Older people at risk of homelessness

Improving early intervention via aged care assessment services

Final report December 2020

Prepared by:
Housing for the Aged Action Group (HAAG),
The National Ageing Research Institute, and
Deakin University

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Glossary

ACAS – Aged Care Assessment Service

ACH – Assistance with Care and Housing

CHSP – Commonwealth Home Support Programme

DHHS - Victorian Department of Health and Human Services

ED – Emergency Department

HAAG – Housing for the Aged Action Group

MAC – My Aged Care

MBS - Medical Benefits Schedule

NDIS – National Disability Insurance Scheme

PBS - Pharmaceutical Benefits Schedule

RAS – Regional assessment service

SHS - Specialist Homelessness Services

Executive summary

Background and aims
Older people are the fastest growing cohort of people seeking support from Specialist Homelessness Services (SHS) within Australia. Due to the Victorian priority system of housing for people aged 55-plus, and older person-specific social housing stock, an early referral into the Assistance with Care and Housing program may result in a long term affordable housing outcome.

Aged Care Assessment Service (ACAS) and the Regional Assessment Service (RAS) are responsible for assessing the support needs of older people and their carers. These services are well placed to identify older people at risk of homelessness, as the assessors routinely gather information from clients – such as income, age and housing tenure - that may indicate an older person is at risk of homelessness.

Focusing on these ACAS and RAS services, the project aimed to intervene early to prevent homelessness by:

- delivering training to ACAS and RAS assessment staff about the risk factors for homelessness, the priority housing system and housing options for older people
- creating and strengthening referral pathways between the housing and aged care sectors
- using existing assessment tools and referral systems to improve client outcomes.

Approach
A mixed methods approach drawing on HAAG's administrative data, quantitative surveys with older people on their quality of life, service use, and health and aged care costs, and qualitative interviews with clients and staff.

Findings
After the provision of the training to ACAS and RAS services there was an increase in the number of referrals (from 39 to 105) and in the appropriateness of the referrals (from 26% acceptance rate to 61%). ACAS and RAS assessors were also more likely to make early referrals rather than when clients were in housing crisis.

Of the 64 accepted referrals, 15 clients met the eligibility criteria of the study, and consented and completed the baseline survey on entry into the HAAG/ACH program. One subsequently dropped out. At 6 months follow-up from the referral, two of the 14 clients (14%) were housed, while the remainder were still living in private housing (paid rent: 71%; rent-free: 14%). As the follow-up data were gathered during COVID-19 and the associated lockdowns in Melbourne, our data are influenced by this broader context. The key findings were:

- Clients' quality of life data at baseline and 6 months follow-up was around 0.45 on the AQoL-4D. This is *half the quality of life* compared to the quality of life of older adults in Australia.
- Clients reported an improvement on psychosocial aspects of quality of life at 6 months: 14% reporting feeling anxious, worried and depressed (declined by 19%); 21% reporting sleeping problems (declined by 6%). However, clients reported higher levels of loneliness (7% at baseline vs 23% at 6 months follow-up).
- At 6 months follow-up, clients reported fewer visits to health professionals compared to baseline, which could be due to the COVID-19 pandemic that limited access, especially for those who were unable to use Telehealth services due to absence of technology.
- A high proportion of clients reporting hospital admission at baseline (27%) and 6 months follow-up (50%), while more clients also reported visits to the emergency department at 6 months (14%) compared to baseline (7%),
- Total health care costs were estimates at $12,979 per person at baseline, which included health care services used over a period of 6 months. Hospital admission contributed to 76% of the total cost, with mean cost of $9,911 per person. Noteworthy are also the high out-of-pocket costs that clients reported for health care services, ranging from zero to $1,334 over a

period of 6 months. Total health care costs at 6 months follow-up reduced substantially, with a mean of $4,352 per person. Access to primary care was reduced due to the COVID-19 pandemic, leading to more frequent hospital admissions but with a shorter length of stay. An increase in cost was also observed for emergency department visits and diagnostic tests. Importantly, we observed a 51% increase in medication cost ($436 at baseline vs. $843 at 6 months follow-up).

- Quantitative survey data of 15 clients provided important insights into clients' quality of life and service use. It is striking that clients reported quality of life scores that were half the scores of what has been reported for older adults in Australia (Hawthorn & Osborne, 2005). While the COVID-19 pandemic increased feelings of loneliness, clients reported sleeping problems and feelings of anxiety, worry and depression at baseline, indicating the impact of housing stress on clients' quality of life. There is an urgent need to improve housing affordability for vulnerable older Australians to improve their quality of life and wellbeing.
- Qualitative interviews with staff and clients reveal that ACH clients are waiting to be housed for long periods because of a severe shortage of affordable housing suitable for older people, who will commonly have health needs and reduced mobility. These pre-existing health concerns complicate the search for affordable and appropriate housing. Maintaining wellbeing and preserving a certain quality of life (however poor) were prioritised over safe and affordable housing that was far away from what was familiar.
- All interviewees entered the ACH program as an outcome of an aged care assessment, yet most were unable to recall how they first got in touch with ACH/HAAG, or they identified the wrong pathway within the plethora of medical and social services they routinely experience.
- COVID-19 impacted on the ACH program's ability to service their clients as not being able to visit clients in their homes made gathering evidence for a priority housing application more difficult. The pandemic also affected clients, most of whom were negatively impacted.

Conclusions

This study demonstrates that increasing the awareness of existing policy levers and assistance programs for older people has the potential to reduce housing stress and homelessness for older people through early detection and timely support.

The actual outcomes for clients during the study period were confounded to an unknown extent by COVID-19, which tended to exacerbate housing stress by lengthening the timelines for housing applications and delaying housing opportunities, especially for those seeking private rental.

In November 2020 the Victorian government announced substantial investment in social housing over the next four years. This presents an opportunity for a second stage of research to examine the impact of an expanded supply of affordable housing on the health and wellbeing of older people at risk of homelessness.

Chapter 1:

Project description

Background

Older people are the fastest growing cohort of people seeking support from Specialist Homelessness Services (SHS) within Australia. The rate of older people accessing SHS services increased by an annual average of 5.8% over the five years to 2017–18, more than three times the annual increase for all SHS clients (1.7%). There are decreased levels of home ownership amongst older people, more people retiring with a mortgage and an increase in the number of older people in private rental (AIHW 2019). Risk factors for homelessness for older people include being on a low fixed income such as Newstart or the Age Pension and living in private rental (AHRC 2019; Power 2020).

Many people, including older women who have experienced a lifetime of financial inequality, may be "hidden" from the homelessness service system due to relying on friends and family, couch surfing and house sitting, or living in overcrowded dwellings (AHRC 2019). A crisis response from the homelessness sector, such as refuges or hotel rooms, may not be available or appropriate as a long-term strategy to addressing homelessness.

However, due to the Victorian priority system of housing for people aged 55-plus, and older person-specific social housing stock, an early referral into the Assistance with Care and Housing program may result in a long term affordable housing outcome. The Assistance with Care and Housing program is a sub-program of the Commonwealth Home Support Program, and provides short term case management support for people aged 50 years and older who are at risk of homelessness, to find long term housing.

In Victoria, the Aged Care Assessment Service (ACAS) and the Regional Assessment Service (RAS) are responsible for assessing the support needs of older people and their carers, thereby enabling access to Commonwealth-funded support packages. These services are also well placed to identify older people at risk of homelessness, as the assessors routinely gather information from clients – such as income, age and housing tenure - that may indicate an older person is at risk of homelessness.

There is however a general lack of knowledge amongst the aged care sector about the risk factors for homelessness for older people and appropriate referral pathways. Hence, ACAS and RAS staff do not typically make an early referral to the Assistance with Care and Housing Program.

Project rationale, objectives and expected outcomes

With professional education, aged care assessors from ACAS and RAS can be encouraged to make early referral to appropriate housing services before clients reach crisis point. This project provided training for ACAS and RAS assessors from two Victorian health regions, in homelessness risk awareness and in making referrals to a specialist housing agency (HAAG) operating the Assistance with Care and Housing program.

