

REABLEMENT AS AN EVOLUTION IN COMMUNITY CARE: A COMPARISON OF IMPLEMENTATION ACROSS FIVE COUNTRIES

Parsons, J., Burton, E., Graff, L., Metzelthin, S., O'Connell, H., Tuntland, H.

Introduction

Until recently, there has been an implicit assumption that in-patient rehabilitation for older people is the gold standard for care through maximising the individual's potential for independence and arresting the functional decline that is prevalent in old age. However, as the number of older people increase, viable alternatives to hospitalisation become increasingly important as it is simply not possible to continue to match population growth with hospital beds.⁽¹⁾ Recent research highlights that hospital is not always the best location to provide rehabilitation and care for older people.⁽²⁻⁴⁾ This is a challenge that most countries have been grappling with over the past 20 to 25 years. Alongside this is the idea that the best place for supporting an older person is within their own home. Overall, evidence shows that this is where they want to remain, where they have established social networks and support and often a lifetime of memories.^(5, 6)

Reablement or restorative home support is a relatively new approach to delivering support for older people. It is a model of care focused on, where possible and appropriate, restoring an individual's capability after an illness or other health setback and therefore restoring their quality of life. Numerous countries, including Australia, Canada, Denmark, Netherlands, New Zealand, Norway, Sweden, UK and US have been developing the approach for several years. However, the fundamental approach, key principles and stage of implementation differs across each country. A study of implementation offers a systematic approach to explore how to get 'what works' to people who need it with greater speed, fidelity, efficiency, and coverage. The three main areas of implementation are: the development of the intervention; the delivery of the intervention itself; and then the scaling up of the intervention. These various perspectives have formed the basis of research in complex healthcare interventions in which questions of implementation have been explored.⁽⁷⁻¹²⁾

This chapter considers the key issues relating to implementation for development, refinement and spread of reablement across five countries. The i-PARIHS^(13, 14) framework has been used as a framework of analysis. i-PARIHS is a well validated method of exploring the implementation of initiatives into clinical practice and has a number of factors that are important to assess. These factors are categorised as:

- a. Those that relate to the innovation that is being introduced (innovation construct);
- b. Those that are linked to the individuals and teams that are involved in adoption of the innovation (individual or recipient); and
- c. Those concerned with the wider environment, both internally (inner context) and externally to the organisation (outer context) in which implementation is taking place.
- d. The key role of facilitation within implementation.

The chapter presents the different approaches taken by these countries and the challenges and facilitating factors that arose in the implementation of the model. This adds to a common understanding of the issues around development and refinement of reablement within a country's health and social care system. In addition, it acknowledges that although each system has its own unique characteristics, there are common components that need to be addressed to enable successful implementation of reablement.

Implementation of Reablement

1) Innovation (fit with existing practice, clarity, complexity, relative advantage and evidence)

New Zealand

From 2001, a model of reablement has been developed and implemented across a number of the health regions.⁽¹⁵⁻²⁰⁾ Key components of the model have been identified and refined. Firstly, there needs to be involvement of the older person, their family and homecare staff in setting goals.^(17-19, 21) Secondly, is the need for comprehensive assessment and diagnosis leading to a multifaceted treatment plan that includes exercise, behavioural changes, environmental adjustments and adaptive equipment.⁽²²⁻²⁸⁾ New Zealand adopted the interRAI Home Care and Contact Assessments and slowly integrated these as the assessment tool. Finally, the model of funding of homecare required modification to incentivise providers to apply the principles of the model. The traditional method of funding homecare services is via "fee-per-hour." Although trials have demonstrated that more responsive, high-quality homecare services can be operated within a fee-per-service environment,^(16, 19) there often remains issues such as inflexible and unresponsive services, unfunded support and reluctance to discharge participants. A case-mix funding model was developed and implemented that uses the interRAI Contact (older people with non-complex needs) and Home Care assessments (for complex needs).⁽²⁹⁾ Traditionally, the coordinator role within the homecare organisation was undertaken by non-health professionals with very large caseloads⁽³⁰⁾ however, a recognition of the complexity of the role and the need for proactive and responsive services has meant that registered health professionals (Registered Nurses and therapists) are now being employed in the role.⁽³⁰⁻³³⁾ The provision of the model is not normally time limited, although regular assessment and reviews mean that service delivery is tailored to meet the needs of the older person.

Denmark

Reablement was first implemented in Denmark in 2007-2008. People applying for or already receiving homecare services with potential to improve functional ability are offered reablement aimed at improving functional ability and reducing the need for ongoing services. The intervention usually lasts up to 12 weeks and is most often performed by support workers / home carers and therapists in cooperation with registered nurses in the home of the recipient.⁽³⁴⁻³⁶⁾

Homecare services are funded by the municipality and free of charge for the participants. When funding reablement, municipalities may choose an activity-based funding model related to the participant's functional level and complexity of the intervention. Some municipalities are experimenting with combining this funding model with a result-based model to provide the private providers with incentives to work towards maximum independence for the participant.⁽³⁷⁾

Assessment for reablement is done by municipal needs assessors. These are organised in a separate department from homecare services in order to ensure a separation of the ordering and the performing units. Needs assessors are most often nurses or therapists, assessing all applications for homecare and associated services.

Norway

Norwegian municipalities started implementing reablement in 2012. The intention was to improve the quality of the health services for the users and to contribute to healthy ageing. The innovative aspects of reablement are its focus on changing the philosophy from one, where delivery of care may create dependency, to provision of care, which maximises independence and health-related quality of life and reduces care needs.^(38, 39) Traditionally, when home dwelling persons needed rehabilitation, they would receive limited input from occupational therapy and physiotherapy and these services were seldom integrated with the homecare services. Hence, another innovative aspect is that in reablement staff from homecare services (ie. nurses, auxiliary nurses and support workers / home carers) work together with staff from home-based rehabilitation services (i.e occupational therapist and physiotherapist) in a joint endeavor to reach the goals defined by the participant.^(40, 41) The reablement intervention is indeed based on the meaningful activities the participant has identified as his/her goals. The target group for reablement is primarily older adults with functional decline irrespective of diagnosis.⁽⁴²⁾

In Norway, reablement is free of charge for the participants, publicly funded and provided at a municipal level. Staff delivering reablement are primarily physiotherapists, occupational therapists, nurses, auxiliary nurses and support workers.⁽⁴²⁾ Therapy personnel are often the ones who perform the needs assessment and assessment of the effects of the intervention. The primary measurement in Norwegian reablement is the Canadian Occupational Performance Measure (COPM), which is used both for goal setting and evaluation purposes.

Western Australia

The first reablement home care program (HIP) in Australia was developed in 1999 by Silver Chain, a large West Australian (WA) homecare provider, as a direct response to the demand for homecare services, exceeding supply. The aim of the Home Independence Program (HIP) was

to actively reduce demand for ongoing homecare services through promoting independence.⁽⁴³⁾ The Personal Enablement Program (PEP) was developed a few years later and was similar to HIP except users were referred from hospital rather than the community. The effectiveness of HIP, PEP and HIP-C (HIP delivered by non-allied health staff) has been evaluated over many years. Between 2006 and 2014 the Health Department of WA Aged Care Policy Directorate undertook a significant reform and change process across Home and Community Care Services. These included 1) the adoption of a Wellness/Reabling Approach to the delivery of homecare services;⁽⁴⁴⁾ 2) the establishment of independent regional assessment agencies (known as RAS) which separated eligibility and assessment from the provision of care services.

As from July 2018 the Commonwealth Government now have full funding, policy and operational responsibility for the delivery of aged care services nationally. Older adults requiring low-level support services continue to be assessed by RAS Assessors. The current funding model for low level support through the Commonwealth Government is based on volumes of care and outputs. This methodology for funding can perversely work against the sector and individuals actively working towards optimising independence and function as it rewards higher levels of support and volumes not reduced levels. Staff delivering HIP/PEP were registered nurses, physiotherapists or occupational therapists, RAS assessors do not need to be tertiary trained.

