

Improving health and disability support services for older people on the West Coast

DRAFT paper for the WISE meeting, 29 April 2004

Summary and recommendations

The WISE group was convened by the West Coast DHB in 2003 to advise on a Workplan to improve the health and independence of older people on the West Coast.

A subgroup of the WISE Group looked at how to improve hospital and community services for older people, and in particular how to improve transfer of care between hospital, primary care and community.

Problems identified

- Opportunities for intervention and rehabilitation are being missed because of the low profile for older persons' services and unclear referral paths.
- Unclear and fragmented system for assessing people's needs and coordinating their services – many different budgets and different staff involved, duplication and confusion for older people and GPs etc.
- Services need to be more responsive to the individual – better for the older person as well as more cost-effective, but not easy to do with current budget structure.
- More complex care is being delivered in peoples' home and in residential care but this is not recognised or planned for – risk of poor quality care.
- Fragmented budgets for older persons and community services – hard to plan for the most cost-effective mix of services or for best practice.
- West Coast DHB has no clear process for managing the uncapped DSS budgets.

Recommendations for change:

1. Set up a Community-Focussed Coordinating Centre

- Combine all existing needs assessment and service coordination functions
- A single entry point and one-stop shop for all community-based services
- Access based on assessed need – centre is able to access all budgets
- A central hub of information for clinicians as well as planners
- Managed by a Coordinator of Older Persons Services

2. Establish a Health of Older Persons Service

- Identify the virtual budget of current spending on older persons services
- Appoint a Coordinator of Older Persons Services to:
 - Manage the Community-Focussed Coordinating Centre
 - Be responsible for ensuring the DHB Workplan for older people is implemented.
 - Advocate for elder-friendly services, including training, best practice...
 - Monitor expenditure on/usage of older persons' services and advise on development of services and allocation of funding.

1. The context

This paper summarises the results of the deliberations of the WISE subgroup that looked at how to improve transfer of care between hospital, primary care and community, as part of WISE's overall Workplace for Older Persons Health.

It also draws on the work being done on the reconfiguration of the Needs Assessment and Service Co-ordination (NASC) service, following the Ministry of Health's review in August 2003.

The WISE group was convened by the West Coast DHB to help the DHB plan for improvements to health and disability support services for older people on the West Coast. This planning is in the context of:

- The need to integrate long-term disability support services with health services, so that there is a smooth continuum of care for older people.
- West Coast DHB's need to manage its overall deficit and the financial risks arising from the newly devolved DSS funding.
- The issues and ideas raised by the community during the consultation undertaken in 2003 on services for older people, and the work done so far in the WISE group, and other projects within the DHB including the NASC reconfiguration work.

2. What is needed

The WISE workshop, the subgroup discussions, and the NASC reconfiguration work identified some common themes in what was needed to improve services, including:

2.1 A clearly defined Health of Older People Service for the West Coast

- A higher profile for health and support services for older people, as required by the national Positive Ageing Strategy and Ministry of Health's Health of Older People Strategies.
- Advocacy for an attitude change among all health and support workers, to be aware of older people's health and support needs.
- A single point of entry to services for older people that is clear for GPs, hospital staff, community agencies and older people and their families.
- Fast, appropriate access for GPs and hospital staff to specialist AT&R services and advice – we are missing opportunities for earlier intervention that would prevent conditions worsening.
- A stronger rehabilitative focus in many services, and more adequate allied health staffing – allied health is particularly under-resourced.

2.2 Simpler arrangements for transfer of care and better coordination of care

- A single entry point to needs assessment and more promotion of the service. A single point of entry (one-stop-shop) for all people needing community care would reduce the number of assessments a person has to go through and improve transfer of care. (Figure 1 shows current pathways to care)

- Access to services needs to be based on the person's need rather than on their diagnosis or funding stream eligibility.
- Staff who are coordinating services need to be able to access all relevant funding streams – DSS, personal health, palliative. Currently different assessors/service coordinators can access some funding but not others.
- Better communication and coordination among providers of care, so that information is sent to all relevant parties, especially with transfer of care (eg timing of hospital discharge).
- Clearer joint case management and regular reviews of care.
- More development of integrated pathways of care eg stroke.

2.3 A stronger focus on community services

- A higher profile for community- and home-based services – increasingly important as population ages and hospital stays get shorter. More home support and district nursing services have been provided as hospital stay has shortened - but this isn't reflected in budgets, which have been fairly static.
- West Coast DHB needs to know what services are actually being provided in the community and to plan for their development – currently services are fragmented and information is poor.
- Putting more resources (eg equipment) into home care would enable people to stay at home and reduce acute hospital admissions.
- Urgent need to address home support workforce issues – recruitment and retention.
- More complex care now done at home and in residential care – need to ensure high quality of services, and training for residential and home support staff.