The project aimed to intervene early to prevent homelessness by:

- delivering training to aged care assessment staff about the risk factors for homelessness, the priority housing system and housing options for older people
- creating and strengthening referral pathways between the housing and aged care sectors

- using existing assessment tools and referral systems to improve client outcomes.

By measuring the effectiveness of this training the project sought to demonstrate positive qualitative outcomes and quantitative cost-outcomes associated with the intervention, and the ability of the intervention to be replicated nationally.

Our intention is to advocate for systemic change across the aged care sector nationally, so that older people at risk of homelessness receive timely specialist support and an affordable housing outcome.

Data collection and analysis

Following ethics approval from Deakin University Human Research Ethics Committee (Approval no. 2019-268), the project measured the effectiveness of early referrals in three domains:

- An expected increase in appropriate referrals from aged care assessment services in two Victorian health regions to a specialist housing agency (HAAG) operating the Assistance with Care and Housing (ACH) program.
- Referred clients who gain affordable housing may experience an increase in their quality of life and reduction in health service use.
- Better efficiency in the service system as a whole.

To assess training effectiveness, the number and appropriateness of referrals from the two health regions for the period 12 months before training were compared with the number and appropriateness of referrals at 12 months after training. The appropriateness of referrals was determined by the rates of true positive to false positive referrals. False positive was defined to be where aged care assessment staff make a referral when there is no risk of homelessness according to risk indicators. The quantitative data is supplemented by qualitative data from interviews with frontline HAAG staff.

Client outcomes were assessed quantitatively by repeated measures employing surveys taken at baseline (entry to HAAG/ACH program) and at 6 months. Data were collected over the phone by a HAAG worker with training in social work, and entered into a secure web platform. Survey measures include the Australian Quality of Life questionnaire (AQoL-4D) covering the domains of independent living, relationships, mental health, and sensory abilities; and questions on clients' use of health care resources, aged care services, work productivity, and other services (financial support, housing support, vocational and educational support, and justice system services). Resource use data were descriptively analysed to determine the cost-outcomes associated with the intervention. The baseline survey collection commenced in October 2019. The 6 months follow-up survey took place between March and October 2020, which covered the timespan of the first and second COVID-19 lockdown in Victoria. Therefore, the 6 months follow-up survey responses are likely to be reflective of the impact of COVID-19 on clients' quality of life and health service use.

All clients referred by aged care assessors to HAAG and accepted for ACH support were invited to participate in the study. During the period 10th September 2019 to 10th March 2020, 43 clients accepted for ACH support were deemed eligible to participate in the study. Of these, 15 consented to participate and completed baseline surveys. The 6 months follow-up survey was completed by 14 clients.

This data were supplemented by qualitative interviews with HAAG clients and staff. All 15 clients participating in the survey were invited to participate in a qualitative telephone interview. Interviews were conducted with ten clients during October 2020. Interviews were conducted in July and August 2020 with all four HAAG staff who worked with the agency's ACH clients during the study period.

Chapter 2:

Impact of early referral training to aged care assessors

Description of training

Training consisted of a 20 minute online video covering:

- recent data on the prevalence of homelessness for older people,
- homelessness risk factors for older people: living in private rental or temporary accommodation; living alone; low income; being female.
- when to refer to the Assistance with Care and Housing program through the My Aged Care (MAC) portal.

Trainees were asked to complete a brief survey after viewing the video. The target training population was all ACAS and RAS assessors in the North and West Melbourne, and Barwon South Western health regions.

Training recruitment

Recruitment was initiated during August 2019 by email requests sent from the Victorian Department of Health and Human Services (DHHS) to all ACAS and RAS services in the two regions.

This was followed up with further emails from HAAG during September 2019, and offers to provide on-site training for assessors. Between November 2019 and February 2020, HAAG conducted seven on-site training sessions for 145 assessors and service managers working in the two regions.

During the period August 2019 to March 2020 the training video was viewed 297 times and 142 people completed the post-training survey. These figures include out-of-area ineligible persons (66% of survey respondents were from interstate) due to inadvertent nationwide emailing of all aged care assessment services by a project stakeholder.

This error plus lower than projected training uptake and MAC referrals during the first six months of the study prompted the project team to expand study eligibility in February 2020 to all MAC referrals to HAAG from all Melbourne metropolitan regions and the Barwon South Western region.

Impact of aged care assessor training

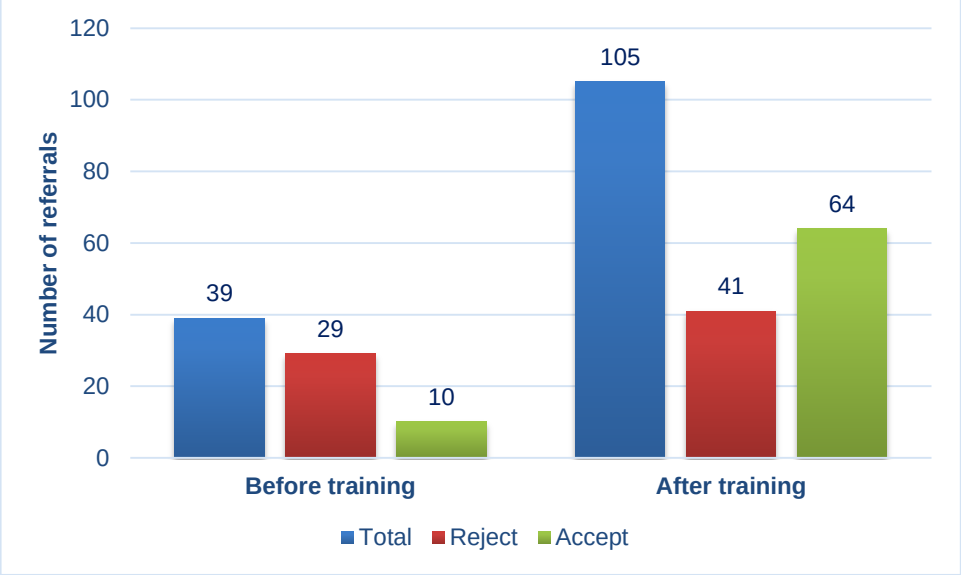
My Aged Care referrals before and after training

It was predicted that training should reduce the proportion of inappropriate MAC referrals, where the referred client is not deemed to be at risk of homelessness according to the risk factors presented in the training video. Analysis of the retrospective data, which refers to the one year period prior to the delivery of the training (10/09/2018 – 10/09/2019), showed that out of the 39 referrals made, 29 (74%) were rejected and only 10 (26%) were accepted by HAAG (Figure 1). Reasons for rejection included i) client not meeting the eligibility criteria for housing services, ii) client no longer requiring assistance or rejected assistance, iii) client residing outside the catchment area, or iv) assistance was already provided by another agency.

After the provision of the training to ACAS and RAS services, the prospective data (10/09/2019 – 10/09/2020) indicated an annual increase of 66 referrals (169%). Most importantly, out of the 105

referrals made, 64 (61%) were accepted and 41 (39%) were rejected. These results confirm that the training was effective, resulting in an increase in the number and appropriateness of referrals.

Figure 1: Number of annual referrals and referral status before and after the training



Comparison of MAC and non-MAC referrals to HAAG

In addition to referrals from aged care assessors via the MAC portal, HAAG also received referrals directly from community services, family and via self-referral. It was predicted that aged care assessor training should increase the proportion of early intervention MAC referrals relative to early intervention referrals from other sources. Early intervention was interpreted as when an older person entered the service before the point of crisis, and this was measured by looking at the "main presenting reason". Housing affordability stress and financial difficulties indicated an early intervention; and a housing crisis, previous accommodation ended, and to a lesser extent, inadequate housing indicate a person in crisis.