The Netherlands

Reablement is a relatively new approach in Dutch homecare. Between 2014 and 2016, researchers from Maastricht University developed a reablement programme called 'Stay Active at Home'. A seven-step approach was used that included a small-scale pilot study as the last step.⁽⁴⁵⁾ The programme aims to equip homecare professionals with the necessary knowledge, skills, self-efficacy and social support to apply reablement in homecare. More specifically: a) assessing capabilities of participants; b) implementing goal-setting and action planning; c) increasing engagement of participants in physical and daily activities; d) motivating older participants by taking into account their phase of behavioural change and making use of Bandura's self-efficacy theory and e) involving the social network of older participants.⁽⁴⁵⁾ From 2016 until 2017 an exploratory trial was conducted to study the feasibility of the 'Stay Active at Home' programme. Semi-structured interviews with homecare professionals showed that they experienced the programme as an empowering way to apply reablement in homecare. However, professionals also expressed a need for more support to deal with challenging situations. In 2017 a cluster randomised controlled trial started to evaluate the feasibility and (cost-) effectiveness of the 'Stay Active at Home' programme.⁽⁴⁶⁾ The first results of this study are expected in 2020.

Reablement care element	Evidence
Goal facilitation	
New Zealand	The results of two cluster randomised controlled trials that had participant centred goal setting as a key feature. The quantity and type of participant derived goals and goal achievement increased. ^(16-18, 21)
Denmark	Several studies show that it is questionable whether goals are really set based on participants` users wishes and needs or set based on the available services and the presumption that participants want to be reabled. ⁽⁴⁷⁻⁵⁵⁾
Norway	Older adults are allowed to prioritise goals beyond those that directly may lead to reduced demand for home-based services and take place inside the home. ^(56,57) Goals are set by participants (in collaboration with health care workers). However, staff-set goals are reported. ⁽⁵⁶⁾
Participant and family experience	
New Zealand	Community based services aligned to the beliefs and values of the carers of older people with significant levels of disability. ⁽⁵⁸⁾
Denmark	All studies and evaluations highlight the importance of participant motivation. One study found that motivated users had a higher outcome in physical functional ability. ^(34, 35, 59) Studies show significant effects. Living with someone significantly increases the potential for improving functional ability. ^(59, 60)
Norway	The participants` intrinsic and extrinsic motivation are found to be driving forces in the reablement process. The relatives wish to a greater extent to give and receive information and be a resource in the reablement process. ⁽⁶¹⁻⁶⁴⁾
Participant outcomes (Activity performance, physical function, health related quality of life, social support)	
New Zealand	The results of three randomised control trials to investigate the impact of reablement type services on physical function, health related quality of life and social support showed significant improvements compared to usual care. ^(16, 19, 65)
Norway	Reablement improves significantly activity performance and satisfaction with that performance. ^(66, 67) Results for the impact on physical function are inconsistent, but with a tendency towards significant effects in favour of reablement in a six months perspective. ^(39, 42) Results are inconsistent for the impact on HRQoL with some evidence showing significant effects in favour of reablement on some dimensions in a six months and twelve months perspective.
Australia	Functional mobility and completing ADLs and IADLs were significantly improved. ⁽⁶⁸⁻⁷⁰⁾ Participants receiving reablement were more physically active than those receiving usual home care services. Reablement participants preferred lifestyle exercise programs to structured and gained greater physical benefits. ⁽⁷¹⁻⁷⁶⁾

Reablement care element	Evidence
Organisation / teamwork	
New Zealand	A study of the experiences of health and social care workers employed in a reablement service showed improvements in staff satisfaction and a reduction in staff turnover ⁽¹⁵⁾ and the potential implications of reablement for physiotherapy. ⁽⁷⁷⁾
Denmark	Studies show that implementing reablement in the regular homecare services are challenging because of organizational factors (eg. lack of time) and motivational factors (eg. support workers / home carers preferring to work more compensating). Cooperation between therapists and support workers / home carers is an important tool. ^(47, 50, 55, 78, 79)
Norway	Health care personnel are enthusiastic towards working collaboratively. Interprofessional collaboration depends on participants defining own goals, which function as a professional unifying platform. Rehabilitation personnel and the homecare personnel collaborate closely across roles. The tight collaboration causes change in roles, often from a particular role to a more general role with broader job tasks. User involvement is a valued ideal that health professionals strive towards. ^(34, 40, 41, 80, 81)
Service usage patterns	
New Zealand	A randomised control trial investigating the impact of reablement on health and social care usage among older people discharged from an acute hospital showed a reduction in healthcare usage over one year. ⁽⁸²⁾
Australia	A third of participants did not require ongoing services and almost 40% reduced their service requirements. ^(83, 84) Reablement significantly reduced the use of services compared to usual care. ^(68-70, 85, 86)
Cost effectiveness	
New Zealand	A randomised control trial investigating the impact of reablement on health and social care usage among older people discharged from an acute hospital showed reduced rates of hospitalisation over one year. ⁽⁸²⁾
Denmark	Four studies show cost-effectiveness, but two of those at the same time found an increase in costs/hours in regular homecare services. One study finds the intervention to be cost neutral as the reduction in the participants/users' need for services are matched by the economic investment in implementing reablement in the regular homecare services. One study finds an increase in costs. ^(50, 87-90)
Norway	Reablement is a cost-effective intervention. ^(66, 91)
Australia	Participants receiving reablement were less likely to use home care services, particularly personal care. Both studies showed large cost savings. ^(85, 86)
Funding	
New Zealand	A description of the development and impact of case-mix funding models on reablement type services. ^(30, 92, 93)

2) Recipient level (*beliefs and values, skills and knowledge*)

New Zealand

A key feature of implementation of the model has comprised a twofold education process. Firstly, a collaborative approach to defining and refining the process within the local context to allow for alignment with the beliefs and values of the reablement staff. Secondly, the development of the skills and knowledge of staff around the key features of the model.^(15, 16, 19, 77) The most effective technique for embedding the model within practice has been formal and regular peer review sessions each month within the health regions to allow for experiential learning and problem solving at a local level.⁽⁹⁴⁾

The model has often been viewed by homecare coordinator staff as more complex than traditional homecare delivery. In addition to the case-mix funding system, the enhanced supervision required by the coordinator of the unregulated support workers, the increased requirement for liaison with primary and secondary care and the need to develop skills around goal setting and planning have all been seen as adding complexity to the provision of homecare. This has often led to issues relating to a perception of an increased workload but with data showing that there is also increased job satisfaction and a reduction in staff turnover.^(15, 30)

Integration of the new model into the practice of clinicians working as coordinators in homecare has been challenging and in most cases, this has aligned to individual disciplines areas of expertise. A team consisting of coordinators from different disciplines has often been observed as the most effective approach with each discipline providing support to their colleagues.⁽⁹⁵⁾

Denmark

The government has been very active in helping the municipalities implement reablement by funding training courses via the national boards. Studies completed in 2012-13 developed evidence- and practice-based knowledge on reablement.⁽⁹⁵⁻⁹⁷⁾ Outputs were an official handbook of reablement published by the National Health Board⁽⁹⁸⁾ and assistance to the Board in developing an evidence-based model of the organisation of reablement. The model was tested in two municipalities and evaluated thoroughly.⁽⁵⁹⁾ Likewise, the national legislation on reablement in 2015 was followed up by a nationwide study of reablement practice and organisation.⁽³⁷⁾