2.4 More flexible, elder-friendly and client-centred services

- Need more elder-friendly procedures – eg timing of hospital discharges, outpatient appointments and theatre schedules – be aware of transport needs of people in outlying areas.
- Lack of transport is a major issue for West Coast older people – need to further explore how to improve this, especially transport to and from outlying areas.
- More flexible packages of care to meet individual needs – be able to use budgets more creatively to enable people to stay independent for as long as possible.
- Greater involvement of people, their family, whanau and carers in all decisions.
- More staff training in Maori tikanga and needs of older Maori.
- Rural areas need to be considered in any change to services.

2.5 Good financial management

- West Coast DHB has limited and fragmented information on what is spent on home- and community-based services – difficult to manage financial risk effectively or to assess impact of any service change.
- The devolved DSS funding is uncapped (ie is paid out case by case on entitlement) – West Coast DHB needs to be able to manage this financial risk.
- Responsibility for the budgets for older persons services is fragmented among different managers - this makes it harder for West Coast DHB to decide on the most cost effective distribution of resources among older persons services (eg the appropriate number of residential beds), or to reallocate resources. (Figure 2 shows expenditure on services, and Figure 3 shows budget responsibilities).

3. Proposals for change

After extensive discussion, the subgroup came up with two major proposals for change, which they believe will address the issues described above.

3.1 Set up a Community-Focussed Co-ordination Centre

This aims to improve the current practical problems in transfer of care between hospital, GP and community by making this process much simpler.

How it would work (see Figure 4):

3.1.1 Combine existing needs assessment & service coordination functions

A Community-Focussed Coordinating Centre would be set up that would draw together into one department all the assessment and service coordination currently being done by various different West Coast DHB staff, including:

- Needs assessments for older people done by social workers, AT&R staff and mental health staff.
- Service coordination for older people done by the Service Coordinator.
- Service coordination of AT&R patients done by the AT&R liaison nurse.
- Needs assessment and service coordination for non-DSS eligible people (including palliative patients) that is done by social workers, district nurses and other allied health staff in Grey Hospital/AT&R unit/Community Services Division.

3.1.2 A single entry point and ‘one-stop-shop’ for easy access

The centre would take referrals from GPs, hospital staff, community agencies, the public etc, for anyone needing any form of home/community based service, and would also be the entry point for older persons’ services. Appendix B gives examples of how people with different needs (including palliative care) would access services through the centre.

People with low needs/simple cases - the centre would screen referrals against set access criteria, ensure that a standard assessment tool has been completed, and quickly send the referral on to the provider. Where

feasible, standard packages would be developed on the ACC model for people needing straightforward care – eg short-term post-discharge care, or minimal long-term home help¹.

People with complex needs - the centre would coordinate their referrals for specialist assessment and would coordinate their service delivery (or ensure that the person had a key worker to do this coordination).²

3.1.3 Centre staff able to access all funding streams

The centre would refer people to all forms of home and community care:

- short-term and long-term home support (and meals on wheels)
- district nursing and home-based rehabilitation, including palliative care
- long-term residential care
- short-term residential care, including respite care, carer support and palliative care
- innovative short-term and long-term packages of care, including rehabilitation

Access to budgets would be based on need, rather than diagnosis or funding eligibility, though it is likely that the buckets of funding would be kept separate to start with.

3.1.4 Closely linked to Older Persons Services

The subgroup debated whether the centre should just take referrals of older people, or anyone needing home- or community-based services.

Just older people – gives Older Persons Service a stronger profile, easier for GPs and hospital staff, most people needing community services (and hospital care) are older anyway.

Anyone needing home/community care – if the centre is just for older people, the DHB would have to set up a parallel structure for people under 65 years - the Coast is too small for this. The needs of people (adults) with chronic illness are much the same as for older people getting frailer – another boundary is created if older people are split off.

A compromise was reached – the centre would accept referrals for people of any age needing home- or community-based services. However there would be clear separate pathways/short-term packages for people who are neither over 65 nor chronically ill adults (eg straightforward post discharge care for appendectomy, caesarean section etc – these would be logged through the centre to capture the information, but sent directly on to the provider).

¹ On the model of the Waitemata DHB pilot project on minimal assessments for people with low needs for routine home help (a paper on this is available).

² A simple one-page form can be used to flag people admitted to ED or acute hospital wards who may need a more detailed AT&R assessment (eg flag could include age, multiple medications, history of falls, living alone, and currently receiving services)

3.1.5 Centre as a hub of information for clinicians and planners

Everyone using a home/community service would be logged at the centre, so it would be a hub of basic information about clients and their key workers that GPs, hospital staff, district nurses, home care agencies etc can access.

The centre would collect and collate client-level information on expenditure and usage for all community based services. The current NASC database could be extended to incorporate non-DSS funded people and people receiving short-term home-based services. This will enable West Coast DHB to monitor its expenditure and usage of community services and see the impact of any changes to services (eg impact on community services of a reduction in length of hospital stay or rate of acute admissions).

