



Research insights – At a glance

Pathways to Non-Complex Assistive Technology for HACC Clients

Introduction

During 2013, the Independent Living Centre WA (ILC) with Deakin University Melbourne researched pathways to low cost aids and equipment provision for Home and Community Care (HACC) clients in Western Australia.

The research was funded by HACC Western Australia to evaluate how low cost aids and equipment can most effectively be assessed, provided, accessed and funded.

The HACC WA Program, through its adoption of the Wellness Approach as an underpinning principle of the program, emphasises the role of aids, equipment and home modifications in enabling HACC clients to remain independent at home.

Assistive Technology (AT) has long been recognised as an effective intervention linked to independence, mobility and physical function; including improved safety and reduced falls; reduced hospitalisation, improved well-being and quality of life; and increased opportunities to continue living at home.

The industry sector has recognised for some time that the current systems are complex and that existing pathways for individuals to access and obtain aids and equipment are convoluted, fragmented and in some instances nonexistent.

This document summarises the results and conclusions of this study which sampled over 65 stakeholders. The research has focused on increasing understanding of the existing system in order to guide change and provides insight into how improvements can be achieved.

The research has been carried out within the context of the Western Australian Assessment Framework (WAAF) with particular attention on the HACC Assessor role in facilitating access, assessment and provision of non complex AT. Whilst Perth metropolitan area was the focus of this research it is recognised that further work to identify appropriate pathways in regional and remote areas is likely to be required.

What are low cost aids and equipment?

What is low cost for one person may not be for another so there needed to be a better way to describe what aids and equipment were being considered in the research.

Instead of low cost aids and equipment the term **non complex assistive technology (AT)** is used to describe the type of aids and equipment usually applicable in the delivery of a HACC service.

Non complex refers to products which support daily living activities, usually in the home. Non complex AT may be low technology, low cost and includes everyday technologies. Table 1 provides many examples of non complex AT and relevant strategies across all daily living areas.

The common feature of non complex AT is that AT users can readily identify and trial devices and ascertain their likely value based on their daily experience.

Soft Technology refers to advice or assessment, trial, customising and sign-off necessary to ensure AT works optimally for people and their desired tasks within their unique environment.

Research Participants

An extensive cross section of industry sector and the community were involved in the research, including:

- General Practitioners (GPs), nurses and pharmacists
- Persons receiving HACC services
- AT suppliers
- Allied health practitioners
- Aged Care Assessment Teams (ACATs)
- HACC day centre programs
- Specialist disability services
- HACC Regional Assessment Service (RAS) Assessors

Summary of Key Findings

The current 'system'

- A comprehensive literature search identified significant evidence based research to support the effectiveness of the use of AT.
- Research evidence describes current barriers for the provision of AT solutions. These are access, wait times, costs and funding, inadequate support and information and complexity of the system.

An improved system

- HACC clients need a simplified process that will ensure timely access to assessment that leads directly to provision of a non complex AT. They also need support with information, advice and advocacy.
- AT stakeholders require a single, accessible information resource that maps pathways suitable for non complex AT provision.
- Research evidence describes an effective AT service model as one that identifies, informs, links and supports an individual throughout the journey.

Recommendations to achieve an improved system

- The key recommendation is to build capacity across the AT sector to support the implementation of a systematic approach to non complex AT provision.

Three areas of focus have been identified, including:

1. Expand HACC Assessor knowledge, skill and role in the provision of non complex AT.
2. Expand the reach, access and role of the ILC in resource development, education and facilitating sharing of AT information amongst stakeholders.
3. Further investigation from a policy point of view to determine if and how non complex AT funding would be applied.

Key Findings Explained

The current 'system'

A complex AT journey

The research confirmed structural problems in the system and provides detailed responses provided by seven HACC clients through face to face interviews, 41 AT providers and stakeholders participants in focus groups and 19 Assessors via interviews.

A total of 109 separate pathways to obtain non complex AT were identified. Of these pathways, the most frequently mentioned by RAS Assessors was the ILC, being identified as a pathway across the range of non complex AT. No other pathway was identified as being a valued pathway across every life area, though the pathway of GP was also highly identified across all but one life area, with TADWA (Technology Assisting Disability WA) also mentioned frequently in many life areas. Whilst a plethora of pathways were identified many do not result directly in the provision of AT.