Danish studies show that implementing reablement can be challenging but rewarding for the homecare workers. It can be seen as a new way of doing things in opposition to the former and more compensatory models of delivering care,⁽⁵⁵⁾ and rewarding because the support workers / home carers get more interesting and challenging tasks and thrive with the closer cooperation with therapists.⁽⁴⁷⁾ For therapists, reablement fits within their existing practice and professional paradigm. Integrating nurses in the reablement interventions has been somewhat difficult, with many evaluations showing a low degree of fit with both the nurses existing practice and their values. Integrating nurses in reablement thus requires attention to their distinct work tasks and the organisation of these.^(86, 99)

Norway

Therapists are often the ones who develop the intervention based on the goals identified by the participant. Although nurses are a part of the reablement team, they have struggled to find their role. Auxiliary nurses do often have the role as support worker / home carer, assisting the participant in daily training under supervision by therapy staff. A challenge here is whether the support personnel has the required qualifications to be able to individually adjust and modify the intervention based on the participant's progress.⁽⁸⁰⁾ When implementing reablement, municipalities provide internal education for the whole team. However, attending external courses/conferences and formal education for competence building, is also common.⁽⁴²⁾

The staff are in large positive towards reablement with only 29% of the respondents of a survey reporting resistance towards implementing reablement.⁽¹⁰⁰⁾ Accordingly, staff working with reablement report interprofessional teamwork as motivating^(40, 41) and closely aligned with professional ideals.⁽¹⁰¹⁾

Western Australia

In 2016 the Regional Assessment Service (RAS) assessors, who had for some years been assessing an individual's support needs within the context of the Wellness Approach, began to undertake specific training in reablement. This targeted training further developed the assessor's skills to, introduce and embed targeted reablement strategies as part of their assessment practice.

RAS Assessors will, as a rule have a non-tertiary, government endorsed (vocational) qualification, similar to that required of homecare support staff. In WA, a robust process is in place to select and train assessors to ensure they not only have the skills and knowledge to perform in the role but also display a positive attitude towards ageing and older people within the context of reablement. Initial training is for two days. After a series of observed assessments, an assessor is deemed as competent by an external reablement expert. Each assessment agency has monthly case meetings, staff receive ongoing mentoring, professional development and their case notes/support plans are reviewed regularly through a formal audit process.

HIP and PEP has most often involved the use of registered health professionals but in 2014 Silver Chain trialled HIP being delivered by coordinators who were non-health professionals and requirements were similar to those of RAS assessors, this was called HIP-C.⁽⁶⁸⁾

The Netherlands

So far the 'Stay Active at Home' programme has been implemented at MeanderGroep South-Limburg, a large healthcare provider that offers different types of homecare services. Personal care and nursing services are provided by small-scale self-directed nursing teams. Each team is guided by a district nurse. The other team members are vocationally-trained registered nurses or certified nurse assistants. Domestic support is provided by support workers / home carers, who work individually under supervision of a manager. Traditionally, Dutch nurses and domestic support workers tend to focus on doing things for their participants rather than with them.⁽¹⁰²⁾ However, participants are sometimes difficult to motivate to participate in daily and physical activities. Reasons may be a lack of motivation, fear of falling, depression or a poor

understanding of the long-term benefits of physical activity.⁽¹⁰³⁾ The ‘Stay Active at Home’ programme was developed to facilitate this change and apply reablement in practice.⁽⁴⁵⁾ Homecare professionals follow a 9-months training, which consists of face-to-face meetings, practical assignments in-between the meetings and weekly newsletters.

3) Inner context – local and organisational level (*leadership and support, culture and organisational priorities*)

New Zealand

Within New Zealand a mixture of For-Profit and Not-For-Profit private organisations are contracted to deliver homecare. An increasing number of these are large national providers whereas there remains a small number who only provide services within one or two health regions.⁽²⁷⁾ The ability of smaller organisations to effectively implement the model has been variable whereas in a number of cases the learning within larger organisations allows for the transfer of experience from previous health regions where they may have been involved in the delivery of the restorative model.

Denmark

Though implemented by law in 2015 and thus spreading to all municipalities in Denmark, reablement was initially a bottom-up initiative to contain costs of elder care and to improve both quality of life for older adults and staff motivation. Evaluations showed potential for economic gain,⁽⁷⁹⁾ which caused reablement to rapidly spread to 92 of 98 municipalities in 2012.⁽³⁴⁾ Being a bottom-up initiative implemented nationwide, reablement seems to fit well into existing practices in the municipalities. Help-to-self-help has been a guiding principle in elder care services for decades but has not had the same impact as the more focused reablement perspective.^(1, 35) Integration of the reablement perspective in regular homecare services, who alongside or after the reablement intervention provide homecare to the same recipients, has been difficult, mostly because of existing and strong values of performing the services in a more traditional way, eg. doing things *for* the participant instead of *with* the participant, but also because of organisational factors.^(34, 47-49, 51)

The municipalities vary in their organisation of reablement, eg. whether therapists or nurses are a part of the homecare reablement team or organised separately, and whether reablement is performed by a specialised team of reablement-trained home carers in cooperation with therapists and nurses – or by the regular homecare service teams. Based on the research to date, it is not possible to claim one form of organisation is more efficient than another, as there are benefits and disadvantages with each.^(34-36, 96) The most common organisation of reablement services is performed by the regular homecare teams with added resources in form of therapist or nurses organised in another part of the organisation, who are responsible for the reablement intervention in question.

Norway

The way the reablement team is organised and the way the intervention is delivered, varies to some degree from municipality to municipality.⁽⁶⁶⁾ Whether reablement is organised as a specialist team or as an integrated team between staff from homecare services and home-based

allied health services, the effect of the rehabilitation for the participants does not differ. Reablement is regarded as a better framework for cooperation and application of professional expertise and judgement. The better working conditions include working with joint goals, and providing times and places for joint meetings for professional communication, collaboration and supervision.^(40, 101)

Implementing reablement is a subtle process involving three phases in which stakeholders move from replicating a full-package reablement programme delivered elsewhere, to an adapting phase and, finally, to an established reablement service tailored to meet local needs.⁽¹⁰⁴⁾ The replication phase is characterised by an effort to replicate an existing reablement service. In the adapting phase, it appears that replication of an existing reablement service model is insufficient. Adapting means tailoring the reablement service to local needs and adapting the community to this new way of offering public health service. The adapting phase is characterised by staff facing a complex reality and being both frustrated and creative. The establishing phase is the final phase and covers how the reablement service integrates into the municipal health service. In this phase the staff is capable of distinguishing between those who can benefit from reablement and those who cannot. The phase is characterised by a frail stability because the health service is a part of a constant process of change caused by economic constraints, lack of qualified staff and other factors.⁽¹⁰⁴⁾

Western Australia

The main aim for community care services in WA is to deliver quality care and assist older adults to remain living independently for as long as they are able to do so. The Regional Assessment Service (RAS) agencies are key to determining whether an older person requires support through the Commonwealth Home Support Program. Many older people will have experienced health and functional declines before they first seek access to community care. The reablement philosophy is about empowering the older adult to maintain existing abilities, adapt to changed circumstances such as functional loss, or to regain confidence and capacity to resume normal activities. RAS agencies are independent organisations to the community service organisations delivering homecare services. This clear separation between assessment and service provision allows RAS assessors, through the lens of transparency, to conduct and maximise the independence of assessments.

The Netherlands

Next to the knowledge, attitude and skills, a facilitating environment is needed to implement reablement in practice.^(40, 41) As a consequence, it is important to ensure that team managers, policy makers, and the board of directors have an understanding of reablement and are supportive of it. Within the 'Stay Active at Home' programme they are regularly informed about the aims, content and progress of the training. In addition, facilitators and barriers regarding the approach to homecare delivery are discussed and addressed. The district nurses and the team managers of the domestic teams are invited to participate in all training activities,⁽⁴⁵⁾ delivery are discussed and addressed.