3.1.6 Staffing and location

The centre would be small, bringing together people currently doing this work, sited near community services/district nursing, social work, AT&R and allied health, and sharing staff with these services.

Location – the subgroup debated whether to have a Greymouth shopfront location, like the Nelson NASC agency, but felt a Grey Hospital base within the community services department was more efficient in terms of close proximity of other relevant staff.

Outlying communities – the centre would act for the whole of the Coast, as the DSS needs assessors and service coordinator do now. Needs assessment and case management can still be done by outlying staff (eg district nurses, primary care nurses etc), so long as the assessments and info about the key worker are logged at the centre.

3.1.7 Management of the centre

It is proposed that the manager of the Community-Focussed Coordinating Centre is also the Coordinator of Health of Older Persons Service – see section 3.2.2. This would give the centre a strong focus on older persons' care, and the information collected by the centre would help the Coordinator in monitoring older persons services and recommending changes.

3.2 Establish a Health of Older Persons Service for the West Coast

Setting up a central agency to coordinate access to community services would address many of the practical problems in the transfer of care from GP to hospital to home. But it does not fully address the need for a higher profile for older persons' services.

So the other proposal is that West Coast DHB formally establish a Health of Older Persons Service for the Coast. (See Figure 5)

The subgroup had much debate as to how a distinct Older Persons Service could be set up within West Coast DHB, given that:

- Services primarily for older people are managed by a number of separate departments in the DHB (see Figure 3).

- West Coast DHB is both small in size and in a deficit situation and so in many cases can't afford separate staff dedicated to older people's care (eg OTs).
- Even general health services (eg medical wards, GPs) see a high proportion of older people.

But there needs to be a higher profile for older persons' services, that enables:

- Better training in the needs of older people for health and support workers.
- Someone within the DHB with the time/resources/responsibility to advocate for older people and for an elder-friendly way of delivering health and support care.

So the subgroup proposes that West Coast DHB set up a Health of Older Persons Service, by:

3.2.1 Identifying expenditure on older people

Formally identifying how much is spent on services for older people by the DHB (ie the actual amount within each service budget in Figure 2 that goes to people 65+ years. See also Table 1).

3.2.2 Appointing a Coordinator of Older Persons Services

The role of this position would be to:

- Work with all health and support services to ensure they are elder-friendly.
- Develop and implement best practice in all older persons' services, including training and quality standards, a stronger rehabilitation focus and career pathways within older persons' services.
- Coordinate planning for older persons services on the Coast, in conjunction with the AT&R service, WISE group etc:
 - be responsible for ensuring the DHB Workplan for older persons' services is implemented.
 - monitor expenditure on and usage of older persons services and advise West Coast DHB on how resources should be allocated.
- Manage the Community-Focussed Coordinating Centre, including:
 - Be responsible for ensuring good communication and coordination among primary care, hospital and community services.
 - Develop and implement access criteria, standard assessment processes, standard packages of care for specific conditions etc.
 - Ensure the centre provides the information needed for planning.

Abbreviations and jargon used

Acute hospital admissions	Urgent or unplanned admissions to hospital
Allied Health	Physio, OT, social work, dietitian, podiatry, speech language.
AT&R	Assessment, treatment and rehabilitation – specialist geriatric services
Assessment tool	Set of questions asked to find out what sort of services a person may need
Carer support	Funding for a person to go into residential care or be cared for at home to give the carer a break
Complex needs	Example: someone living alone, 80s, arthritis, hard to get around, mild continence problems, occasional memory problems, had mild stroke
Community allied health	Allied health services delivered in peoples homes
DSS	Disability Support Services
DSS-eligible person	Someone assessed as having an age-related, physical, sensory, intellectual, or mental disability that is expected to continue for 6+ months
Devolved DSS funding	Funding for long-term home support, residential care etc for older people was transferred from Ministry of Health to DHBs in October 2003
DN	District nursing
ED	Emergency Department
Enable	Agency that provides long-term equipment eg wheelchairs
HH	Home help
Home support	Home help and personal care together
Inpat	Inpatient
MoH	Ministry of Health
NA	Needs assessor
NASC agency	Needs assessment and service coordination agency
OT	Occupational therapist
Outpat	Outpatient
Package of care	Eg for pelvic fracture: 1 district nurse visit + 2 hours home help for 6 weeks + 1 physio session (wholly hypothetical example!)
Palliative care	Specialist care (eg pain and symptom control) for people for whom active treatment is no longer appropriate
Pathways to care	How a person gets the services they need – who they have to see and who refers them to each service
PC	Personal cares (showering etc)
PHO	Primary Health Organisations – groupings of GPs, practice nurses and other primary health workers
Psycho-geriatric	Mental health problems that occur mostly in older people eg dementia
PT	Physiotherapy
Residential care	Rest homes and long-stay hospitals
Respite care	Funding to enable a disabled person to go into residential care for a break or to give their carer a break
SC	Service coordinator
SW	Social worker
Uncapped budget	Open-ended - the funder pays all invoices that come in (eg residential care subsidies)

