



**HEALTH OF OLDER PEOPLE
COMMUNITY HOME BASED SUPPORT
SERVICES QUALITY IMPROVEMENT
INITIATIVE**

PROJECT DESCRIPTION

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July 2007*

PART ONE: VISION AND BACKGROUND

1.0 PROJECT VISION

The overall vision of the project is to design and implement a system of community and home based healthcare for older people residing within central Auckland which is easily accessed, user friendly and represents optimum efficiency from both a financial and service user perspective. In order to design such a model, all aspects of the current service spectrum will be examined to ensure that key linkages, referral processes and service delivery are integrated and complimentary.

1.1 EXCEPTIONS

The project is currently limited to people aged 65 years and over with a physical health condition and/or an age-related disability but depending on outcomes may be appropriately applied to those under 65 years with a disability or chronic illness and to palliative care clients at a later stage. Although mental health and ACC funded clients are also excluded, models to improve inter-agency working, reduce duplication and improve the service user experience will be included.

2.0 BACKGROUND

The main aims of the ADHB's Healthy Ageing 2020 strategy are to promote independence and healthier lifestyles in our older people through exploring concepts such as 'ageing in place' and 'single point of entry'. This work is aligned to national strategic work and current international best practice, which both tell us that residential care is becoming less popular with many service users, as long as adequate and flexible supports are available to make it safe and viable to remain in ones own home. It is timely therefore that ADHB embarks on a comprehensive quality initiative to assist in making these outcomes more achievable for older people, and to ensure that primary care and community services are playing an equally valued role in the care of older people, irrespective of where they choose to age.

2.1 CONSUMER EXPECTATIONS AND NATIONAL POLICY WORK

Service user expectations are driving the sector to change, and increasingly older people are opting to remain at home, with adequate support rather to enter aged care. Increasingly policy frameworks are emphasising the importance of 'ageing in place', the promotion of independence, improving health outcomes, strengthening primary care services, delivering robust community based service alternatives, and the promotion of 'continuity of care'.

In response to these issues, most developed countries, including New Zealand (since 2003) are:-

- (a) Increasing the scope and infrastructure of primary care, as robust primary care infrastructures tend to deliver optimum outcomes, better access to services,

higher quality of care and result in higher consumer satisfaction and cost effectiveness.

- (b) Increasing the focus on chronic disease management, by reducing acute admissions and facilitating quality of life for adults with chronic illness. Chronic conditions require a different approach to the organisation of care, where education, advice, support and follow-ups are important processes for the consumer, family / whanau and carer. Evidence supports home based chronic care programmes are in reach to hospital bases, rather than through outreach programmes from hospitals.
- (c) Expanding home and community care options through community development programmes such as hospital in the home, supported by early discharge, admission prevention, and home rehabilitation services and promoting active recovery. The promotion of independence with the elderly improves outcomes and the management of multiple chronic conditions.

2.2 RECENT NATIONAL STRATEGY

This project is also guided by, and aligned to the following national and local strategies:

- New Zealand Health of Older Person Strategy (2002)
- New Zealand Disability Strategy (2001)
- New Zealand Primary Health Care Strategy (2001)
- He Korowai Oranga, The Maori Health Strategy (2002)
- The New Zealand Pacific Health and Disability Action Plan (2002)
- Our Health 2020 (ADHB 2006)
- Healthy Ageing 2020 (ADHB 2006)

2.3 NATIONAL INITIATIVES

ASPIRE

(Assessment of Services Promoting Independence & Recovery in Elders)

The ASPIRE programme funded by the Ministry of Health, led by Dr Matthew Parsons, from The University of Auckland recognised that the majority of older people prefer to remain living at home rather than spend protracted periods of time at a residential facility. This trend is anticipated to continue and strengthen as these people reach old age.

ASPIRE had several key objectives to assess; mainly in the effectiveness of ageing-in-place initiatives as compared to usual care. The programme also evaluated the prevention or delaying of the time before a community based older person requires permanent residential care.