Data from the prospective assessment year (10 Sep 2019 – 30 Aug 2020) presented in Table 1 revealed that referrals coming from MAC were more likely due to housing affordability stress (31%), inadequate or inappropriate housing (23%) and financial difficulties (16%). Non-MAC referrals, on the other hand, resulted primarily from inadequate housing (29%) and housing crisis (26%).

The higher proportion of clients presenting in circumstances that indicate they were not at the point of housing crisis shows the training provided to ACAS and RAS was effective and highlights the importance of aged care assessors in making early referrals.

Table 1: Main presenting reason by MAC versus Non-MAC referrals

	MAC	Non-MAC
Housing affordability stress	31%	16%
Inadequate or inappropriate dwelling conditions	23%	29%
Relationship/family breakdown	12%	3%
Housing crisis (e.g. eviction)	10%	26%
Financial difficulties	16%	4%
Previous accommodation ended	3%	5%
Medical issues	1%	2%
Other	4%	14%
Missing	0%	1%

Observations from HAAG/ACH frontline workers

HAAG/ACH workers report improved referrals from ACAS and RAS assessors since the roll-out of training. One worker believed that inappropriate referrals may have been due in part to lack of knowledge about the ACH program:

> *We did get referrals before where it wasn't really obvious why they referred them to us because they were living in a home that they owned or whatever. I think part of it's in the name of the program, Care and Housing, so I think sometimes the assessors just see care and housing, assistance with care and housing and kind of interpret it wrongly.*

Another worker stated that HAAG is now also receiving extra details highlighting the urgency of a referral:

> *They add some comments for me like highlighting the urgency, if the person's going to be evicted in four weeks' time, or the family, they've asked them to leave, they're going to be homeless in two weeks – so they highlight the urgency, they don't just send the formal referral.*

Chapter 3:

Impact of the ACH program on clients quality of life, service use, and health and aged care costs

In total, 15 clients (n=7 male and n=8 female) completed the baseline survey when entering the HAAG/ACH program. The mean age of clients was 74, with the youngest client being 67 years old and the oldest client 91 years old. The proportion of clients with the education level 'year 10 or less' was the same as the proportion of clients with a 'university degree' (40%). The majority of clients were single (27%) or divorced (40%) and lived either alone (40%) or with a non-family member (27%). Only two clients reported to be engaged in part-time or full-time work, with the majority of clients being on a pension (80%). The cohort comprised clients of low-income, with 80% reporting earning of less than $30,000 per year. Table 2 shows further characteristics of the clients.

Table 2: Characteristics of survey respondents

	N (%)
Gender	
Men	7 (46.67%)
Women	8 (53.33%)
Age, mean (SD), min; max	74 (7.21), 67; 91
Born in Australia, yes	7 (46.67)
Speak English at home, yes	12 (80%)
Highest education level	
Year 10 or less	6 (40%)
Year 11/12	2 (13.33%)
Diploma	1 (6.67%)
University degree	6 (40%)
Living situation (multiple responses)	
Nobody, I live alone, yes	6 (40%)
With my partner/ spouse, yes	1 (6.67%)
With my child/ children, yes	1 (6.67%)
With some other family member, yes	2 (13.33%)
With a non-family member, unpaid (e.g. roommate), yes	4 (26.67%)
Other living arrangement, yes (subletting)	1 (6.67%)
Marital status	
Single	4 (26.67%)
Married	1 (6.67%)
Divorced	6 (40%)
Separated	1 (6.67%)
Widowed	3 (20%)
Occupation (multiple responses)	
Full-time employed, yes	1 (6.67%)
Part-time, yes	1 (6.67%)
Retired, yes	1 (6.67%)
Pension, yes	12 (80%)

Household income	
Less than $30,000 per year	12 (80%)
$30,000 - $52,000 per year	2 (13.33%)
$52,000 or more per year	1 (6.67%)

At the time of entering the HAAG/ACH program, 93% of the clients reported to be living in a house/townhouse or flat, where they have lived on average for 48 months. Of those, 80% were renting a private house, 7% boarding/rooming house, 7% other rent and 7% rent-free in private housing.

The reasons for seeking assistance from housing services (see Table 3) covered housing affordability stress (67%), inadequate or inappropriate dwelling conditions (27%) or financial difficulties (20%).

Table 3: Reason for seeking assistance from housing service (asked at baseline)

	N (%)
Financial difficulties	3 (20%)
Housing affordability stress (e.g. rent too high)	10 (66.67%)
Housing crisis	1 (6.67%)
Inadequate or inappropriate dwelling conditions	4 (26.67%)
Domestic and family violence	1 (6.67%)
Mental health issues	1 (6.67%)
Medical issues	1 (6.67%)
Other*	3 (20%)

*living on their own and close to friends/church, uncertainty/lack of security of tenure, risk of homelessness.

At 6 months follow-up, two of the 14 clients (14%) were housed, while the remaining were still living in private housing (paid rent: 71%; rent-free: 14%).

Impact on quality of life

Clients' quality of life was measured using the AQoL-4D questionnaire at baselines and 6 months follow-up. The AQoL-4D comprises 12 questions that describe four broad areas of quality of life: independent living, relationships, senses and mental health. A total utility score was derived from the AQoL-4D that is anchored on a scale of 0 to 1.00, where 1.00 represents full health-related quality of life and zero is equivalent to being dead.

The Table 4 below shows clients' quality of life data at baseline and 6 months follow-up, where at both time-point the total AQoL-4D score was around 0.45. **This is *half the quality of life* compared to the quality of life of older adults in Australia**, which was found to be between 0.7, in those aged 80-85 years, and 0.8 in those aged 60-69 years (Hawthorn & Osborne, 2005). Compared with clients' quality of life at baseline, the 6 months AQoL-4D score remained stable at 0.454. When considering the four AQoL-4D dimensions, it can be observed from Table 4 below that clients reported an improvement across all four dimensions, except for the relationships domain. This can be possibly explained by the COVID-19 lockdown measures, which particularly affected people's social interactions with others.

Of the 10 clients that reported 'housing affordability stress' as reason for seeking assistance from housing services, their AQoL-4D score improved from baseline that was 0.405 (SD=0.28) to 0.534 (SD=0.28) at 6-months follow-up, indicating the positive impact of the ACH program on clients' quality of life.

