating with local government, primary and secondary health alliances can find a platform for community-level activities that address broader determinants of health and bring a health focus to local government. Alliance models are sustained at the top level by the commitment and input of their major partners, with working groups for other community members and partners to collaborate on different initiatives at lower levels. In geographically dispersed communities, it can be difficult to implement programs without locating them in spaces that disadvantage some of the community.

This case study is based on a video-conference interview held with Madison Jarrett, Project Officer for the Wollondilly Health Alliance on 11th May 2020.

Wollondilly is a council that covers a peri-urban area South West of Sydney, with a geographically dispersed population. In 2014, Wollondilly Shire Council, South Western Sydney Primary Health Network and South Western Sydney Local Health District formed the Wollondilly Health Alliance (WHA) to address population health issues, specifically arising from the lack of a hospital and shortage of GPs and allied health providers in the local area. We spoke to Madison Jarrett, Project Officer for WHA, about their alliance.

The WHA's three main aims are to support a healthier community, a community that has quicker and easier access to quality health services, and a community that has a say in the development and provision of health services that affect them [83]. WHA is best understood as a model for integrating population healthcare strategies. It is foremost an initiative that coordinates activities across its three major partners. It also has collaborative relationships with several other local organisations, including non-government organisations, community groups and other health or aged care providers. As such, WHA is not addressed at a specific age group or disease group, but rather the health and wellbeing of the Wollondilly community in general. However, WHA is contains a range of individual initiatives, some which are targeted at specific groups or specific health or welfare problems. To establish its priority areas, a health needs assessment of the Wollondilly area was commissioned in 2014. This involved demographic analysis and consultations with 500 residents and 105 service providers. Since then, WHA has continued to adjust its priorities and targets through continued input from the community, the alliance partners, as well as other collaborating entities.

The kinds of programs that WHA undertakes are broadly reflective of its partners. There are programs addressed integrating the delivery of care for specific chronic illnesses, such as diabetes and heart disease [48]. Here the alliance serves as a way for coordinating clinical care between GPs and hospital-based specialists, by facilitating case conferencing, digital health support, video consultations, as well as by connecting patients with health education, and other local health promotion activities. For instance, the video conferencing program allows people to consult with specialists from their GP's office. There are also plans in place to expand this program into local residential aged care facilities, in order to support residents' access to specialists without having to attend the GP's clinic. However, the COVID-19 pandemic has delayed the initiative.

WHA runs several programs that have the broader goals of supporting healthy lifestyles, social connectedness and addressing the social determinants of health. These include health promotion workshops, community gardens, exercise equipment and walking groups [82]. One of WHA's targets is to reduce the social isolation of older people in the Wollondilly area, especially given many experience geographical isolation, through organizing social meetups and other community activities. Some community services are specially tailored to local Aboriginal Elders, and there are plans to develop a partnership with an Aboriginal Health Service.

The alliance is based on an MOU between a Local Health District, Primary Health Network and local council. The MOU establishes the responsibilities of each partner and is reviewed on a 12-monthly basis. Governance is provided by an Executive Committee, which consists of representatives from the three major partners and meets biannually. There is also an Operational Committee, which meets quarterly and consists of major partners as well as local GPs, non-government organisations, aged care providers and Aboriginal Health services. The alliance also undertakes biannual workshops to review its priority areas. At a lower level, the alliance consists of three working groups, which meet monthly: Care Process, Health Promotion, and Health in Planning. These are each defined by their own terms of reference and consist of community members and representatives from other partnering organisations.

The initial funding was provider through a grant from NSW Health, which supported the establishment of the alliance. Currently, funding is sustained by contributions from the three major partners. The alliance itself is a way of pooling resources, with the Executive Committee allocating resources to working groups based on the alliances continually developing priorities.

> The bushfires… kind of came out of nowhere. So, you know the next thing that we discussed is can we use some of this money with wellbeing activities or something like that. The money is pooled and then it's kind of flexible, up to the working groups, what it's spent on. So obviously approved at the higher level, but yeah very flexible otherwise.

The main barrier identified during our consultation was conflicting priorities between the three main partners. This was especially the case during critical periods – such as the bushfires or the COVID-19 pandemic – when Executive Committee members found it difficult to meet. Incidents like this could create a blockage for initiatives that need Executive approval. Another obstacle was variable commitment or capacity from other partners or collaborating organisations within working groups and initiatives. This is mainly a problem when key partners do not attend key meetings or do not follow through on actions. This illustrates a frequently made point in the academic literature, that the sustainability of integrated models depend fundamentally on commitment of participants, whether that involves a commitment of time, commitment to values, or commitment or resources [44].

Another challenge facing WHA is the broad geographical dispersion and lack of transportation for the Wollondilly population. It is difficult to implement some community activities without locating them in spaces that disadvantage some of the community through distance.

WHA has been held up as an example of how a successful alliance model might work in Australia, in particular the partnering of a PHN, LHD and local council in order to coordinate a holistic approach to community care [148]. The role of the local council in this partnership creates a geographically focused and community-centred approach, which bridges the gaps between primary health, hospital care and community-based health and welfare services. Vice versa, the resources and partnership of a PHN and LHD help "embed health policies and health planning ideas into the council's day to day business".

The Productivity Commission argues that governments should avoid prescriptive and centralised integration of care, and instead look at ways of facilitating local initiative, which begins with an understanding of what a community needs and sets program priorities and activities around them [4]. Wollondilly is a good example of this and shows the considerable scope for innovation and experimentation that local models allow. However, such initiative generally depends on what the partners and community members bring to the table. It would therefore be appropriate to explore whether current funding or governance policy for providers

in the aged care are creating impediments to them becoming more active collaborators and leaders in alliances such as this.