Figure 1. PATHWAYS TO CARE - how it works now

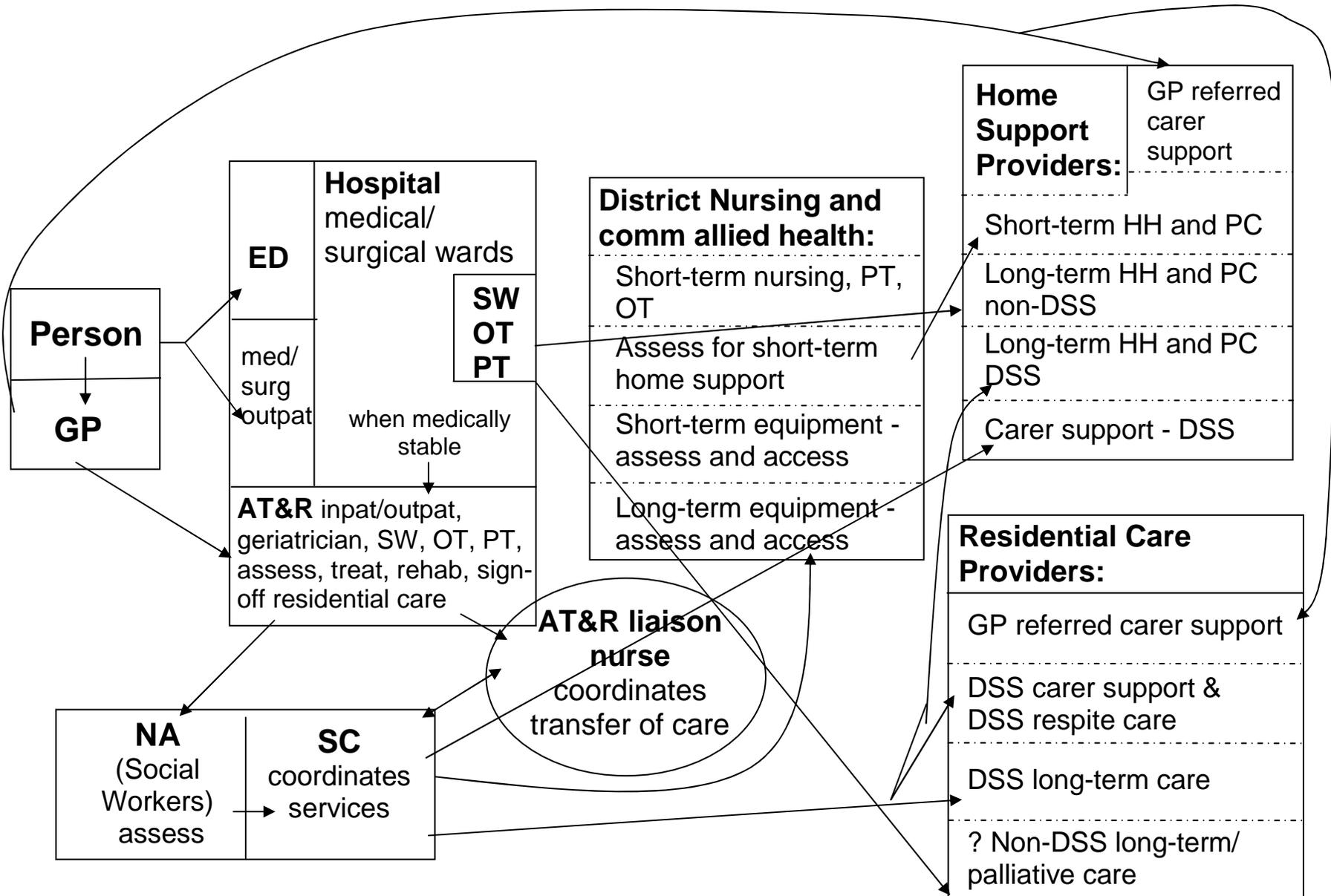
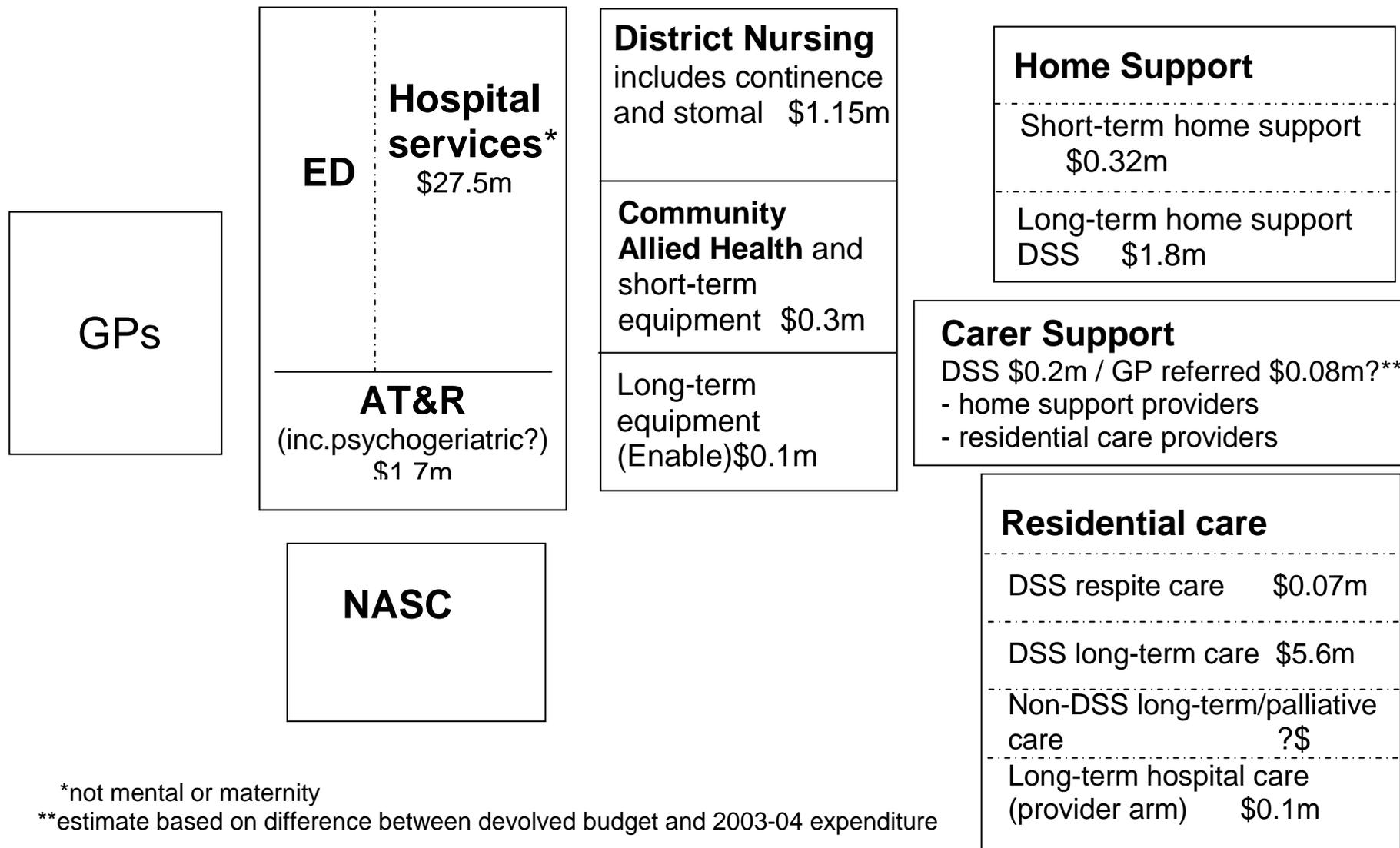