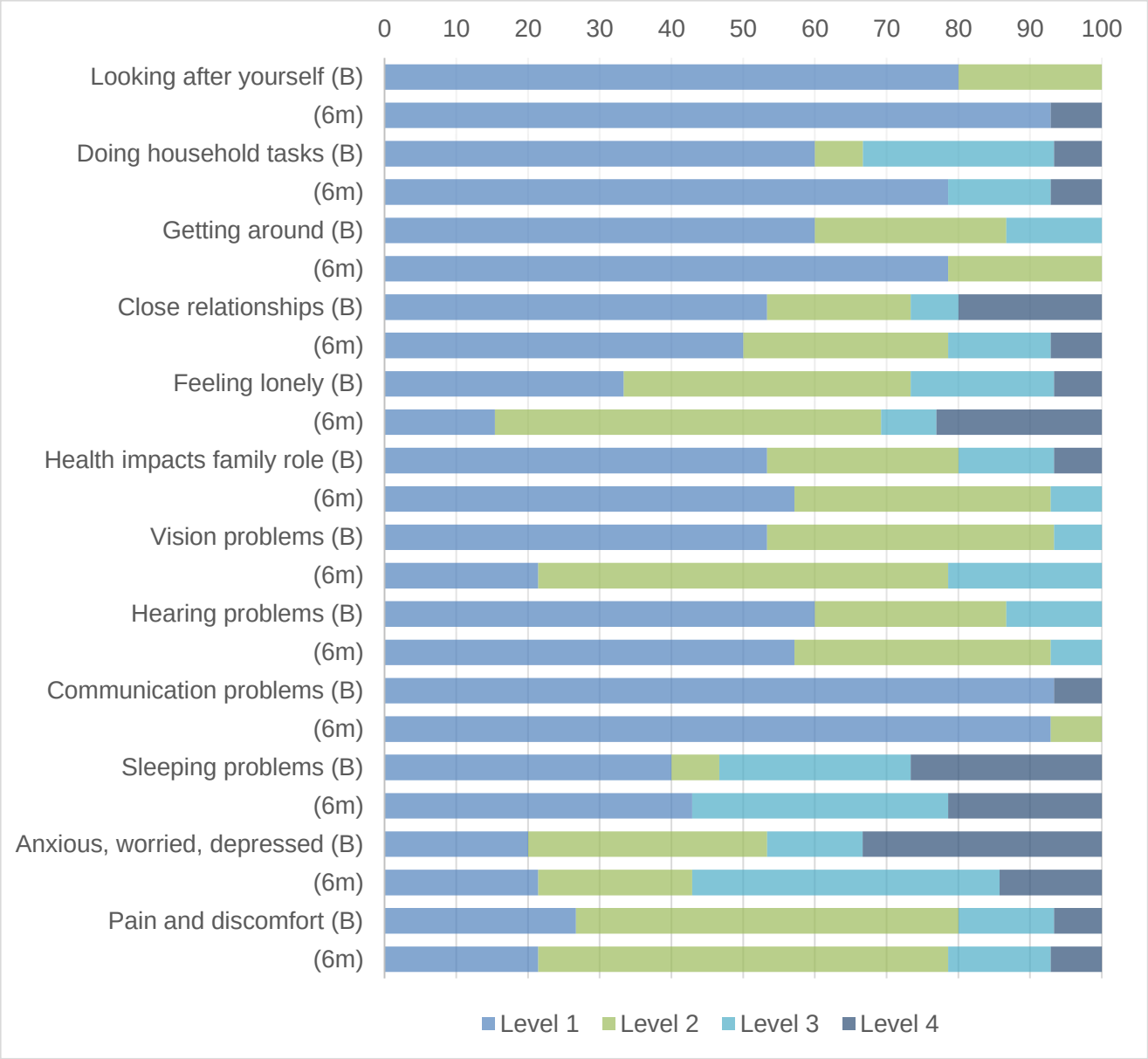
Table 4: Clients' Quality of Life at baseline and 6 months follow-up

	Baseline					6 months				
	N	**Mean**	**SD**	**Min**	**Max**	**N**	**Mean**	**SD**	**Min**	**Max**
AQoL-4D	15	0.445	0.302	-0.039	0.919	14	0.454	0.302	0.023	0.839
Independent Living	15	0.823	0.210	0.308	1	14	0.885	0.261	0.088	1
Relationships	15	0.716	0.321	-0.005	1	14	0.694	0.292	0.076	1
Senses	15	0.889	0.156	0.383	1	14	0.892	0.084	0.731	1
Mental Health	15	0.715	0.287	-0.001	1	14	0.745	0.256	0.079	0.953

Figure 2 below shows the distribution of responses to the 12 questions of the AQoL-4D questionnaire. Each question has four response options, where level 1 denotes no problems or impairment and level 4 indicates the highest level of problems or impairment. It is evident from the figure below that clients experienced the greatest level of impairment (level 4) on psychosocial aspects of quality of life, including feeling anxious, worried, and depressed (33%), sleeping problems (27%), and felt that their health affected their close relationships (20%).

At 6 months follow-up, clients showed improvement on some quality of life domains. While at baseline, 33% of clients reported the lowest level 4 on feeling anxious, worried and depressed, this reduced to 14% at 6 months. There was also a slight reduction in sleeping problems (27% vs 21%) and clients reported a lesser amount of interference of their health with their close relationships (20% vs 7%). Contrary to this, we could observe at 6 months that clients reported higher levels of loneliness (7% at baseline vs 23% at 6 months follow-up). This finding can be explained considering the COVID-19 social distancing measures introduced during the follow-up survey.

Figure 2: Distribution of responses to the 12 AQoL-4D items at baseline and 6m follow-up



* Higher levels indicate greater severity/impairment. B=Baseline; 6m=6 months follow-up.

Impact on service use

Clients' use of health care and other services was collected at baseline when entering the HAAG/ACH program and at 6 month follow-up. The recall period in the resource use questionnaire referred to services used over the past 6 months. Table 5 below shows that all clients were seeing a general practitioner at baseline (mean visits: 7.2). Clients visited also other health professionals, including a podiatrist (40%), physiotherapist (33%), social worker (27%) and other health professionals (40%), such as optometrist, endocrinologist, or neurologist. Only a small proportion reported use of mental health-related services, such as psychologist (20%), psychiatrist (13%) or counsellor (13%).

At 6 months follow-up, clients reported fewer visits to health professionals compared to baseline, which could be due to the COVID-19 pandemic that limited access, especially for those who were unable to use Telehealth services due to absence of technology. Most clients were taking medications (93%), with 60-71% of clients taking more than 4 different medications. Classifying those for treating physical health problems and mental health problems, most medications were used for physical health reasons. Again, these results highlight the limited treatment of mental health-relates symptoms of clients, despite reporting high levels of impairment.

Table 5: Clients 6-months health service use at baseline and 6-months follow-up

	Baseline (n=15)		6 months (n=14)	
	N (%)	**Mean visits (SD)**	**N (%)**	**Mean visits (SD)**
General practitioner	15 (100%)	7.2 (6.36)	14 (93.33%)	6.21 (5.95)
Physiotherapist	5 (33.33%)	20.6 (32.27)	3 (21.43%)	4.67 (1.52)
Psychiatrist	2 (13.33%)	2.5 (2.12)	1 (7.14%)	5
Psychologist	3 (20%)	8 (3.46)	2 (14.29)	5.5 (3.53)
Case manager	3 (20%)	13 (19.92)	1 (7.14%)	3
Social worker	4 (26.67)	3.5 (2.38)	-	-
Occupational therapist	1 (6.67%)	78	1 (7.14%)	1
Mental Health Nurse	1 (6.67%)	6	1 (7.14%)	10
Counsellor	2 (13.33%)	1.5 (0.71)	1 (7.14%)	2
Podiatrist	6 (40%)	3 (2.1)	7 (50%)	2.14 (1.34)
Complementary or alternative specialist	3 (20%)	3.67 (3.06)	-	-
Other*	6 (40%)	1.83 (1.3)	6 (42.86)	1.83 (0.98)
Emergency department visits	1 (6.67%)	1	2 (14.29%)	1.5 (0.71)
Hospital admission	4 (26.67)	2 (0.82)	7 (50%)	1.28 (0.76)
Stay onsite at an Organisation (emergency housing)	1 (6.67%)	-	-	-
Medication use	14 (93.33)	-	13 (92.86%)	-
Consume more than 4 medications	9 (60%)	-	10 (71.4%)	-
Number of medications (mean SD)	4.21 (1.85)	-	4.38 (2.02)	-
Medications used for Physical health	4.14 (1.87)	-	4.15 (1.99)	-
Medications used for Mental health	1	-	1.5	-
Took Diagnostic Tests	13 (86.67%)	-	13 (92.86%)	-
No of diagnostic test taken (mean SD)	2.08 (0.86)	-	2 (0.82)	-
No of times diagnostic test taken (mean SD)	5 (8.48)	-	3.76 (3.67)	-

*Other: Optometrist, Pain specialist, Endocrinologist, neurologist, vascular surgeon, dermatologist, haematologist, endocrinologist, urologist, audiologist, dietician, community nurse etc.