4) Outer context – national level (*policy, social, regulatory and political infrastructures*)

New Zealand

This model of reorientating homecare is a response to New Zealand government policy developed in the early 2000s,⁽¹⁰⁵⁻¹¹⁰⁾ which provided a focus for providers of health services to ensure equitable, timely, affordable and accessible health services for older people.^(16, 20, 94, 111) Of particular relevance is that homecare needed to have a rehabilitation and empowerment focus that supported specialist health services for older people and collaborative relationships needed to be developed between health and disability support services to ensure a co-ordinated approach and continuity of care for older people.

Denmark

The implementation of reablement in Denmark has been supported by legislation and financially by large funding schemes with different aims from the National Health Board. Municipalities are obliged by law to offer a free choice of homecare provider. They can but are not obliged to let private providers of homecare participate in delivering reablement interventions, but there is a quite large political focus on the subject. The subject of private providers of reablement interventions is severely under-researched,⁽³⁵⁾ and studies show contradicting opinions on the subject.^(34, 96, 110) Finally, the implementation of reablement is supported by the homecare support workers' educations, in which reablement is now a part of the curriculum.

Norway

The Norwegian Occupational Therapy Association initiated in 2012 the project "Reablement in Norway".⁽¹¹²⁾ The reablement project was supported economically by the Norwegian Ministry of Health and Care Services. Since then, the government has supported implementation of reablement in several white papers and other governmental plans.⁽¹¹³⁻¹¹⁵⁾ From the national budget for the years 2013-2015, 6.8 million Euros in stimulation funds were distributed to municipalities that wanted to implement reablement. Moreover, the government commissioned that this implementation was followed by research documenting the effects and impacts of reablement.⁽⁴²⁾ Hence, many municipalities started reablement as a project financed by governmental stimulation funds. The challenge for them has been to prioritise transferring the project into a regular service provided on a permanent basis and to find funding for this within existing budgets.⁽⁶⁶⁾

Western Australia

The aged care sector in Australia has been undergoing major reform for some years to ensure it is the best possible system, now and into the future. With these reforms, homecare is moving towards a more consumer-driven, market-based and nationally consistent system. Whilst WA has been on the "Reablement Journey" for some years, the Commonwealth Government is also supportive of both wellness and reablement and has essentially mandated these approaches in their key resources available to Regional Assessment Agencies and Home Care providers, and has an expectation that all providers will report against their wellness and reablement activities

every year.^(116, 117) Regional Assessment Services (RAS) assessors in WA currently take a reablement approach with all assessments, which includes strategies to help individuals achieve their goals and referral to a reablement specific service and to short term intensive support such as allied health interventions to address specific health, functional or wellbeing concerns. While RAS Reablement is in its infancy in Australia the Commonwealth Government have committed to RAS Reablement as being part of the future of community and homecare in Australia.

The Netherlands

In the Netherlands, homecare is funded on a fee-for-service basis. This funding model creates perverse incentives to stimulate quantity of care rather than quality of care: the more services are delivered, the more money homecare providers will earn. This is inconsistent with reablement that aims to stimulate independence of participants. Therefore, a new sustainable funding model is needed that facilitates goal-oriented, holistic and person-centred homecare that takes into account the capabilities and resources of participants instead of focusing on disease and dependency.^(118, 119) In 2017, on behalf of the Dutch Ministry of Health, Welfare and Sport, the Dutch Healthcare Authority initiated a joint venture with three Dutch universities to create a knowledge base for the development of a new funding model for homecare in the Netherlands. Rather than incentivising the volume of care, the new model should incentivise homecare professionals to - based on their professional knowledge and experience - provide high-quality care that is tailored to participants' needs.⁽¹¹⁹⁾

5) Facilitation

New Zealand

A major factor in successful implementation has been the facilitator role played by the Funding and Planning portfolio manager within a health region, (who is responsible for strategic responses for the health needs of the population at a regional level) and the local manager of the assessment agency. To a certain extent the manager of the homecare agencies have also been the facilitators.^(30, 94, 111)

Denmark

Being a bottom-up initiative, the municipality of Fredericia has been the foremost facilitator of reablement in Denmark, and the municipalities themselves have been the most important facilitators. Other important facilitators are the National Board of Social Services, who was the responsible agency until 2015, and the National Health Board since then.

Norway

From 2012 and onwards the Norwegian Occupational Therapy Association promoted reablement extensively to national and local health authorities, as well as to interested clinicians, administrators and scholars nationwide. The association created a widespread enthusiasm for reablement, encouraging and supporting clinicians and municipalities that wanted to start implementing the new service. In addition, national authorities stimulated implementation.

Western Australia

Reablement in WA commenced and was driven through the introduction of HIP and PEP and subsequent “Independence Programs” developed by one health and community care organisation. The WA state government Aged Care Policy Directorate played a key facilitator role through strategic support and ongoing funding. As the Australian homecare landscape changes, reablement is now an underpinning philosophy of the Aged Care reform agenda and therefore predominantly funded by the Commonwealth Government, who may, along with the Regional Assessment Services, be viewed as fulfilling the role of facilitator of reablement in Australia.

The Netherlands

The researchers from Maastricht University developed the ‘Stay Active at Home’ programme in co-creation with relevant Dutch stakeholders (i.e. nurses and other healthcare professionals, older adults, policy makers, training officers, managers and the board of directors).⁽⁴⁵⁾ By participating in the development process they got enthusiastic about the programme and felt responsible for spreading the programme inside and outside their organisation. Also the stepwise implementation approach, namely conducting a pilot study, an exploratory trial before a cluster randomised controlled trial started facilitated the implementation of the programme, as relevant experiences could be made that were used to further improve the feasibility and (cost-) effectiveness of the programme. Finally, as addressed earlier the support from the inner and outer context is/ was important to facilitate the implementation of reablement.

Discussion

In order to spread successful models of reablement, it is not sufficient to simply understand how models and activities are related to specific outcomes.^(120, 121) Transferring models from one jurisdiction/country to another requires an understanding of how reablement is organised differently across multiple jurisdictions and how differences in organisations affect the transfer of ideas and innovations both within and across jurisdictions.^(9, 121) The i-PARIHS framework allows for exploration of barriers and enablers that influence implementation and spread of reablement.⁽¹³⁾ As can clearly be seen, the implementation of reablement across the five countries has a number of common features in addition to features unique to each country.

Within New Zealand reablement type services have been implemented across 15 of the 20 semi-autonomous health regions. In Denmark, all municipalities have implemented reablement, driven by legislation from the National Health Board. In a similar fashion, Norway has seen reablement implemented across the majority of the municipalities. The Norwegian model is a well-developed approach to scaling up and spread of reablement into a new municipality. The complex nature of the health system in Australia with both federal and state funding and policy has meant that the spread of reablement has been variable and at times lost in translation. In Western Australia and Victoria, a reablement approach became the underpinning philosophy of both states with regards how support was provided to people receiving home and community care services. Although not universally adopted, a number of service providers across Australia have changed the way their services are delivered and have developed reablement focused support services and programs. In the Netherlands reablement is in its infancy with small pilot

projects informing robust research to build the evidence base within the local context. It is proposed that a major factor in driving the scale and spread in New Zealand, Denmark and Norway is the centralised policy and planning structures within these fairly small countries, which has enabled a coherent and sustained approach to widespread implementation.

The description of the innovation itself shows that there are key common features in the composition of reablement across the five countries. All have a focus on community-dwelling older adults with functional decline and share a common philosophy that includes an interdisciplinary approach to delivering care and support and a move away from services that may promote dependency. The differences in structuring reablement may predominantly be due to the local context within the countries. For example, the degree of integration of reablement services within homecare shows considerable variation. In New Zealand there is full integration, whereas in Norway there was a focus on the integration of rehabilitation and homecare resources. In Denmark there is a split model with some municipalities delivering reablement using homecare staff and others using designated reablement teams in cooperation with homecare staff.