Figure 2. WHERE THE FUNDING GOES - West Coast DHB

Sources: MoH devolved DSS budget for 2003-04 released Oct. 2004. The rest from price volume schedule for 2003-04. **Note - these are rough and provisional estimates only**



*not mental or maternity

**estimate based on difference between devolved budget and 2003-04 expenditure

Figure 3. CURRENT BUDGET & MANAGEMENT RESPONSIBILITIES
- for services used only/mostly by older people

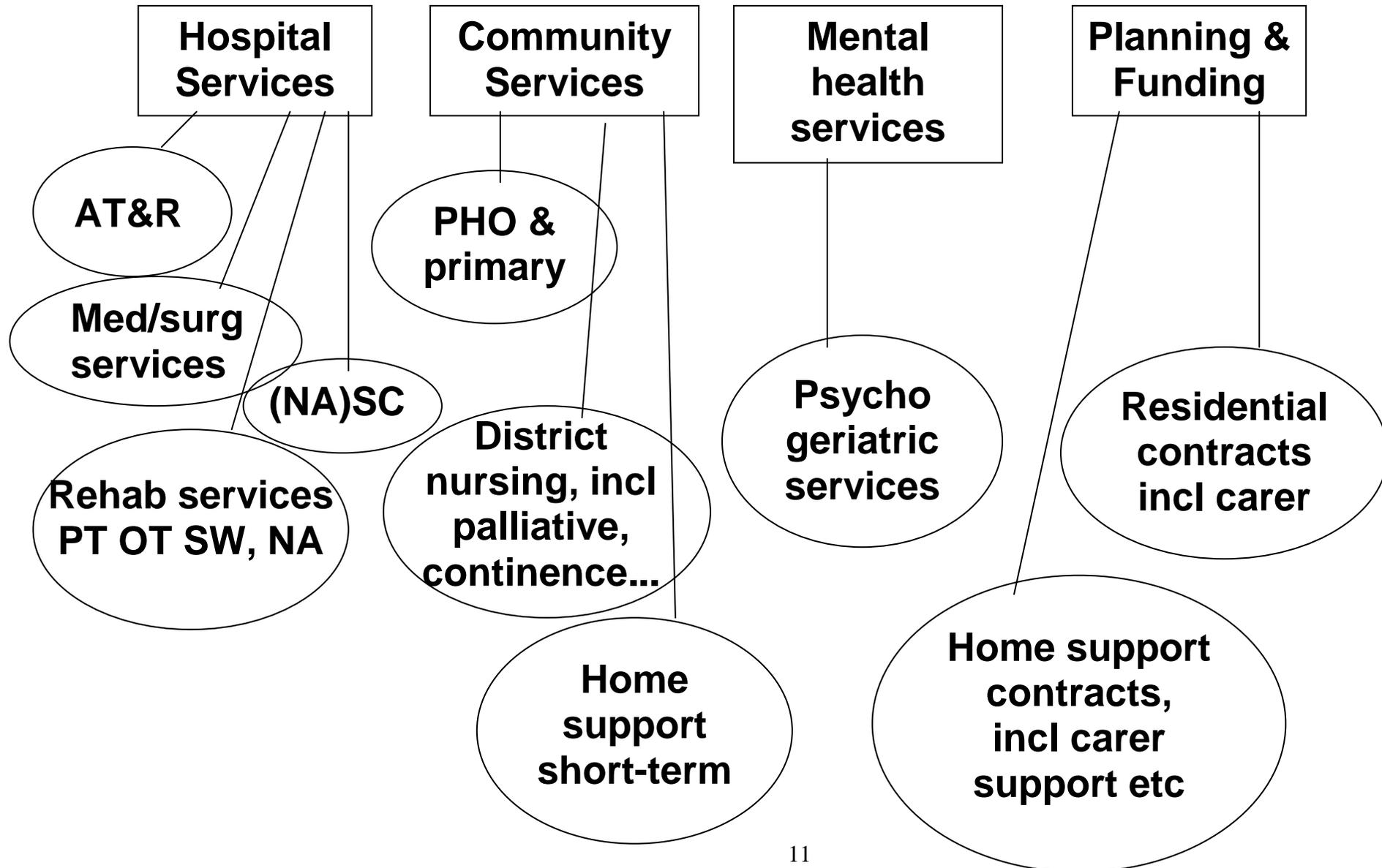


Figure 4. COMMUNITY COORDINATING CENTRE - how it could work

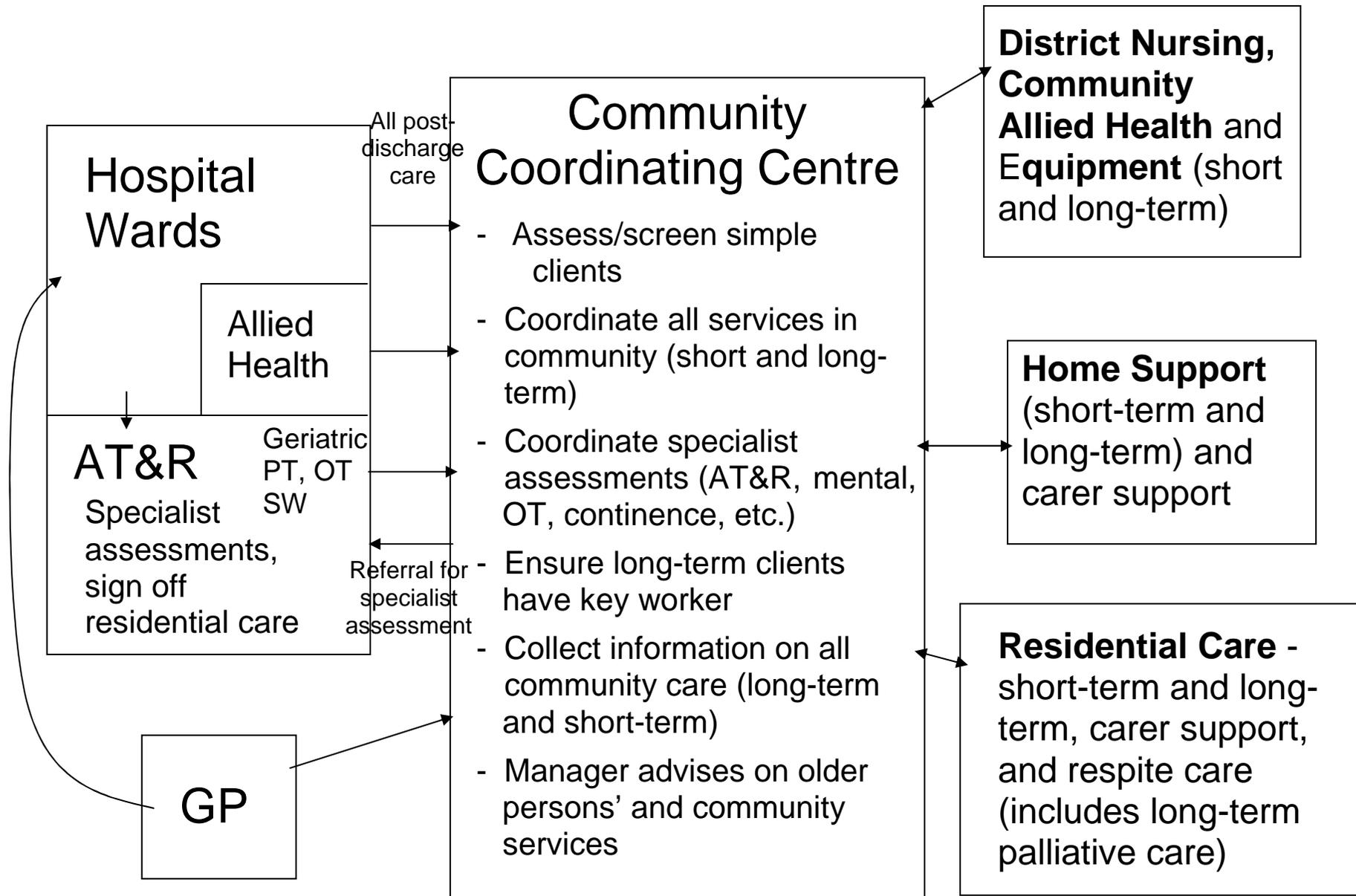


Figure 5. AN OLDER PERSONS' SERVICE - how it could work

Very rough estimate of percentage of older people in each service

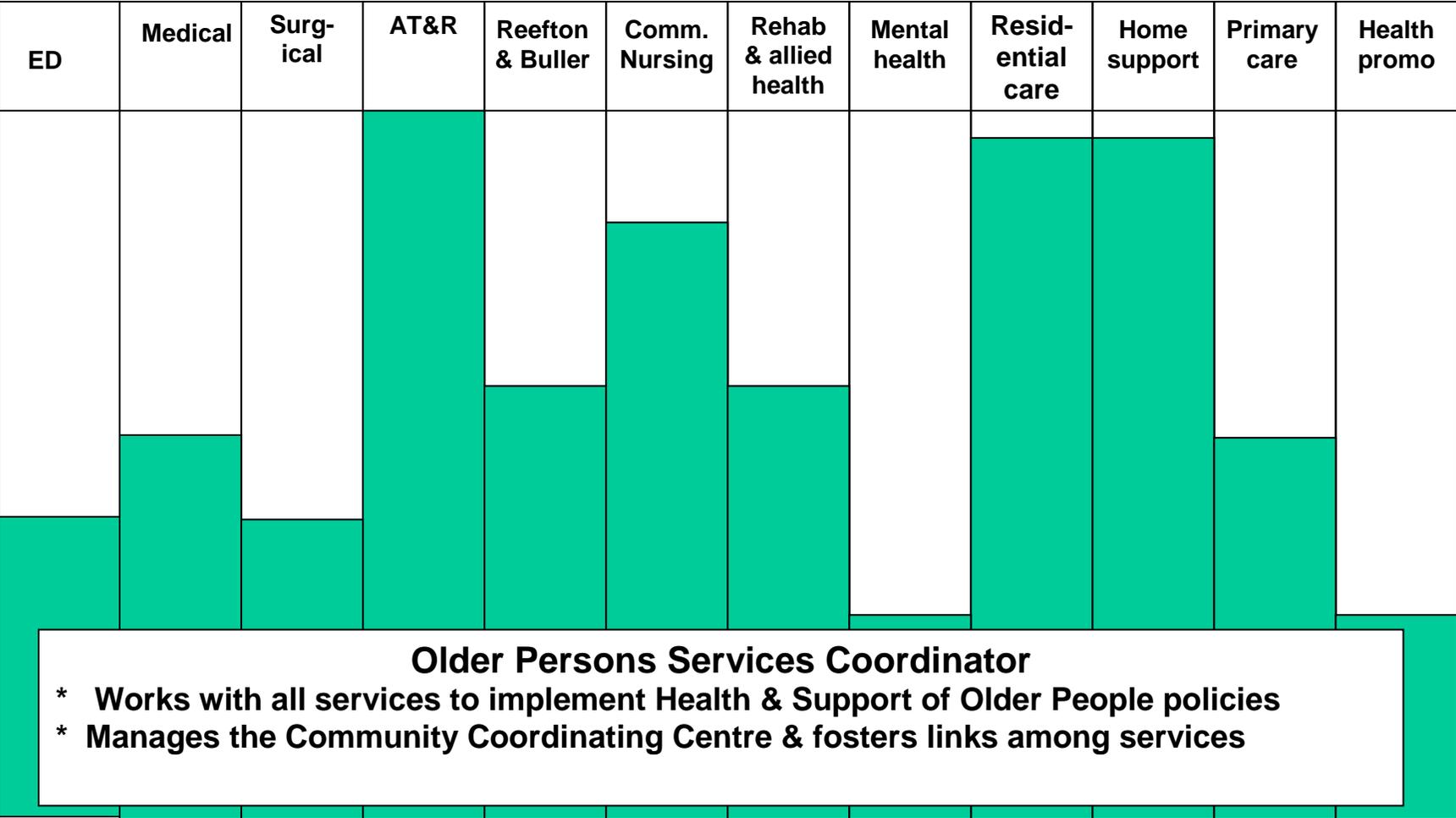


Table 1 Proportion of Personal and Mental Health Services Provided for Patients Aged 65 and Over - 2002/2003

Major Service Category	% For People Aged 65 and Over
1 Inpatient Services at Grey Base Hospital	
Dental Surgery	2.6%
General Surgery	45.2%
Orthopaedics	49.6%
Gynaecology	6.9%
Paediatric Surgery	0%
Paediatric Medical	0%