HACC clients obtained their non complex AT through a mix of specialist services such as outpatient clinics, AT specialist providers such as home healthcare shop fronts and generic providers such as Bunnings or Big W.

Rowena – A case study

Rowena is an 84-year-old lady living alone in a retirement village, with a history of arthritis and reduced mobility but is determined to be as active and independent for as long as possible. She receives domestic assistance but declined gardening support. The “universally designed” nature of her home (wheelchair accessible with good security) means Rowena requires fewer supports than other clients who live with steps and slopes. She prides herself on being very active and sociable, including belonging to a few social groups despite her age.

Rowena was unclear on costs and who funded her rails, she has self purchased a walking frame and a lid opener, and has a half step and reaching aid on permanent loan. She sees it largely her responsibility to access services and AT as needed. She is still waiting for handrails at the front door having been told it could take three to six months.

Barriers

The complexity of the current system gives rise to a number of barriers including access, wait times, funding, inadequate support and information and soft technologies.

Detailed research responses highlight areas for improvement.

Access

Problems were identified with location of providers, cost of transport, difficulties in utilising public transport and reliance on others to provide or assist with transport. Logistical and physical issues in lifting and transporting cumbersome AT were identified “if you don’t have a car it is difficult to get a toilet frame home”. Frailty of some clients who tire easily when travelling, having to go beyond their local area, was noted. At times there is a lack of public transport and some AT providers refuse to sell to a third party (such as a family member) due to concerns about not having a face to face observation of the client. Transport issues were raised as the biggest issue by clients, RAS Assessors and AT stakeholders.

Wait Times

RAS Assessors identified the barrier of wait times for equipment assessment through a health professional which led to some clients finding it easier to identify and source AT themselves. Self funding enabled AT to be obtained “instantly”, yet frequently meant no professional advice was available and in many instances this led to inappropriate purchases and abandonment of AT.

One HACC client purchased a power wheelchair privately, yet was unable to get in and out of his home as he required a ramp. An outpatient service provided a ramp on loan without a home assessment, and this ramp did not fit. Six months later, this client described himself as largely housebound and feeling depressed, as no service had stepped in to address the issues of fit between the device and environment.

Waiting for handrail installation was identified as a key issue with one client reporting “still waiting on the rail, could be three to six months, a lot of people wanting rails, the fellow next door is waiting for them”.

Funding

Sixty eight (68%) of RAS Assessors and five stakeholders identified cost as a barrier to AT provision, including cost of equipment and transport. In every instance clients required multiple items, hence costs multiplied. RAS Assessors commented on the lack of client knowledge in relation to funding. There were a range of responses from clients around funding. Given many items cost under \$150, this was felt to be affordable, even on a pension. In some instances, family stepped in, with one client commenting “we exhausted the funding trail and nobody came, in the end we thought mum and dad will be buried by the time we got the walker, so we put the hat amongst the family”.

The findings reflect a disparity in funding pathways, with the likelihood of any support to loan, purchase or otherwise obtain AT appearing to be the “luck of the draw” rather than based on the type of AT or eligibility.

Inadequate Support and Information

Seventy four (74%) of RAS Assessors identified the lack of client knowledge and information about both potential AT and suppliers as a major barrier. For example, a lack of knowledge in regard to basic devices, such as eye droppers or pick up sticks, as well as a lack of information about where to purchase devices, or costs and funding involved. Some pathways such as pharmacies do sell a range of AT but do not always provide information, to aid device selection, or support, to adjust devices, demonstrate their use or trial the device with the user.

Soft Technologies

Client interviews showed in other instances the AT was present but not the use of soft technology or knowledge about how to use it. One client commented “I was given a dressing stick from another patient in the hospital but didn’t know what it was for until going to the ILC and they explained how to use it”.

An improved system

A systematic approach to the provision of non complex AT provision

It has been identified in a range of policy and AT literature that rationed AT provision and limited program boundaries contributes to system complexity. That is, a range of small schemes, complex ‘top-up’ or alternative arrangements, and varying interpretation of policies come about in the absence of a comprehensive approach to the actual needs of a community group. The wide range of narrowly defined pathway options for HACC clients uncovered in this research is no exception.