Each country would appear to have had particular success in the refinement of different aspects of reablement service provision. In New Zealand there has been a strong focus on comprehensive geriatric assessment using interRAI and the development of funding models to provide incentives to contracted organisations in line with economic theory.^(122, 123) In Denmark, considerable innovation has occurred in education and resourcing. Norway has concentrated significant effort into developing a strong therapy focus with occupational therapy championing reablement services. Australia has demonstrated unique approaches to assessment and resourcing of staff within reablement service provision. The Netherlands has been able to choose features from the different models of reablement implemented in other countries.

There is conflicting evidence relating to the ability to set meaningful participant centred goals within reablement with Danish evidence that goals are often constrained by available services.⁽⁴⁷⁻⁵⁵⁾ This is supported by goal setting within rehabilitation settings where goals aligned to clinician priorities is a common issue,^(124, 125) with such ‘privileged goals’ representing known territory for clinicians as they relate to activities that they were comfortable performing and addressed their main work responsibilities and priorities. However, in New Zealand and Norway, training for clinicians in the use of specific goal setting tools (TARGET and COPM) resulted in a greater emphasis on participant driven goals.^(16-18, 21, 56) The level of engagement of participants within reablement service provision is closely linked to evidence highlighting the impact of participatory goal setting.⁽¹²⁶⁻¹²⁸⁾ In addition, demonstrable alignment of the values of a service with those of the participant and their family,⁽⁵⁸⁾ a focus on enhancing motivation^(34, 35, 59) and involvement of the family^(58, 61-64) were also associated with effective engagement of the participant within the reablement process.

Across the five countries there was robust evidence for the impact of reablement on activity performance, physical function, health related quality of life, social support with significant changes observed.^(16, 19, 65-70) Furthermore, there is strong support for the idea that reablement leads to a change in service usage patterns^(68-70, 82-86) although the impact on cost is less clear

with an increase in cost effectiveness observed across New Zealand, Norway and Australia^(42, 66, 82, 85, 86, 91) but inconclusive evidence from Denmark.^(50, 87-90)

The focus on integrated teamwork across reablement teams appears to be a significant factor in delivering these changes in key outcomes. However, there is also evidence that the team approach led to higher levels of staff satisfaction^(34, 40, 41, 80, 81) and reduced staff turnover.⁽¹⁵⁾ It is interesting to note that this increased satisfaction is accompanied by evidence that staff find the implementation of reablement to be challenging because of organisational factors (eg. lack of time) and motivational factors (eg. support workers / home carers preferring to work more compensating).^(94, 129)

A common feature at a recipient level is the acknowledgement of the need for robust training to enable any necessary change in culture of dependency among homecare or community health and social care workers and to manage the complex nature of the participants. There is evidence from a number of the countries that the implementation of the model is challenging for health professionals and may involve delegation of some tasks, that may have been aligned to specific disciplines, to home carers/support workers.⁽⁷⁷⁾

Conversely, there is a level of divergence in the disciplines involved in the delivery of reablement services. In New Zealand the model primarily uses registered nurses to undertake assessments and coordinate services with home carers/support workers providing assistance and support to the participant. Therapy input is provided in a consulting or advisory capacity.⁽⁷⁷⁾ This is a model that has been replicated in the Netherlands with registered nurses being the key discipline involved in coordination of reablement. Within Denmark and Norway the delivery of reablement is most often led by therapists in cooperation with home carers, with registered nurses having either a minimal or an unclear role. In the Western Australian model initially reablement was delivered by therapists and nurse with assistance from support staff. However, more recently there has been innovation around the use of non-health professionals in assessment and coordination roles. These variations in skills-mix can be ascribed differences in supply and organisation of health services between the countries.

At the inner context level of the i-PARIHS it is interesting to note the variation in the composition of organisations providing reablement services. In Norway and Denmark staff are employed directly by the municipality, for Denmark there are examples of private providers of home care offering reablement services under contract with the municipalities, whereas the majority of providers in the other countries are contracted organisations that are a mix of for-profit (FPO) and not-for-profit (NFP) non-governmental organisations. However, in general, there is evidence to suggest that the type of organisation (FPO versus NPO) has little effect on client or staff satisfaction^(130, 131) and that inter-organisational relationships and communication is a far more important factor in effective service provision.^(132, 133)

The authors of iPARIHS described facilitation as the “active ingredient” for implementation.⁽¹³⁾ It was defined as “the construct that activates implementation through assessing and responding to characteristics of the innovation and the recipients” in context⁽¹³⁾, p 8). iPARIHS situates the success of implementation upon whether the facilitator can enable the recipients to make the desired change. Across the five countries there were various approaches to facilitation of implementation. Within New Zealand and Denmark this was undertaken by regional and

local managers in the health region or municipality. In Norway the national occupational therapy association played a key advocacy and facilitation role. Within Australia the state government and Commonwealth governments and the Silver Chain organisation were key to facilitating implementation.

Conclusion

Implementation of a new intervention like reablement is a complex and dynamic process influenced by many factors. This chapter has shown factors that have influenced the variation in implementation of reablement across five countries. Despite variations in health care systems across the countries, the driving forces are similar, namely the sustainability threats due to the demographic change, lack of qualified personnel, and demand for homecare service exceeding supply. Implementation of reablement across five countries has a number of common features, as well as features unique to each country and this highlights the importance of context in successful implementation of complex interventions.

References

1. Moise P, Jacobzone S. Population ageing, health expenditure and treatment: an ARD perspective. In: A disease based comparison of health systems. Paris: OECD; 2003.
2. Boyd CM, Ricks M, Fried LP, Guralnik JM, Xue QL, Xia J, et al. Functional Decline and Recovery of Activities of Daily Living in Hospitalized, Disabled Older Women: The Women's Health and Aging Study I. *JAGS*. 2009;57(10):1757-66.
3. Sager MA, Franke T, Inouye SK, Landefeld CS, Morgan TM, Rudberg MA, et al. Functional outcomes of acute medical illness and hospitalization in older persons. *Archives of Internal Medicine*. 1996;156(6):645-52.
4. Sager MA, Rudberg MA. Functional decline associated with hospitalization for acute illness. *Clin Ger Med*. 1998;14(4):669-79.
5. Crane J. Housing and health in older people: ageing in place. *Social Policy Journal of New Zealand*. 1999;13:14-30.
6. Olsberg D, Winters M. Ageing in place: intergenerational and intrafamilial housing transfers and shifts in later life. Final Report. 2005;88.
7. Greenhalgh T, Papoutsi C. Studying complexity in health services research: desperately seeking an overdue paradigm shift. *BioMed Central*; 2018.
8. Greenhalgh T, Wherton J, Papoutsi C, Lynch J, Hughes G, A'Court C, et al. Beyond adoption: a new framework for theorizing and evaluating nonadoption, abandonment, and challenges to the scale-up, spread, and sustainability of health and care technologies. *Journal of Medical Internet Research*. 2017;19(11).
9. Gray CS, Wodchis W, Baker G, Carswell P, Sheridan N, Breton M, et al. Mapping for conceptual clarity: Exploring implementation of integrated community-based primary health care from a whole system perspective. *International Journal of Integrated Care*. 2017;17(5).
10. Kuluski K, Sheridan N, Kenealy T, Breton M, McKillop A, Shaw J, et al. "On the Margins and Not the Mainstream:" Case Selection for the Implementation of Community based Primary Health Care in Canada and New Zealand. *International Journal of Integrated Care*. 2017;17(2).
11. Durlak JA, DuPre EP. Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*. 2008;41(3-4):327.
12. Kaplan HC, Brady PW, Dritz MC, Hooper DK, Linam WM, Froehle CM, et al. The influence of context on quality improvement success in health care: a systematic review of the literature. *The Milbank Quarterly*. 2010;88(4):500-59.