Noteworthy is also the high proportion of clients reporting hospital admission at baseline (27%) and 6 months follow-up (50%). While more clients also reported visits to the emergency department at 6 months (14%) compared to baseline (7%), it is striking that half of the clients were admitted to the hospital. It is possible that the increase in hospitalisation was caused by the COVID-19 pandemic that created limited access to primary care. Reasons for hospital admission included:

- Stroke
- Cellulitis
- Pain management
- Bowel problems
- High blood pressure
- Mental health
- Suspected COVID-19
- Kidney problems
- Bladder infection
- Dizziness
- Bowel cancer check
- Chest pain

Other services used were also captured by the resource use questionnaire. This included welfare benefits, aged care services, financial support services, housing services, vocational and educational support services, and justice system services. None of the clients reported having used financial, vocational and educational, or justice system services at baseline or 6 month follow-up. Most of the clients were receiving age pension at baseline (67%) and 6 months follow-up (87%). Two clients were also receiving disability and carer payment at baseline. While all clients received an aged care assessment, only 47% were receiving services at baseline and 14% at 6 months follow-up. The reduction in services is again reflective of the potential impact of the COVID-19 pandemic that created a barrier for clients to accessing aged care services.

Health care and aged care costs

Health care and aged care services were costed by attaching unit cost to the services used. These costs are expressed in 2020 AU$. Unit costs were sourced from the Medical Benefits Schedule (MBS) for health professional visits and diagnostic tests, the Pharmaceutical Benefits Schedule (PBS) for medication and the Independent Hospital Pricing Authority for hospital services. Since data collection took place during the COVID-19 pandemic, where Telehealth MBS items were introduced, unit cost for MBS items reflected the weighted average unit costs of non-Telehealth and Telehealth items. Aged care services unit costs were obtained from the Department of Health for residential care, home care, transition care, and respite care, while Commonwealth Home Support Program were sourced from service providers.

Table 6 below provides an overview of the costs by cost categories. Total health care costs were estimates at $12,979 per person at baseline, which included health care services used over a period of 6 months. Hospital admission contributed to 76% of the total cost, with mean cost of $9,911 per person. Noteworthy are also the high out-of-pocket costs that clients reported for health care services, ranging from zero to $1,334 over a period of 6 months. Total health care costs at 6 months follow-up reduced substantially, with a mean of $4,352 per person. A significant drop could be observed in costs of health professional visits. While more clients reported admissions to the hospital at 6 months (see Table 5), the mean number of visits was lower at 6 months resulting in lower total hospital cost. This finding is important, as it supports the assumptions that access to primary care was reduced due to the COVID-19 pandemic, leading to more frequent hospital admissions but with a shorter length of stay. An increase in cost was also observed for emergency department visits and diagnostic tests. Importantly, we observed a 51% increase in medication cost ($436 at baseline vs. $843 at 6 months follow-up).

More clients reported the use of aged care services at baseline compared with 6 months follow-up, resulting in corresponding mean costs of $1,344 and $56 per person respectively. However, costs information need to be interpreted carefully, as total baseline costs were highly driven by one client who reported the use of residential care, residential respite care, transition care, a level 4 home care package, as well as out-of-pocket costs. Commonwealth Home Support Program were most frequently used with a maximum cost of $344 over 6 months.

Table 6: Costs in 2020 AU$ by service categories

	Baseline (n=15)					6 months (n=14)			
	Mean	**SD**	**Min**	**Max**		**Mean**	**SD**	**Min**	**Max**
Health care costs									
Health professional visits	1,946	4,485	44	17,874		585	513	88	1,540
Medication	436	1,383	0	5,421		843	2,883	0	10,842
Diagnostic test	187	261	0	953		264	344	0	1036
ED visit	38	145	0	563		121	326	0	1125
Hospital admission	9,911	18,715	0	54,309		2,079	4,291	0	14,812
Out-of-pocket	462	402	0	1,334		459	296	0	1,251
Total	**12,979**	**21,359**	**213**	**57,066**		**4,352**	**5,064**	**319**	**16,532**
Aged care costs									
Residential care	413	15,613	0	60,480		0	0	0	0
Home Care	1	6	0	21		0	0	0	0
Commonwealth Home Support Program	69	142	0	344		49	125	0	344
Transition Care	10	38	0	149		0	0	0	0
Residential Respite	146	566	0	2,194		0	0	0	0
Out-of-pocket	705	2,679	0	10,388		7	24	0	91
Total	**1,344**	**4,873**	**0**	**18,947**		**56**	**143**	**0**	**435**

Chapter 4:

Client and staff perspectives of the impact of the ACH program

Only two out of the ten clients who agreed to be interviewed had obtained affordable and appropriate housing by the time of their interview in October 2020. The remainder were on waiting lists for social housing or were seeking affordable private housing. Table 7 below shows the housing status of clients at the time of interview.

Table 7: Interviewee housing status

Client initials	Age	Housing Situation at time of interview
Sylvia	83	Rehoused in an independent living unit that is affordable (30% of income) and in her preferred area near her friends and church community. In the three years prior she lived far from her friends in cramped conditions with her daughter's family.
Jack	76	Rehoused in a supported independent living unit that is affordable (33% of income) and meets his needs. He previously lived in unaffordable private rental that required him to take in extra tenants.
Lois	69	Living in a high cost rental at a private retirement village (75% of income, meals inclusive) that she moved to in order to escape family violence. She would like similar accommodation that is affordable.
Joan	69	Sharing private rental accommodation that is affordable (33% of income) as long as she continues to work part-time. She wishes to retire when she turns 70 but must find affordable accommodation first, otherwise she will pay 65% of her income to stay where she is. She has too much superannuation to be eligible for public housing but not enough to buy a standalone property. She is looking for a communal retirement village but their waiting lists are three to five years.
Hannah	67	Living in private rental paying 58% of her income. Her flat is currently on the market to be sold. She has physical and mental disabilities that narrow her housing options to living in her current locality that she is familiar with, and in secure accommodation above ground floor due to safety concerns.
Anwar	70	Living with and caring for his sister for the past three years in unsafe conditions due to threatened and actual violence from extended family members. He would like safe independent accommodation living by himself.
Ken	79	Lives in private rental that is unaffordable and not suitable due to stairs. He has been on the public housing waiting list for four years. He is very active in the local community and wants to stay in his area.
Norma	70	Living with her sister since she was retired from her employment and evicted from her rental accommodation due to sale of property. She sees no point in pursuing public housing due to the long wait. The only housing option she has been offered is a 'run down' retirement village far from her friends.
Harold	91	Living in private rental, he successfully negotiated with his landlord to stop the annual rent increase in 2019 on the basis that he is the perfect tenant – he does all the maintenance on his flat including replacing tap valves, globes and security sensors, and cleaning the guttering. He is happy to live in private rental as long as the landlord is fair. He does not want to live in public housing.

Rose	81	Living in unaffordable private rental for the past three years that is unsafe due to neighbours. She does not want to live in public housing, so is seeking affordable private rental.

The two interviewees who had obtained affordable and appropriate housing were very pleased and content with their new accommodation. By contrast, some of those still waiting on housing expressed a patient stoicism that belied the seriousness of their circumstances:

> *Well it's affordable but you don't sort of have much left over.* [Lois, who pays 75% of her income for rent including meals]

> *I'm renting a one bedroom unit and it's upstairs, and the rent is starting to get a little bit too high (…) I noticed lately that the old calf muscles start to tighten up after a little while, getting up and down the stairs (…) I'm still there now until I get a chance to have a look for a place, because with the virus they can't do anything.* (Ken)

Only those living in extraordinarily difficult circumstances portrayed a sense of urgency:

> *The situation is bad, and one of the conditions, one of the most important conditions is for me to get out. I was threatened to be killed and that was reported to the police because the guy, the son was purchasing pistol or a gun, and then I reported to the police and I'm really, you know [in a] bad situation.* (Anwar. The 'bad situation' has been going on for three years)

> *Where I am now there's nothing, it's a 1960s disgusting old block and there's no security, the front door doesn't shut, doesn't work, no cameras or anything. People can just walk off the street and up the stairs, and they do. I'm absolutely terrified, all he has to do is come up two flights of stairs, he's at my door, and no one here that lives in the flats is going to bother with me, no one takes any notice of anybody.* [Hannah, who is under threat of family violence, has lived there for five years]