Research evidence describes best practice principles for AT provision. An AT service model is recommended to embed a systematic approach to non complex AT management and maximize existing pathways.

The components of this model are outlined in the table opposite

Research indicates that “a single, accessible information resource that maps assistive technology pathways suitable for HACC clients is required by all stakeholders”.

| | |
|---------------------|---|
| IDENTIFY | AT needs |
| INFORM about | AT devices / strategies further AT assessment if required referral requirement / processes providers costs and funding sources |
| LINK to | online and other information to show client device options ILC for trial, preview and advice GP, practice nurses, OT etc. other providers funder information and requirements |
| SUPPORT | provision follow up and problem solve supply fitting, modification and training in use of AT |

System Insights

A key learning across the focus groups was the limited lens or perspectives people held through the nature of their roles.

In the absence of a comprehensive resource detailing pathways to AT provision, professionals suggest “tried and true” options within their knowledge base, and this limits the ability to “fit the solution to the client”.

All HACC clients interviewed had instances of unmet or under met needs. These needs had been missed or, if they had occurred between HACC assessments, remained unresolved. HACC clients for whom these gaps occurred demonstrated a decrease in wellbeing and independence due to participation restrictions.

One stakeholder found out about the Community Aids and Equipment Program (CAEP) only through attendance at the focus group stating “just today I saw someone who needs a special bed and can’t afford it, I need to come and talk to you people (ILC) here.

Recommendations to achieve an improved system

Building capacity across the AT sector will support the implementation of a systematic approach to non complex AT provision

To achieve this key recommendation, three areas of focus have been identified. These are:

1) Build capacity of Assessors by expanding their AT knowledge, skill and role in the provision of non complex AT

The Western Australian Assessment Framework provides the foundations and structure to maximise existing pathways. Research indicated that there is capacity to expand the AT knowledge of RAS Assessors and strengthen their role in facilitating non complex AT provision.

“Research showed that there is a tension between resourcing people to organise their own supports (a strategy identified by RAS Assessors to foster client autonomy and choice) and the barriers which people describe as preventing outcomes being achieved.”

Given the extent of need demonstrated in even the small sample of HACC clients researched for this study, it would appear that, while empowering clients with information to follow up is an appropriate starting point, for many, additional support is required to ensure a solution is arrived at.

One Assessor stated “Most people say yes I will look into that... back a year later and they often haven’t. Once we have done the assessment and the referral our role is finished; the service provider takes over and because they are going in usually every day or three to four times a week for personal care they should also be identifying what these clients need.”

Ninety percent (90%) of Assessors felt they did not have adequate training in non complex AT.

Assessors provided a range of suggestions on how they could be better resourced and informed.

Assessor Insights

RAS Assessors understand that AT, environmental modifications and related strategies can achieve wellness related goals, and that the role of the RAS Assessor is to identify the need and connect the person with appropriate pathways.

When referrals to AT are followed through by the RAS Assessor it ensures an AT outcome is reached which is a crucial step in achieving positive client outcomes.

RAS Assessors reported limited background knowledge regarding AT itself, other than the work history or training they may bring into their RAS role. Given approximately 50% of RAS Assessors interviewed lacked significant knowledge of AT, suppliers and funding for the HACC population, then opportunities for professional development and knowledge acquisition become increasingly important. While several Assessors reported undertaking formal manual handling training as part of their job, none had received formal AT training in this way.

Each RAS Assessor demonstrated an individual ‘mix’ of experience and knowledge, specific attitudes to learning and knowledge and perspectives of the capacity of their specific RAS team in terms of manageable workloads and atmosphere of continuous improvement. While these all impacted upon the effectiveness of the pathways provided through the RAS assessment process, arguably attitude was found to be the key characteristic.

2) Expand the reach and access to the ILC

The ILC is perceived as a key pathway, well positioned to provide a single accessible, information resource that maps assistive technology pathways suitable for HACC clients and available for all AT stakeholders”.

An overarching goal is developing strategies to reduce the number of steps for HACC clients to obtain their AT as this will improve outcomes for clients. ILC training for Assessors will expand their skills and knowledge. Also exploring the ILC’s role in AT provision was suggested along with extension of community AT education, including GPs.