The key objectives of the evaluation were as follows:-

1. To assess the effectiveness of ageing-in-place initiative in improving survival as compared to conventional care.

2. To determine the impact of ageing-in-place initiative on an older person's independence and quality of life as compared to conventional care.
3. To establish the degree of improvement in quality of life of informal care givers to this ageing-in-place initiative, in comparison to those receiving conventional care.
4. To determine the cost effectiveness of ageing-in-place initiative to the consumer, family, providers and funding agency in relation to the conventional care model.
5. To assess the sustainability of the ageing-in-place initiative to improve outcomes and cost changes over a two year period.
6. To identify the key elements of the ageing-in-place initiative that lead to beneficial outcomes.

The ASPIRE programme focused on three significant ageing-in-place initiatives in New Zealand. Briefly, these initiatives are as follows:-

Coordination of Services for Elderly (COSE) in Christchurch.

COSE is an evolution of the current NASC services that is operating across New Zealand. NASC is hospital based with an extensive outreach component and provides assessment and services facility for people requiring access to disability services.

COSE was established in 2000 through a collaboration of Canterbury DHB and Pegasus Health and was a community-based needs assessment and service coordination initiative. It was established with the aim of avoiding duplication in service provision. A key worker (COSE) is based in primary health care and is assigned to several general practice (GP) teams, though works independently of the practices.

The model allows the COSE worker to identify resources and opportunities within communities, both funded and non-funded. This offers older people a greater choice of service support, facilitating their remaining safely in the community. There is a strong evidence base for COSE, which is an example of case management.

They have been found to reduce hospital admissions, length of hospital stay, mortality, emergency department visits and admission to long-term facilities as well as costs of care. The COSE worker undertakes comprehensive assessments of the older person and liaises with the GPs and Practice Nurses ensuring that there is recognition of and a quick response to any change in an older person's circumstances, thereby allowing the level of care that is required for safe continuous ageing-in-place.

The Promoting Independence Programme (PIP) - Wellington.

The Promoting Independence Programme (PIP) is for older people who would not be able to maximise their potential for recovery within the average hospital stay. The initiative was developed by the Wellington Masonic Villages Trust in collaboration with Hutt Valley District Health Board and it operates currently both in Woburn, Hutt Valley as well as Horowhenua and Levin.

Referrals to the programme are made through Medical Consultants (private and public), General Practitioners, Sigma (NASC) or other referral agencies. A key worker is assigned to each older person and their role is to initiate and coordinate that person's pathway through the rehabilitation process. The team includes a Rehabilitation Coordinator who has overall responsibility for the team and is the first point of contact for the client, their family/whanau and outside agencies.

The team consists of Registered Nurses, Occupational Therapists, Physiotherapists, a Speech and Language therapist, Social Worker, Podiatrist, Dietitian, Kaiawhina, designated caregivers, Rehabilitation Assistants and a Rehabilitation Specialist/Geriatrician. Older people, who are at risk, are able to receive up to 12 weeks of facility based rehabilitation in the Promoting Independence Programme (not offered through the Masonic facility).

Consumers who are assessed as having high or very high needs but are able to receive rehabilitation services in the community, or clients who have been discharged to the community from a residential facility may receive a monitored amount of input up to a maximum of one year from the health event.

On completion of the residential home based rehabilitation programme, the team undertakes a comprehensive handover to designated home care providers, which allows for an individually tailored education programme to be delivered to the formal and informal care givers.

The Promoting Independence Programme does not replace current NASC as COSE has, more it aims to integrate with current practice and overall case management remains with NASC.

Community First (Flexible Integrated Support Team) - Hamilton

Community FIRST offers a different approach and was established in 2002 in Hamilton through collaboration between Presbyterian Support Northern, Waikato District Health Board and the Ministry of Health.

Community FIRST was the first example of restorative home support for older people with high and complex needs in New Zealand. The model relies on a multi-disciplinary team (primarily Registered Nurse, Physiotherapist and Occupational Therapist resource) providing an in-depth support plan, which is delivered by well trained Support Workers/Therapy Assistants under the close supervision of a multi-disciplinary team.

Contact by support workers is up to four times a day and by Registered Nurses, a minimum of once every two weeks. The delivery of restorative home based support

services can be divided into several levels according to the needs of the older person.