Housing affordability

ACH staff gave an overview of housing affordability for their clients:

> *A lot of the clients are in some form of housing, often private rental or often staying with family in a temporary arrangement. So private rental, usually why they've contacted us is because the private rental is way beyond what they can afford, so they're paying most of their income in it, or it's become unstable, it's being sold or whatever.* (Leanne)

> *In the case of our clients they are ageing, they are finding themselves very difficult to find a rental in the case that they are given a notice to vacate – so then they have like 60 days to find a place, so the private market is like very expensive for someone that is in their age range, and there is discrimination, like a high discrimination for them.* (Felisa)

Several clients explained that despite working their entire lives, they have not ended up owning property outright or with sufficient savings to fund their housing into later life:

> *Every September my landlord jacked up the rent $10 a week (…) having no other income bar the pension, because the superannuation scheme started very late in my working life,*

and ended up when I retired at 70 it paid out $20,000 which didn't go very far towards my future living (…) I worked full time 'til I was 70. (Harold, 91 years of age)

I'm over 65, single, I'm still working but I was very aware because I rent that there's going to become a point where I was looking to see what accommodation, what housing is available to women like me who actually have got super, not a lot but super, and who are renting (…) My only concern is that I will become homeless, I will get to a point where I will not be able to find somewhere and I am going to be living either where I am and spending virtually everything I've got on rent or then have to try and find somewhere that is just appalling. (Joan)

You know I've had a very, very full life, I'm well-travelled, I brought my sons up on my own, you know I sold everything to get them their degrees and their masters. That I find just terribly insulting, and it undermines the pride I feel in the life I lived and the input I had to society (…) And I'm just treated like, well this underlying feeling of well you know you've got yourself into this situation, why didn't you run your life better. They have no idea of who I am or what I've achieved, or why, why things went wrong. (Hannah)

Shortage of social housing

They took down my particulars and had a couple of interviews, and ended up with a notice, a letter telling me that I was enrolled in the housing for the aged scheme for a one bedroom unit in Highton when it became available. But you know looking at it, I won't live long enough for it to become available. (Harold, 91 years of age)

According to HAAG staff: to be eligible for priority public and community housing support, a person's income should be no more than $595 per week, and their total accessible assets (superannuation, savings, property) no more than $13,000.

Despite their priority status, ACH clients are waiting to be housed for long periods because of a severe shortage of affordable housing suitable for older people, who will commonly have health needs and reduced mobility.

HAAG staff explained that it takes on average four to six months for a housing application to be lodged and processed, and from there it takes up to two years to find appropriate housing for a client with priority status. Clients with higher support needs entailing specific housing requirements, or with particular location preferences, will take longer to house:

Every case is just different, we have housed people in literally three weeks - like wow how did that happen - because the client was flexible and the vacancy came in, we've offered them and they've said yes. And there are cases that can literally take one or two years for clients to be housed, so every case is different because [of] clients' housing needs, health, support and community links (…) In the past like four years ago it was easier, I could get a place in four months or six months. Now it is taking a year or more for someone who is homeless. [Felisa]

So it could average, you know some people might be fortunate and get a housing offer quite quickly within a few months, or sometimes there might be some housing become available in the community housing sector (…) Usually people are waiting one, two years at least for public housing. That also depends on their needs, if they've got special needs like you know they've got exemptions for steps, or you know accessible showers and bathrooms and that, takes longer because it's all based on the availability. (Leanne)

Clients who are ineligible for social housing are no easier to house. Their options are to find affordable private rental; survive long enough to reach the top of the waiting list for a community-run retirement village; or secure an independent living unit operated by a charitable agency:

> *If they've got too much money to be eligible for social housing, public and community housing, another option we can look at is independent living units (…) For example I've got a person who's over the asset limit to public housing so I've secured housing through [a Catholic housing agency]. So I just try and think outside the square and I use my contacts because I've been doing this job since 2012, got a lot of contacts, and I know a lot of the housing providers so I can ring them directly and advocate.* [Heather]

Ageing in place

One interviewee had specific requirements for her to stay in her immediate locality due to physical and mental health conditions. Several interviewees said they needed to stay within their established communities or within a short commute. Others were more flexible but did not want to be housed at the metropolitan fringe or in a township far from the services and community facilities they would require to maintain their wellbeing and establish an acceptable quality of life. Two said they did not mind where they went as long as their housing was affordable and safe.

Several clients said they had rejected housing offers because they were too far away (30-40km), too run down, or for shared accommodation:

> *One of them rang me a few months ago (…) she offered me a unit at the next town about 40 kilometres down the road (…) All my social contacts, the few that I have, are in this particular area, and to think of moving that distance and at my age trying to establish a new area of social contacts, seemed a little bit hard when it wasn't actually necessary.* (Harold)

> *There's one that they've shown me that I am on the waiting list for but I've filled out no paperwork for, is one over in Frankston, very very old and very very rundown, so my family sort of doesn't want me to move into that sort of environment when I am not used to it. But if worst came to worst I know my middle son who lives up in _____ would put up a granny flat in the backyard, that's an option but I don't want to move to _____, it's too far away from all my friends and family, yeah.* (Norma)

Clients' confusion about the aged care and housing support systems

All interviewees entered the ACH program as an outcome of an aged care assessment, yet most were unable to recall how they first got in touch with ACH/HAAG, or they identified the wrong pathway within the plethora of medical and social services they routinely experience.

Several believed they were not eligible for priority housing because they were 'too healthy' and that this was the reason they were still waiting for housing, whereas all the interviewees who were eligible for public housing did in fact have priority status due to their age and risk of, or actual homelessness.

This confusion about eligibility for housing support extends to the My Aged Care platform itself. HAAG staff reported that they encounter difficulties registering clients aged younger than 65 with My Aged Care, even though a client may be eligible at 50 depending on their housing history and Indigenous status. HAAG workers sometimes have to quote passages from Departmental facts sheets to My Aged Care call centre staff in order to register clients.

Making do with being old

Unless client interviewees were in dire circumstances they tended to downplay the severity of their health conditions:

> *I did go through the prostate situation. Yeah the prostate cancer, went through the 39 day irradiation. I came out, I actually thrived on it, you're not supposed to, but I did, it seemed to give me more energy (…) So yeah and I came through that real good, and I just had my blood tests, and everything's come all clear.* (Ken, 79 years of age)

> *I didn't get the virus [COVID-19], but I got a very strange virus, my bones ached, it was incredibly painful to turn my head or to move at night, and I got the ambulance and I was taken off to hospital, mainly because of Corona. I didn't have the - I was too ill, you know feeling too ill to go to a clinic to get tested - so off I went, and I was tested negative, and that evening the doctor checked me out and then she said 'do you want to stay or go home?' 'Oh no' I said, 'I want to go home', and 'would I cope?' I said 'yes' because you have to. It makes you get up, make your meals, wash the dishes, go lie down again. And that lasted about two weeks and it all passed.* (Sylvia, 83 years of age)

Only the interviewees with the very worst health and housing situations declared that their living conditions were negatively impacting their health:

> *I'm diabetic so my diabetes is not well controlled because you really need to live calmly and in a place that you don't have to worry about anything, so that's not helping my diabetes (…) It doesn't matter what I do, the problems I have in my head, my head I think it's affecting my sugar levels. Plus I have a back problem, like today as I'm talking to you I've got sciatica.* (Anwar. He has suffered extreme physical violence from extended family members who still threaten him)

> *I've been homelessness for almost six years, and it's become more dire and more dire, and I was just going everywhere I possibly could and contacting people constantly, and my doctor is very very very concerned about my state of health, my mental health and my physical health, and said look this is just ridiculous, you need housing. And I said*

well I'm on the housing list, I've been on it since 2015 (…) I can't do my housework anymore, I have spinal damage, and I'm also about to have an operation - I'm on the waiting list - on my hands (…) I don't have full use of my hands and I'm in an enormous amount of pain with them, so it's very difficult for me to run my tiny little home. (Hannah)