General Medical	65.6%
TOTAL FOR INPATIENT SERVICES:	48.5%
2 Specialist Personal Health Outpatient Services	
Surgical Specialties	28.3%
Medical Specialties	41.8%
3 General Medical Bed Occupancy at Peripheral Hospitals	
Bed Days - Buller Hospital (excludes Long Stay beds)	62.8%
Bed Days - Reefton Hospital (excludes Long Stay beds)	75.7%
4 A&E Department Attendances	
Grey Base Hospital	17.8%
Buller Hospital	36.8%
Reefton Hospital	37.4%
TOTAL FOR A&E	20.9%
5 Allied Health Outpatient & Community Services	
Dietitian	19.0%
Occupational Therapy	62.1%
Physiotherapy	35.4%
Social Work	63.3%
Speech Therapy	32.7%
Medical Technicians	36.8%
Nurse-led Outpatients	35.7%
6 District Nursing (excluding PRIME response)	
District Nursing (excluding DSS and AT&R Referred)	62.7%
District Nursing (including DSS and AT&R Referred)	70.0%
7 Community Mental Health Services	
Rural and Community Mental Health Services	10.0%
Alcohol and Drug Services	0.4%
8 Acute & Sub-Acute Inpatient Mental Health	
Beddays	9.4%
9 Laboratory Services	37.7%

Table 2 2002/2003 Attendances to Specialist Outpatient Clinics