Older people accessing the Community FIRST service in Hamilton require a needs assessment and are eligible if they have high and complex needs. The funding arrangement allows the older person, in collaboration with the team coordinator, to negotiate service provision. This would include frequency of visits, day centre attendance and caregiver residential respite.

The service is based on core values such as care management, comprehensive geriatric assessment and functional and repetitive ADL training. All support programmes are orientated around the meaningful and socially integrated goals of the older person, which are translated into support and exercise plans that ensure higher compliance.

The key findings of ASPIRE are:

- Older people with high and complex needs who naturally would be admitted to residential care can remain living at home with no apparent increase of risk of harm with a coordinated and integrated Home Based Services.
- All three services appear to reduce the risk of mortality compared with usual services. Table 1 shows the reduced risks when the three services were implemented.

Table 1

Service	Region	Reduced Risk of Mortality
Community First	Hamilton	28%
PIP	Lower Hutt/Wellington	10%
COSE	Christchurch	10%

- COSE reduced the risk of older people to residential care in comparison with the usual care NASC services by 43%.
- Community First reduced the risk of entry to residential care by 33%.
- The PIP programme reduced the risk of entry to residential care by 16%.

Other results of ASPIRE includes the following:

- If a functional decline occurs in older people and the deterioration is not stopped, the older person is 11 times more likely to enter residential care.
- An older person is almost twice as likely to enter residential care if they are socially isolated.
- If an older person reports as having a negative mood, they are over twice as likely to be admitted to residential care.
- For every one unit increase on the Caregiver Reaction Assessment (which measures caregiver stress), there is a 7% increased risk of residential care entry.

- When an older person experiences inadequate meals and dehydration, they are over twice and 1.7 times more likely to be admitted to residential care, respectively.
- Delirium is highly correlated with risk of admission to residential care; those older people with delirium are 3.6 times more likely to be institutionalised.
- A lack of medication review (almost twice as likely), negative mood (1.5 times more likely) and previous hospitalisation (1.8 times more likely) are correlated with increased risk of hospitalisation.

In summary, ASPIRE has provided DHBs with valuable information around the successes of the ageing-in-place initiatives. It will allow informed decision making around the evolution of ageing-in-place services. There have been different approaches to facilitate this and there are clear benefits in exploring multiple means to support older people to age-in-place.

Note: *The strength of ASPIRE is to isolate the factors that are effective in facilitating this process and to also allow new and existing services to evolve and develop.*

2.4 INTERNATIONAL AND NATIONAL RESEARCH

The major worldwide issues being faced by the health and social systems and drivers of change are: -

- increasing pressures from an ageing population
- the demands of multiple clinical problems
- the increase prevalence of chronic illness
- the ageing and declining health workforce
- the projections that demand will outstrip supply in 5-7 years in terms of workforce sustainability.

From the research therefore, we are able to articulate that the following outcomes are all evidence based factors which should characterise components of the service model which will need to be designed as an outcome of this project.

3.0 PROJECT OBJECTIVES

The project aims to:-

1. Increase pro-active intervention to prevent or delay deterioration which results in increasing levels of care, acute admissions and premature or inappropriate residential care admissions.
2. Support caregivers/families/whanau to provide for the physical, emotional and social needs of consumers.
3. Provide flexible, integrated and responsive services.
4. Ensure that the dignity and safety needs of the consumer and their caregivers/family/ whanau are met.
5. Facilitate the ability of consumers and their caregiver/family/whanau to achieve their goals and participate in their community of choice with a holistic support package that includes a rehabilitation focus.
6. Provide a seamless continuum of care through cooperative working arrangements with other services.
7. Work with consumers to identify care and support solutions from a wide variety of community based options.
8. Be efficient and effective, including creative and innovative use of resources to address consumers' goals, needs and risks.
9. Provide holistic outcome focused services based on the assessed goals, needs and risks of consumers and their caregiver/family/whanau.
10. Integrate with improved assessment and care planning processes.
11. Provide a range of services within a contract.
12. Work within the funding and policy boundaries of the funder when allocating public resources.