13. Harvey G, Kitson A. PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. *Implement Sci.* 2015;11(1):33.
14. Rycroft-Malone J. The PARIHS framework--a framework for guiding the implementation of evidence-based practice. *J Nurs Care Qual.* 2004;19(4):297-304.
15. King AII, Parsons M, Robinson E. A restorative home care intervention in New Zealand: perceptions of paid caregivers. *Health & Social Care in the Community.* 2012;20(1):70-9.
16. King AII, Parsons M, Robinson E, Jørgensen D. Assessing the impact of a restorative home care service in New Zealand: a cluster randomised controlled trial. *Health & Social Care in the Community.* 2011;20(4):365-74.
17. Parsons J, Rouse P, Robinson EM, Sheridan N, Connolly MJ. Goal setting as a feature of homecare services for older people: does it make a difference? *Age and Ageing.* 2012;41(1):24-9.
18. Parsons JGM, Parsons MJG. The effect of a designated tool on person-centred goal identification and service planning among older people receiving homecare in New Zealand. *Health & Social Care in the Community.* 2012;20(6):653-62.
19. Parsons JGM, Sheridan N, Rouse P, Robinson E, Connolly M. A Randomized Controlled Trial to Determine the Effect of a Model of Restorative Home Care on Physical Function and Social Support Among Older People. *Arch Phys Med Rehabil.* 2013;94(6):1015-22.
20. Parsons M, Senior H, Kerse N, Chen M-h, Jacobs S, Anderson C. Randomised trial of restorative home care for frail older people in New Zealand. *Nursing Older People.* 2017;29(7):27-33.
21. Parsons J, Jacobs S, Parsons M. The use of goals as a focus for services for community dwelling older people. In: Siegert RJ, and Levack, W, , editor. *Handbook of Rehabilitation Goal Setting.* San Francisco: CRC Press/Taylor & Francis; 2014.
22. Baker DI, Gottschalk M, Eng C, Weber S, Tinetti ME. The Design and Implementation of a Restorative Care Model for Home Care. *JAGS.* 2001;41(2):257-63.
23. Nadash PBP, Feldman P. The Effectiveness of a " Restorative" Model of Care for Home Care Patients. *Home Healthc Nurse.* 2003;21(6):421-3.
24. Tinetti ME, Baker D, Gallo WT, Nanda A, Charpentier P, O'Leary J. Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care. *Journal of the American Medical Association.* 2002;287(16):2098-105.
25. Stone RI. Research on frontline workers in Long-Term Care. *Generations.* 2001;25(1):49-57.
26. Stone RI, Wiener J. *Who will care for us? Addressing the Long-Term Care workforce crisis.* New York: The Urban Institute and the American Association of Homes and Services for the Aging; 2001.
27. Francis J, Netten A. *Home care workers: careers, commitments and motivations.* Kent: University of Kent at Canterbury, Personal Social Services Research Unit; 2003.
28. Harris-Kojectin L, Lipson D, Fielding J, Kiefer K, Stone RI. *Recent findings on frontline long-term care workers: a research synthesis 1999-2003.* Washington DC: U.S. Department of Health and Human Services; 2004.
29. Parsons M, Rouse P, Sajtos L, Harrison J, Parsons J, Gestro L. Developing and utilising a new funding model for home-care services in New Zealand. *Health & Social Care in the Community.* 2018;26(3):345-55.
30. Jacobs SP, Parsons M, Rouse P, Parsons J, Gunderson-Reid M. Using benchmarking to assist the improvement of service quality in home support services for older people—IN TOUCH (Integrated Networks Towards Optimising Understanding of Community Health). *Evaluation and Program Planning.* 2018;67:113-21.
31. Ministry of Health. *Service Specifications for Home Based Support Services.* Wellington: Ministry of Health; 2006.
32. Bryan B, Dickerson D, Fleming MA, Gholston L, Thompson L. Nursing case management: affecting quality and cost. *Hospital Materiel Management Quarterly.* 1994;16(2):63-75.
33. Challis D. *Achieving co-ordinated and integrated care among long term care services: the role of care management.* Geneva: World Health Organization; 2003.
34. Bertelsen ATM, Hansen MB. *Hverdagsrehabilitering og velfærdsinnovation i ældreplejens organisering [Reablement - specialised or integrated?]. Nordisk Tidsskrift for Helseforskning [Nordic Journal of Health Research].* 2018;14(1):20.

35. Petersen A, Graff, L, Rostgaard, T, Kjellberg, J, Kjellberg, P. Rehabilitering på ældreområdet. Hvad fortæller danske undersøgelser os om kommunernes arbejde med rehabilitering i hjemmeplejen? København: Sundhedsstyrelsen; 2017.
36. Rambøll Management Consulting. Praksisundersøgelse af servicelovens § 83a. København: Rambøll; 2017.
37. Rambøll Management Consulting. Innovationspartnerskaber om rehabilitering. København: Rambøll Management Consulting; 2016.
38. Moe CFaG-N, L. Hverdagsrehabilitering som innovasjon. Økt oppmerksomhet om aktørers samspill. [Reablement as innovation. Increased attention regarding collaboration], in *Innovasjoner i offentlig tjenesteyting (Innovations in public service delivery)*. Bergen: Fagbokforlaget; 2015.
39. Tuntland H. Reablement in home-dwelling older adults. Bergen: University of Bergen; 2017.
40. Hjelle KM, Skutle O, Førland O, Alvsvåg H. The reablement team's voice: a qualitative study of how an integrated multidisciplinary team experiences participation in reablement. *J Multidiscip Healthc*. 2016;9:575.
41. Birkeland A, Tuntland H, Førland O, Jakobsen FF, Langeland E. Interdisciplinary collaboration in reablement—a qualitative study. *J Multidiscip Healthc*. 2017;10:195.
42. Langeland E, Førland O, Aas E, Birkeland A, Folkestad B, Kjekken I, et al. Modeller for hverdagsrehabilitering-en følgeevaluering i norske kommuner. Effekter for brukerne og gevinster for kommunene? Senter for omsorgsforskning vest: Høgskolen i Bergen, CHARM: Bergen; 2016. Report No.: 8283400436.
43. Silver Chain Nursing Association. Home Independence Program (HIP) User Manual. Perth: Silver Chain Nursing Association; 2007.
44. O'Connell H. Challenging community care with wellness: An implementation overview of the WA HACC Program's Wellness Approach. Western Australia: Community West inc; 2013.
45. Metzelthin SF, Zijlstra GA, Van Rossum E, de Man-van Ginkel JM, Resnick B, Lewin G, et al. 'Doing with...' rather than 'doing for...' older adults: rationale and content of the 'Stay Active at Home' programme. *Clin Rehabil*. 2017;31(11):1419-30.
46. Metzelthin SF, Rooijackers TH, Zijlstra GA, van Rossum E, Veenstra MY, Koster A, et al. Effects, costs and feasibility of the 'Stay Active at Home' Reablement training programme for home care professionals: study protocol of a cluster randomised controlled trial. *BMC Geriatrics*. 2018;18(1):276.
47. Rostgaard T, Graff, L. Med hænderne i lommen. borger og medarbejders samspil og samarbejde i rehabilitering. København: KORA; 2016.
48. Tonnesen M, Sørensen, JB, Nygaard, K. Grib hverdagen, slutevaluering. Aarhus: Aarhus Kommune; 2012.
49. Navne L, Kjellberg, PK. . Aktiv i din hverdag i hillerød kommune. København: KORA; 2013.
50. Kjellberg P, Kjellberg, J, Navne, LE, Ibsen, R. Trænende hjemmehjælp i fredericia kommune. organisations- og økonomievaluering. København: KORA; 2013.
51. Kjellberg P. Træning som hjælp. tidlige projekterfaringer fra odense kommune. København: KORA; 2012.
52. Hansen A. Rehabilitating elderly bodies and selves. new forms of care work, professional identity and status in rehabilitative home care. Roskilde: Roskilde University; 2015.
53. Hansen A. Rehabilitative bodywork: Cleaning up the dirty work of homecare. *Sociology of Health and Illness*. 2016;38(7):1092-105.
54. Christensen U, Malling, G, Christensen, B. Hverdagsrehabilitering. rapport fra en kvalitativ undersøgelse. København: Københavns Kommune; 2014.
55. Petersen A, Kjellberg, P.K. Det gode hverdagsliv i egedal kommune. København: KORA; 2016.
56. Moe A, Ingstad K, Brataas HV. Patient influence in home-based reablement for older persons: qualitative research. *BMC Health Serv Res*. 2017;17(1):736.
57. Tuntland H, et al.,. Everyday occupations that older adults participating in reablement prioritise: A cross-sectional study. *Scand J Occup Ther*. in press.
58. Wong-Cornall C, Parsons J, Sheridan N, Kenealy T, Peckham A. Extending "Continuity of Care" to include the Contribution of Family Carers. *International Journal of Integrated Care*. 2017;17(2).
59. Lauritzen HH, Bjerre M, Graff L, Rostgaard T, Casier F, Fridberg T. Rehabilitering på ældreområdet: Afprøvning af en model for rehabiliteringsforløb i to kommuner Test of a Rehabilitation