3) Funding non complex AT

Research findings indicated variation in perceptions of whether non complex AT should be funded with responses along the continuum, e.g. fully funded to self purchased. The findings suggest that skilled advice and support to identify, set up and trial devices, transport devices home and ensure that clients are confident with device use is more critical than the device cost. This points to further investigation from a policy point of view to determine if and how non complex AT funding would be applied.

AT stakeholder and supplier Insights

Few AT stakeholders had skills and knowledge across the full range of non complex AT.

No single AT stakeholder was aware of all the pathways available. People knew “part” of the AT story which limited their ability to identify solutions outside their knowledge base.

The increasing availability of technology through generic suppliers such as Bunnings raised the issue of “soft technology” skills for generic providers and/or up skilling the consumer.

TADWA was a well know pathway yet it was noted it “closes its books” to manage supply, and this impacted on its usefulness.

Pharmacies were a preferred pathway and offer a wide variety of AT however they do not provide soft technology. Adverse outcomes were reported by HACC clients and their families for products they purchased at pharmacies that did not relate to medications.

GPs were perceived as important yet unreliable sources of information due to their workload and lack of specific AT knowledge.

Conclusion

The research provides an empirical foundation on which to base development work around processes, roles and competencies of HACC Assessors. The full report extends the evidence base available regarding the key facilitators of AT, environmental adaption and related strategies; and the recommendations made provide the sector and policy makers with indicators for change.

These findings confirm the service directions and continuous improvements proposed by O’Connell (2013). O’Connell’s implementation overview of the WA HACC program’s Wellness Approach presents current evidence for the efficacy of the Wellness Approach as released to date in WA. She concludes that “The section and policy makers therefore have a responsibility to ensure that they plan for and provide support services that are targeted - and that those services are evidence based and/or current best practice to provide optimal outcomes for individuals in need of support”.

**The full report can be downloaded in Resources – Research and Projects –
@ www.ilc.com.au**

Table 1: Common non complex AT and strategies across daily living areas

| Area of daily living | Sample devices | |
|--|--|--|
| Self-care activities | | |
| Walking, Transferring and Mobility | walking sticks wheelie walkers slide pads and transfer discs | (manual wheelchair) chair raisers threshold ramps |
| Showering, Grooming, Dressing and Clothing | hand showers handrails shower stools buttonhooks long handled toe washers | shoe horns and shoe doffers dressing sticks long handled combs tap turners long handled sponges |
| Toileting and Continence | over toilet frames toilet raisers | kylie sheets reusable continence wear |
| Eating, Drinking and Meal Preparation | adapted crockery and cutlery non-slip kitchenware ergonomic knives | kitchen trolleys one handed breadboards two handled cups |
| Medication Management | dossette boxes pill splitters | eye drop dispensers medication timers |
| Communication, Writing, Reading, Hearing, Telephoning, Emergency Call Systems, Managing Money | communication cards magnifying glasses universal remote control | adapted pen grips personal alarms GPS and reminder systems modified headphones for TV |
| Housework activities | | |
| Vacuuming, Sweeping/mopping, Cleaning the bath or shower, Dusting, Making beds, Clothes Washing, Ironing, Drying the washing | lightweight mops and brooms lightweight or automatic vacuum cleaners microfibre cleaning mitts adapted bed making techniques wheeled laundry trolley | furniture raisers (to enable cleaning) adapted mop bucket lightweight iron adapted pegs pull out washing line or clothes horse |
| Community access | | |
| Transferring into/out of cars/vehicles, Shopping and Unpacking | wheeled shopping trolleys methods to load shopping methods to push trolleys | swivel disc for car seat handle adaptation for car transfers |
| Recreation | | |
| Maintaining the garden | adapted / lightweight gardening tools long handled weeder | raised beds garden kneeler |
| Leisure pursuits | tailored information/communication technology embroidery hoop, needle threader | accessible board games Nintendo Wii bookstands |
| Principles of work simplification | Task adaption/analysis/breakdown Doing the activity in the most efficient and safe way Use suitable work heights Store items for frequency of use | |
| Principles of energy conservation | Planning ahead Balance activity with rest periods | |