3.1 OUTCOMES

Taking into account the key messages from the extensive consultation undertaken during the development of Healthy Ageing 2020, and combining these themes with national policy work and international best practice, the Board of ADHB has committed to four key outcomes, which when implemented collectively will realise the overarching vision as outlined above. The four components are:

1. Streamline access for service users to all aspects of our Older Persons Health service ensuring a 'right service at the right time in the right place' experience.
2. Develop a delivery model for home based support services which is strengths based and promotes dependence through goal setting
3. Develop and Implement flexible packages of funding to better meet the needs of clients wishing to remain at home with supports
4. Introduce and roll out a comprehensive uniform assessment tool for use across all aspects of the sector

Separate working parties will need to be convened to focus on each of the components, but the project's success depends on the successful integration of each component during rollout and implementation.

3.2 AUCKLAND IS UNIQUE

In the design, development and implementation of improved service models it is imperative that the unique characteristics of the Central Auckland population are considered. Best practice models being implemented elsewhere must be tested for their relevance and applicability in our environment, and this means being cognisant of factors such as our significant Asian and new migrant population, our highly urban metropolitan status, and our highly specialised acute hospital which sees a significant number of out of area clients each year.

PART TWO: PROCESS

1.0 ACCOUNTABILITY

The project will be undertaken by an external Project Manager, who has been contracted to undertake all analysis and initial consultation with key stakeholders. The Project Manager will provide recommendations to the Board at the end of phase Three (see below) prior to which roll out of the agreed models will begin.

The Project Manager is accountable to the Project Sponsors, and has an operational accountability to the Planning and Funding Manager for Older Persons Health.

Project Manager:	Jenny Chong, Strategic Directions Limited
Project Sponsors:	Chief Planning and Funding Officer (<i>Denis Jury</i>) Director of Allied Health (<i>Janice Mueller</i>)
Operational Accountability:	Planning and Funding Manager (<i>Lisa Gestro</i>) (HOP, Palliative Care and Disability Services)
Key Working Relationships:	Manager, Our Health 2020 (<i>Thomas Schaefer</i>) Clinical Leader Planning and Funding (<i>Celia Palmer</i>) Other Planning and Funding Managers (<i>as appropriate</i>)

Note:

- Regular project updates will be provided to the CPHAC committee via the Planning and Funding Manager.
- All external and media enquiries will be directed to the agreed project sponsor unless explicit delegation is otherwise made.

2.0 SCOPE

So as to ensure that there is minimal disruption to the current model of service delivery, any changes will be implemented using a phased approach.

Following comprehensive analysis of the current service model any recommended service changes will be fully discussed with the sector to ensure timeframes align to what is realistically achievable and will cause the least amount of disruption to current service delivery. To achieve this, the project has committed to first rolling out an enhanced assessment function and an improved home care service prior to undertaking any further change, which will be undertaken as part of subsequent phases. All of these options will be fully discussed with all relevant services and management once a report of recommendations become available.

In order to ensure that the key outcomes as identified in Part One of this document are achieved, the following specific service components will be consulted to ensure that a complete understanding of all services is gained, as is the way in which services inter-relate with each other.

Services Currently Provided by ADHB:

- Older Persons Health Needs Assessment and Service Coordination
- Community Services (Specialist Nursing, Home Health, District Nursing, Allied Health, Mental Health)
- ACH Allied Health
- A+ Links Home Help Services

External service providers:

- Primary Health Organisations
- Non Government Organisations, including
 - *Home Care Services*
 - *Residential Care services*
 - *Community Based Services*

Service User and Advocacy groups, including:

- *Maori Consumer groups*
- *Pacific Consumer groups*
- *Asian Consumer groups*
- *Disability Services*
- *Palliative Care Services*
- *Other related professional agencies in the community*

3.0 EXCLUSIONS

The following services are excluded from the review:

- *Paediatric services*
- *Non-age related DSS*
- *Mental Health services*
- *ACC funded consumers*
- *Adult Services < 65 years*
- Specialist Services for Older People which are not funded through HoP funding:, including
 - *General Medicine*
 - *Renal*
 - *Respiratory*
 - *Cardiovascular Services*
 - *Orthopaedics*

4.0 METHODOLOGY

The project will be broken into six main phases, as follows:

Phase One: Research on National and International Models January – May 2007 (complete)

These findings, as summarised, are considerations for quality enhancements and service improvements to meet the consumer's needs. A more comprehensive report on the findings will be provided at the end of Phase Two.