Programme Model in Two Municipalities. København: Sfi – Det Nationale Forskningscenter For Velfærd; 2017. Report No.: 1396-1810.

60. Winkel A, Langberg, H, Wæhrens, EE. Reablement in a community setting. *Disabil Rehabil.* 2015;37(15):1347-52.

61. Hjelle KM, Tuntland H, Førland O, Alvsvåg H. Driving forces for home-based reablement; a qualitative study of older adults' experiences. *Health & Social Care in the Community.* 2017;25(5):1581-9.

62. Jokstad K, Landmark BT, Hauge S, Skovdahl K-I. Eldres erfaringer med hverdagsrehabilitering-Mestring og muligheter– krav og støtte i et dynamisk samspill. *Tidsskrift for omsorgsforskning.* 2016;2(03):212-21.

63. Hjelle KM, Alvsvåg H, Førland O. The relatives' voice: how do relatives experience participation in reablement? A qualitative study. *J Multidiscip Healthc.* 2017;10:1.

64. Jakobsen FA, Vik K. Health professionals' perspectives of next of kin in the context of reablement. *Disabil Rehabil.* 2018:1-8.

65. Peri K, Kerse N, Robinson E, Parsons M, Parsons J, Latham N. Does functionally based activity make a difference to health status and mobility? A randomised controlled trial in residential care facilities (The Promoting Independent Living Study; PILS). *Age and Ageing.* 2007;37(1):57-63.

66. Langeland E, Tuntland H, Folkestad B, Førland O, Jacobsen F, Kjekken I. A multicenter investigation of reablement in Norway: a clinical controlled trial. *BMC Geriatrics.* 2019;19(1):29.

67. Tuntland H, Aaslund MK, Espehaug B, Førland O, Kjekken I. Reablement in community-dwelling older adults: a randomised controlled trial. *BMC Geriatrics.* 2015;15(1):145.

68. Lewin G, Concanen K, Youens D. The Home Independence Program with non-health professionals as care managers: an evaluation. *Clinical Interventions in Aging.* 2016;11:807.

69. Lewin G, De San Miguel K, Knuiman M, Alan J, Boldy D, Hendrie D, et al. A randomised controlled trial of the Home Independence Program, an Australian restorative home-care programme for older adults. *Health & Social Care in the Community.* 2013;21(1):69-78.

70. Lewin G, Vandermeulen S. A non-randomised controlled trial of the Home Independence Program (HIP): an Australian restorative programme for older home-care clients. *Health & Social Care in the Community.* 2010;18(1):91-9.

71. Burton E, Lewin G, Boldy D. Barriers and motivators to being physically active for older home care clients. *Phys Occup Ther Geriatr.* 2013;31(1):21-36.

72. Burton E, Lewin G, Boldy D. Physical activity levels of older adults receiving a home care service. *Journal of Aging and Physical Activity.* 2013;21(2):140-54.

73. Burton E, Lewin G, Boldy D. Physical activity preferences of older home care clients. *International Journal of Older People Nursing.* 2015;10(3):170-8.

74. Burton E, Lewin G, Clemson L, Boldy D. Effectiveness of a lifestyle exercise program for older people receiving a restorative home care service: a pragmatic randomized controlled trial. *Clinical Interventions in Aging.* 2013;8:1591.

75. Burton E, Lewin G, Clemson L, Boldy D. Effectiveness of a lifestyle exercise program for older people receiving a restorative home care service: study protocol for a pragmatic randomised controlled trial. *BMC Health Serv Res.* 2013;13(1):419.

76. Burton E, Lewin G, Clemson L, Boldy D. Determining the feasibility of a lifestyle activity program for inclusion in a restorative home care service: a pilot study. *Activities, Adaptation & Aging.* 2014;38(2):79-93.

77. Parsons J, Mathieson S, Parsons M. Home Care: An opportunity for physiotherapy. *New Zealand Journal of Physiotherapy.* 2015;43(1):24-31.

78. Kjellberg P, Ibsen, R, Kjellberg, J. Fra pleje og omsorg til rehabilitering. erfaringer fra fredericia kommune. København: Dansk Sundhedsinstitut; 2011.

79. Kjellberg P. Hverdagsrehabilitering i fredericia kommune. 1. devaluering. København: Dansk Sundhedsinstitut; 2010.

80. Eliassen M, Henriksen N, Moe S. The practice of support personnel, supervised by physiotherapists, in Norwegian reablement services. *Physiotherapy Research International.* 2019;24(1):e1754.

81. Eliassen M, Henriksen NO, Moe S. Physiotherapy supervision of home trainers in interprofessional reablement teams. *Journal of Interprofessional Care.* 2018:1-7.