Clients' recommendations for affordable and appropriate housing

We deserve to have our end of life feeling safe and secure. Not having to go without food for the last three days or four days of the month, so we can pay the rent (…) I believe I deserve a nice safe home that I can, with rent that allows me, to eat what I want, as much as anybody else. (Hannah)

There's a lack of preventative [services] (...) friends have said to me you need to get just yourself homeless. I mean if I had a car, sleep in the car and then they could get you somewhere, and I sort of think this is crazy this is just crazy, there could be more housing, more public housing, more accessible then you'd stop the situation of people having to live homeless. (Joan)

Impact of COVID-19 on clients

COVID-19 affected clients differently depending on their circumstances. One client living with the threat of violence said that the lockdowns made things easier for him:

Well to tell you the truth it's made it better a little bit (…) I don't go out very much, and it is easier actually because I'm not worried that somebody knock on the door and break my arm again. (Anwar)

A couple of clients said that the lockdowns made little difference to them, but most said they were negatively impacted:

I'm not a very social person, so I read a lot, I've got, although my eyesight isn't so good anymore, large print books, the libraries are wonderful here (…) So I read, I've got television, chat a bit to the neighbours. (Sylvia)

[*My son has] set me up with a decent computer, screens, and so it hasn't affected me (…) the social has been difficult but no more than difficult than for anyone else. I've got a small garden (…) I can get to shops, I can get to hospitals, I can get to what I need to get to.* (Joan)

Oh it's terrible I reckon (…) My heart doctor told me not to go in the shops, and so that means I'm home most of the time except now and again I go to my daughter's place, and when they go somewhere in the car I go in the car, but I don't get out (…) When the estate agents all open up again I'm hoping to get about and see what I can find. (Rose)

Right at the moment we're not doing the community things because of COVID, we've had to be sort of in our own units (…) I was getting my food every day through the door, usually it's in the community hall, we have a main lunch at lunch time, but because of the virus it's just stopped everything (…) It's just sort of stopped the whole world. (Lois)

With my contacts with internet it didn't affect me, but usually I was meeting my children about once a week, and after this we use Skype to see our faces, and yeah it was not so good, not so good contact during this. (Jack)

I'm still there now [in unaffordable and inappropriate housing] until I get a chance to have a look for a place, because with the virus they can't do anything. (Ken)

I was renting and then I lost my job, retired me early. Because of the pandemic. And then the agents told me that they were selling the unit. (Norma)

Seeing that's it all virtually contact, I doubt whether I'll live long enough for it to come back again. (Harold, referring to his highly valued recreational and social activities)

HAAG staff reported considerable impact on their ACH clients overall:

*I've got a number clients who are victims of elder abuse – and I've just noticed with the coronavirus there's just more family breakdown and families that might have sort of allowed for the person to stay on the couch or something they're asking them to move out and to leave – family pressures, like some family members losing their jobs and yeah – just sort of the family dynamics and stuff. (*Heather)

Because of Covid-19 they're at home more of the time so with your energy bills (…) they don't turn the heater on they can't afford to run the heater, or they might go without food, so things are very tight for them. (Heather)

A lot of my clients are living with depression or anxiety and like due to COVID-19 well they've informed me that their anxiety has increased, so mental health like definitely increasing anxiety and worry. Like this person I've just seen today, she's very worried about that she might have the virus so she went to Northern Hospital and they said because you don't have the symptoms they sort of turned her away, didn't test her, and then she went to the clinic up her way and the same thing, they turned her away sitting in her car for an hour and they turned her away because she – but she said she was trying to the right thing, that increased her worry and anxiety because she hasn't been able to be tested. (Heather)

I get the sense from the intake calls and the volume that (…) people are possibly if they're somewhere where they can stay they're staying put and they're not thinking about you know what they can do about housing in the future quite at the moment (…) And then there's other people who are contacting us because they were staying with family or friends or whatever, mainly family, and they don't want them there, you know what I mean, because of the COVID situation. So if they were couch surfing between a couple of places, yeah there's been a few like that. (Leanne)

Impact of COVID-19 on ACH program operations

COVID-19 impacted on the ACH program's ability to service their clients:

I've actually reached capacity because, well, so I've been obviously making the initial phone call like in case, assessing, phone assessments and either accepting or rejecting the referral and I've been then doing the housing support, so I've been looking after all of those clients so that's part of my job I'm at a capacity. (Heather)

The outreach workers obviously they're not doing face to face work, so it's affected how we work with people at the moment. (Leanne)

The only hold up with [getting a client into his allocated housing] is that the management team, the provider because of coronavirus, they need to do a deep clean of every apartment because there's been all the tradies there and contractors there, and then they're going to arrange for the inspections and they're going to have cleaners onsite on the day of inspection when the clients go and look at the properties. (Heather)

You need to build some trust with the clients to make them be able to talk about their issues, so now we are conducting everything by phone now, so when you make the call they don't know you so they don't know your face and it is difficult for them. (Felisa)

Not being able to visit clients in their homes makes gathering evidence for a priority housing application more difficult:

You need to show evidence that they are living in an unsuitable housing, because of a medical condition. So basically with this COVID, as a worker I am not able to see this condition, so when I ask them where is that – where you are is unsuitable – in what way? This place is unsuitable for you – so they said to me "no it is ok" so it is just lack of – "I cannot afford this place, I cannot make the payments, I am struggling with rent, I don't know what to do," so then I explain to them how the system works and I explain to them "look I cannot complete an application and then you will be like very down in the waiting list in the priority list, you will be very down and I need to know if the place where you is unsuitable because of your medical condition," so then I will – it makes me ask them to describe how is the kitchen where you live and how is the bathroom that – do you have difficult when you go to take a shower (…) do you have to climb the stairs, so I have to ask them questions because they don't have the understanding. (Felisa)

Chapter 5:

Project issues and obstacles

The project experienced a sequence of unexpected obstacles resulting in lower recruitment to training and consequently fewer MAC referrals than predicted from historical HAAG/ACH program data. Some of the impinging factors were external to the My Aged Care system while others arose within the system. The known issues are outlined below.

Communication breakdown

Within the first month of project implementation it became clear that notification of the project and training were not reaching the targeted ACAS and RAS assessors. On 13th September 2019 the project team were informed by HAAG that their staff had spoken with three RAS and ACAS teams in the North and West region who had not received any information regarding the training.

During the first two weeks of October 2019 a project team member attempted telephone contact with 17 of the 19 ACAS and RAS teams in the North and West region.

Out of the four ACAS services in the North and West region:

- One ACAS manager said they had received the DHHS email notification but decided not to pass it on due to the current high burden on staff including: being under close scrutiny and performance management by DHHS; imminent agency accreditation; additional professional development requirements on staff; and job uncertainty due to the proposed tendering of all aged care assessment services. The manager stated that staff could not take on more at present and the training is too low on their list of priorities. The manager emphasised that the proposed tendering of aged care assessment services was causing significant stress and employment uncertainty for their team.
- One ACAS manager said they had received the DHHS email but did not pass it on to assessors because they did not realise its importance. The manager apologised and said they would send the email to the team and ensure they do the training and the survey. The manager also said they thought that referral to ACH was already routine practice.
- One ACAS team member said they had heard nothing about the email or the project.
- One ACAS manager agreed to participate after direct contact by another project team member with whom they had a prior working relationship.

Out of the 13 RAS services based at local government Councils in the North and West region:

- The project team member was unable to establish contact with any RAS assessor or team manager at ten Councils, but spoke to RAS administrative personnel at three Councils who were not able to help beyond providing contact details for their RAS team, which were followed up. Despite leaving voice mail messages where this facility was available and sending emails where addresses were provided, no email responses or call-backs were received from these ten agencies.
- The project team member spoke with RAS assessors at three Councils. None of them were aware of the project or the DHHS email.