Summary of findings

1. Effective management of the healthcare system depends on the efficient care of older people with complex and often co-existing conditions
2. Comprehensive assessment is vital to providing efficient care
3. All parts of the health system must be recognised as being of equal value
4. Effective, sustainable programmes need to be comprehensive and adequately resourced
5. Health resource may be scarce in the future as environmental challenges are faced
6. Integrated Primary care vital to the delivery of integrated care in the community
7. Every aspect of the Older Person's journey needs to be considered
8. Effective links between general practice and the secondary and tertiary care services are essential
9. Changing culture to accept the primacy of aged care in the health system is paramount
10. Health professionals must be up-skilled to be able to provide comprehensive assessments
11. Finding the workforce (which is also ageing) willing to provide aged care is going to be a key challenge and must be a primary consideration
12. Facilities will need to be adapted to provide aged friendly environments, particularly in the management of delirium
13. The current community service 'maze' must be simplified
14. Transition between parts of the health system must be streamlined

Phase Two: Engagement with service providers to ascertain what is working well and to determine options for service improvements. June – August 2007

Key Objectives of Phase Two:

To determine current services in the community i.e. what is effective, what is not? What are the barriers to the consumers and providers? What are the gaps in service delivery? What are the processes and robust systems in place? What are the best practices and quality service improvements to optimise services?

To determine opportunities for service enhancement and quality improvements which allow a coordinated multidisciplinary response that is customised to meet the individual health and disability needs of people in their homes.

Phase Two will be undertaken in conjunction with a sector wide steering group, who have been brought together as service representatives, and whom are responsible for ensuring that key objectives are on track. The working group will contribute to any final recommendations made to the Board at the end of phase three.

The working group is made up of:

Consumer Group (*Emsie Walters*)
Disability Representative (*Maree Hull - Brown*)
Older Person's Health/ A+ Links (*Sandi Milner*)
Home Based Support Sector (*Andrea McLeod*)
Allied Health (*Linda Haultain / Phillipa Neads*)
Nursing (*Jo Wright / Jane Lees*)
Specialist (Gerontology) (*Hilary Birch*)
PHOs or GP and Practice Nurse (*Barbara Stevens*)
Mental Health (*Miriam Hogan*)
Maori Health (*Tania Waitokia / Rebecca Ruwhiu- Collins*)
Pacific Health (*Hilda Faasalele*)
Asian Health (*Indu Bajaj, Kitty Chiu*)
Northern District Support Agency (NDSA) (*Manjula Sickler*)
Auckland University (*Matthew Parsons*)
Information Management (*Lucy Westbrooke*)

Engagement and Consultation

Stakeholders will be consulted through various mediums, including presentations, workshops, interviews and questionnaires. There will be two-way communication and opportunities to discuss the concept and vision of the project through open days and clinics facilitated by the Project Manager.

**Phase Three: Development of options based on key findings and consultation in Phase Two and consideration of options and suggested models
August – October 2007**

**Phase Four: Consultation on preferred option/s
November – December 2007**

Phase Five: Agreement and sign off by the Board

January – February 2008

Phase Six: Implementation Plan and Process

Early 2008

5.0 PROJECT MILESTONES & DELIVERABLES

Phase One

- 1 Completion of research of international and national models

Phase Two

- 1 Establishment of website and communication strategy
- 2 Completion of engagement and consultation with consumers and stakeholders
- 3 ADHB's community health services and systems reviewed and assessed
- 4 Funding models reviewed

Phase Three

- 1 Consideration of options for quality improvements
- 2 Discussion with all relevant providers and management to determine feasibility and achievability of models and timeframes
- 3 Presentation of recommendations to ADHB Senior Management Team with endorsements from Working Group
- 4 Presentation of recommendations to ADHB Board with endorsements from Working Group

Phase Four

- 1 Consultation on recommended model(s)
- 2 Comprehensive report on consultation findings and recommendations reviewed as appropriate

Phase Five

- 1 Final agreement and sign off on agreed option(s) by SMT and Board.

Phase Six

- 1 Implementation of options
- 2 Project evaluation