82. Parsons M, Parsons J, Rouse P, Pillai A, Mathieson S, Parsons R, et al. Supported Discharge Teams for older people in hospital acute care hospital: a randomised controlled trial. *Age Ageing*. 2017;0:1-6.
83. Lewin G, Calver J, McCormack B, Coster C, O'Connell H, Wheeler B, et al. The home independence project. *Geriatrician*. 2008;26(3):13.
84. Lewin G, Vandermeulen S, Coster C. Programs to promote independence at home: how effective are they? *Generations Review*. 2006;16(3/4):24.
85. Lewin GF, Alfonso HS, Alan JJ. Evidence for the long term cost effectiveness of home care reablement programs. *Clinical Interventions in Aging*. 2013;8:1273.
86. Lewin G, Allan J, Patterson C, Knuiman M, Boldy D, Hendrie D. A comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional home-care service. *Health & Social Care in the Community*. 2014;22(3):328-36.
87. Kjellberg J, Ibsen R, Sundhedsinstitut iTracks D. Økonomisk evaluering af Længst Muligt i Eget Liv i Fredericia Kommune. København: Dansk Sundhedsinstitut. 2010.
88. Kjellberg J, Ibsen R. Rehabiliterende hjemmepleje efter Egedal-modellen: En analyse af de økonomiske konsekvenser af initiativer igangsat i hjemmeplejen i Egedal Kommune i løbet af 2015. 2016.
89. Kjellberg J, Ibsen R. Rehabiliterende hjemmepleje efter Roskilde-modellen: En analyse af de økonomiske konsekvenser af Roskilde-modellen for rehabilitering. 2016.
90. Kjellberg J, Ibsen R. Træning som hjælp. Økonomevaluering. 2012.
91. Kjerstad E, Tuntland, H. Reablement in community dwelling older adults: a cost-effectiveness analysis alongside a randomized controlled trial. *Health Economics Review*. 2016;6(15).
92. Parsons M, Rouse, P., Sajtos, L., Harrison, J., Parsons, J., Gestro, L. . Developing and utilising a new funding model for home-care services in New Zealand. *Health and Social Care in the Community*. 2017:1-11.
93. Sajtos L, Rouse P, Harrison J, Parsons M. Case-mix system as a boundary object: the case of home care services. *Australasian Marketing Journal (AMJ)*. 2014;22(3):189-96.
94. Parsons M, Parsons J, Gundersen Reid M, Jacobs S. Restorative home support evaluation. Timaru: South Canterbury DHB; 2008.
95. Rasmussen S, Kjellberg, PK. Brug af redskaber i rehabilitering til hverdagsaktiviteter på ældreområdet. en beskrivelse af kommunernes erfaringer og analyse af anvendeligheden. Odense: Socialstyrelsen; 2013.
96. Kjellberg P, Hauge-Helgestad, A, Madsen, MH, Rasmussen, SR. Kortlægning af kommunernes erfaringer med rehabilitering på ældreområdet. Odense: Socialstyrelsen; 2013.
97. Københavns Universitet I, KORA, Socialstyrelsen. Socialstyrelsen. Evidens for effekten af rehabilitering for ældre med nedsat funktionsevne. litteraturgennemgang. Odense: Socialstyrelsen; 2013.
98. Sundhedsstyrelsen. Håndbog i rehabiliteringsforløb på ældreområdet. København: Sundhedsstyrelsen; 2016.
99. Kjellberg P, Graff, L. Sygeplejerskernes rolle i rehabilitering i ældreplejen. hvad kan vi lære af danske studier. København: KORA; 2017.
100. Hartviksen T, Sjølie, B. . Hverdagsrehabilitering. Kvalitetsforbedring i norske kommuner. [Reablement. Quality improvement in Norwegian municipalities]. Oslo: Cappelen Damm Akademisk; 2017.
101. Vik K. Hverdagsrehabilitering og tværfaglig samarbeid; en empirisk studie i fire norske kommuner. [Reablement and interprofessional collaboration; an empirical study in four Norwegian municipalities]. *Tidsskrift for omsorgsforskning [Journal of Care Research]*. 2018;4(1):6-15.
102. Schuurmans M, ... Beroepsprofiel verpleegkundige. *Verpleegkundigen & Verzorgenden Nederland (V&VN)*; 2012.
103. Resnick B. Functional performance and exercise of older adults in long- term care settings. *J Gerontol Nurs*. 2000;26(3):7-16.
104. Moe C, Brinchmann, B. Optimising Capacity - A service User and Caregiver Perspective on Reablement. *Grounded Theory Review*. 2016;15(2):25-39.
105. Ministry of Health. New Zealand Health Care Strategy. Wellington, New Zealand: Ministry of Health; 2000.

106. Ministry of Health. The Primary Health Care Strategy. Wellington, New Zealand: Ministry of Health; 2001.
107. Ministry of Health. Disability Support Services: increasing participation and independence. Wellington: Ministry of Health; 2002.
108. Ministry of Health. Health of Older People Strategy. Wellington: Ministry of Health; 2002.
109. Ministry of Health. Guideline for specialist health services for older people. Wellington, New Zealand: Ministry of Health; 2004.
110. Ministry of Health. Disability in New Zealand. Wellington: Ministry of Health; 2007.
111. Senior HE, Parsons M, Kerse N, Chen M-H, Jacobs S, Hoorn SV, et al. Promoting independence in frail older people: a randomised controlled trial of a restorative care service in New Zealand. *Age and Ageing*. 2014;43(3):418-24.
112. Ness NE, Laberg T, Haneborg M, Granbo R, Færevaaag L, Butli H. Hverdagsmestring og hverdagsrehabilitering. Oslo: Ergoterapeutene, Norsk Sykepleierforbund, Norsk fysioterapeutforbund. 2012.
113. Meld S. Report to the Storting (White Paper). In: Future Care 2013. Oslo: Norwegian Ministry of Health and Care Services; 2013.
114. Meld S. Report to the Storting (White Paper) Summary: The primary health and care services of tomorrow - localised and integrated. Oslo: Norwegian Ministry of Health and Care Services; 2015.
115. Norwegian Ministry of Health and Care Services. Care Plan 2020. The government's plan for the care services field for 2015-2020. Oslo; 2015.
116. Commonwealth of Australia (Department of Social Services). Living well at home: CHSP Good Practice Guide. Canberra: Department of Social Services; 2015.
117. Commonwealth of Australia (Department of Health). Commonwealth Home Support Programme – Program Manual 2018. Canberra: Department of Health; 2018.
118. Elissen A, Metzelthin, S, van den Bulck, A, Verbeek, H, Ruwaard, D. Case-mix classificatie als basis voor bekostiging van wijkverpleging. Een verkennend onderzoek in opdracht van MeanderGroep Zuid-Limburg. Maastricht, the Netherlands: Maastricht University; 2017.
119. van den Bulck AO, Metzelthin SF, Elissen AM, Stadlander MC, Stam JE, Wallinga G, et al. Which client characteristics predict home-care needs? Results of a survey study among Dutch home-care nurses. *Health & Social Care in the Community*. 2019;27(1):93-104.
120. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci*. 2009;4:50.
121. Harrison MI, Grantham S. Learning from implementation setbacks: Identifying and responding to contextual challenges. *Learning Health Systems*. 2018:e10068.
122. Laffont J, Martimort D. The theory of incentives: the principal-agent model. Princeton, NJ: Princeton University Press; 2002.
123. Williamson O. Transaction cost economics and organization theory. In: Smelser NJ, Swedberg R, editors. *The handbook of economic sociology*. Princeton, NJ: Princeton University Press; 1994. p. 77-107.
124. Levack WM, Dean SG, Siegert RJ, McPherson KM. Navigating patient-centered goal setting in inpatient stroke rehabilitation: how clinicians control the process to meet perceived professional responsibilities. *Patient Educ Couns*. 2011;85(2):206-13.
125. Parsons JG, . Plant, S.E., Slark, J., Tyson, S.F. How active are patients in setting goals during rehabilitation after stroke? A qualitative study of clinician perceptions. *Disabil Rehabil*. 2016:1-8.
126. Eccles JS, Wigfield A. Motivational beliefs, values and goals. *Annual Reviews in Psychology*. 2002;53(1):109-32.
127. Levack WMM, Taylor K, Siegert RJ, Dean SG, McPherson KM, Weatherall M. Is goal planning in rehabilitation effective? A systematic review. *Clin Rehabil*. 2006;20(9):739.
128. Rosewilliam S, Roskell CA, Pandyan AD. A systematic review and synthesis of the quantitative and qualitative evidence behind patient-centred goal setting in stroke rehabilitation. *Clin Rehabil*. 2011;25(6):501.
129. Cochrane A, Furlong, M, McGilloway, S, Molloy, DW, Stevenson, M, Donnelly, M. Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. *Cochrane Database of Systematic Reviews*. 2016;10:CD010825.

130. Schmid H. Nonprofit organizations and for-profit organizations providing home care services for the Israeli frail elderly: a comparative analysis. *International Journal of Public Administration*. 2001;24(11):1233-65.
131. Schmid H. Relationships Between Organizational Properties and Organizational Effectiveness in Three Types of Nonprofit Human Service Organizations. *Public Personnel Management*. 2002;31(3):377-96.
132. Eklund K, Wilhelmson K. Outcomes of coordinated and integrated interventions targeting frail elderly people: a systematic review of randomised controlled trials. *Health & Social Care in the Community*. 2009;17(5):447-58.
133. Powell Davies G, Williams AM, Larsen K, Perkins D, Roland M, Harris MF. Coordinating primary health care: an analysis of the outcomes of a systematic review. *Med J Aust*. 2008;188:S65-S8.