Training recruitment was further confused when a well-intentioned aged care system stakeholder emailed a project recruitment letter to aged care agencies across Australia on 24th October 2019. This resulted in a large number of training and survey completions by non-target individuals.

Proposed tendering of aged care assessment services

One possible reason there may have been low to no response from the RAS teams is because during the study period, the Commonwealth government signalled its intention to defund ACAS and RAS teams and put aged care assessment services to tender. This proposed plan caused considerable concern for assessors and agencies hosting those services. This extra burden of stress made assessors less amenable to taking on extra training, as reported in the previous section.

Assessors were kept uncertain of their immediate job security until 28th February 2020 when it was announced that the Commonwealth Government would postpone any decision until it "received input from the Royal Commission on Aged Care on Quality and Safety [sic] on the future delivery of aged care assessment services." (Reported in *Australian Ageing Agenda*, 3rd March 2020).

By this time, the tender process had been formal government policy since December 2019 and rumoured for the whole of this project's existence. In this climate of job uncertainty, some RAS teams were either downsized or completely shut down. In February 2020, funding for CHSP programs was extended until June 2022.

My Aged Care portal issues

Assessors who completed the online training and survey reported that My Aged Care would not accept referrals for people under 65 years of age. Below are post-training comments left by assessors who had attempted to do so:

- *MAC tends to shut referrals down before sending to RAS or ACAS if they are 'under age.'*
- *Even asking My Aged Care for a referral to an ACH provider was an issue in itself, as they stated all people under 65yo first needed to apply to the NDIS & be rejected.*
- *Clients under age of 65 are not eligible for ALL services, with reference to Commonwealth Home Support Program/RAS.*

Enquiries by HAAG staff with aged care assessors identified a further issue that when making a MAC referral to agencies hosting the ACH program, assessors needed to click a button labelled 'Broadcast to all' for the referral to be sent. Many assessors were not aware of this necessary procedure.

Impact of COVID-19 on MAC referrals and project participation

Due to COVID-19, aged care assessors were instructed in February to conduct over the phone assessments only, with eligible clients "fast tracked" into services without the need for a full assessment. From May 22, telephone assessments were no longer the "default" and face-to-face could reoccur if safe. It is surmised that this resulted in fewer referrals to ACH as the priority for assessment was for other Commonwealth Home Support services, such as meals, shopping assistance and cleaning.

HAAG workers report that MAC referrals to the ACH program slowed to almost nothing for a month before picking up slightly. Processing of clients into the ACH program has been slowed further by the need to conduct assessments by phone instead of face to face appointments in the clients' homes, and the difficulties in obtaining paperwork while relying on Australia Post. COVID-19 has similarly reduced client participation in follow-up quantitative surveys for this project.

Clients reported high levels of anxiety and stress, with some medical appointments cancelled. Two clients declined to be interviewed or surveyed due to COVID-19. One client declined a housing offer due to COVID-19. Clients also declined in-home aged care services, despite eligibility, due to fears around COVID-19 and cost.

Chapter 6:

Key findings

Despite some setbacks in project implementation, the findings demonstrate that a targeted training intervention can improve early detection and appropriate referral of older people who are at risk of homelessness or homeless, using existing aged care assessment processes and instruments. We observed an annual increase of 66 referrals (169%), 61% were accepted and 39% were rejected, demonstrating that the training was effective, resulting in an increase in the number and appropriateness of referrals.

The initial difficulties the project experienced in communicating the project to aged care assessors highlights the complex structure of our aged care system, wherein all three levels of government may be involved in funding, supervision and delivery of aged care assessment.

Quantitative survey data of 15 clients provided important insights into clients' quality of life and service use. It is striking that clients reported quality of life scores that were half the scores of what has been reported for older adults in Australia (Hawthorn & Osborne, 2005). While the COVID-19 pandemic increased feelings of loneliness, clients reported sleeping problems and feelings of anxiety, worry and depression at baseline, indicating the impact of housing stress on clients' quality of life. There is an urgent need to improve housing affordability for vulnerable older Australians to improve their quality of life and wellbeing.

While quality of life data indicated a high proportion of clients with mental health needs, survey results have shown that only a small proportion reported use of mental health-related services, such as psychologist, psychiatrist, counsellor, as well as medication use for mental health-related problems. In the absence of information of a formal mental health diagnosis of clients, we cannot conclude with full certainty if this finding indicates an unmet need or not. However, our survey data indicated that the COVID-19 created barriers for clients to accessing primary care. This was evident in the decrease of health professional visits and an increase in emergency department visits and hospital admissions. Many health professionals switched from face-to-face to telehealth services during the COVID-19 pandemic. However, it is likely that this created a barrier for clients, especially if not equipped with skills and technology in using telehealth services. Other barriers may have included accessibility (e.g., accessing transport), accommodation (e.g., long waiting times), affordability (e.g., high out-of-pocket costs), and acceptability (e.g., language barriers and stigma), which were identified in a previous review that examined the accessibility to health services by older Australians (van Gaans & Dent, 2018). Service use data also showed that only a small proportion of clients were receiving aged care services. It is important to recognise the challenge to provide aged care in the home if someone does not have stable housing. Therefore, attaining stable housing for older Australians will also enable access to aged care services.

Compared with the annual health service use reported for older adults in Australia (AIHW, 2016), clients seeking housing support services who completed the survey reported a higher proportion of health service use. While 95-98% of older Australians had visited a GP in last 12 months, our cohort reported the same proportion over a 6-month period. Similarly, around 18% of older adults in Australia had attended an emergency department in 12 months, compared with 7% (baseline) or 14% (6 months follow-up) of our clients for only 6 months. The greatest difference between national figures and our clients was observed in hospital admissions. Where 22%-25% of older adults in Australia had been admitted to hospital in the last 12 months, 27% (baseline) and 50% (6 months follow-up) of our clients were admitted to hospital in the past 6 months. Total health care costs for 6 months were estimates at $12,979 per person at baseline and $4,352 at 6 months follow-up. Compared with the annual cost of depression in Australia, which were estimated at $808 per person, based on the Australian National Survey of Mental Health and Wellbeing (Lee et al. 2017), it is evident that older adults who experience housing stress and are at risk of homelessness have higher health service use and associated costs.

Qualitative interviews with staff and clients reveal that ACH clients are waiting to be housed for long periods because of a severe shortage of affordable housing suitable for older people, who will commonly have health needs and reduced mobility. These pre-existing health concerns complicate the search for affordable and appropriate housing as many older clients have specific housing requirements, or prefer to remain within particular locations in order to access their local GP and/or remain connected to their local services and community facilities. This preference was so strong, that unless their health conditions were very acute, most clients downplayed the severity of their health, in a bid to remain where they were. Maintaining wellbeing and preserving a certain quality of life (however poor) were prioritised over safe and affordable housing that was far away from what was familiar.

All interviewees entered the ACH program as an outcome of an aged care assessment, yet most were unable to recall how they first got in touch with ACH/HAAG, or they identified the wrong pathway within the plethora of medical and social services they routinely experience.

COVID-19 impacted on the ACH program's ability to service their clients as not being able to visit clients in their homes made gathering evidence for a priority housing application more difficult. Additionally, facilitating client's access to housing options was challenging due to lockdown restrictions as well as physical distancing and hygiene mandates to deep clean properties between visits. The pandemic also affected clients, most of whom were negatively impacted.

Concluding remarks

This study demonstrates that increasing the awareness of existing policy levers and assistance programs for older people has the potential to reduce housing stress and homelessness for older people through early detection and timely support.

The actual outcomes for clients during the study period were confounded to an unknown extent by COVID-19, which tended to exacerbate housing stress by lengthening the timelines for housing applications and delaying housing opportunities, especially for those seeking private rental.

In November 2020 the Victorian government announced substantial investment in social housing over the next four years. This presents an opportunity for a second stage of research to examine the impact of an expanded supply of affordable housing on the health and wellbeing of older people at risk of homelessness.

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