			TOTAL (ALL AGES)	PATIENTS AGED 65 AND OVER	% AGED 65 AND OVER
S0.06	General Surgical	1 st attends.	1,390	490	35.25%
S0.07		Subsequent attends.	1,564	601	38.43%
S30.02	Gynaecology	1st	330	33	10.00%
S30.03		Subsequent	708	128	18.08%
S45.02	Orthopaedic	1st	1,176	257	21.85%
S45.03		Subsequent	2,384	632	26.51%
M55.02	Paediatric Medical	1st	304	0	0.00%
M55.03		Subsequent	535	0	0.00%
S25.02	ENT	1st	389	55	14.14%
S25.03		Subsequent	499	106	21.24%
S40.02	Ophthalmology	1st	194	96	49.48%
S40.03		Subsequent	458	269	58.73%
S60.02	Plastic	1st	73	25	34.25%
S60.03		Subsequent	111	33	29.73%
S70.02	Urology	1st	190	99	52.11%
S70.03		Subsequent	234	162	69.23%
TOTAL FOR SURGICAL SPECIALTIES			10,539	2,986	28.33%
M00.02	General Medical	1st	685	283	41.31%
M00.03		Subsequent	1,427	617	43.24%
M10.02	Cardiology	1st	49	16	32.65%
M10.03		Subsequent	55	28	50.91%
M15.02	Dermatology	1st	92	23	25.00%
M15.03		Subsequent	144	47	32.64%
M30.02	Haematology	1st	21	10	47.62%
M30.03		Subsequent	62	28	45.16%
M60.02	Nephrology	1st	16	6	37.50%
M60.03		Subsequent	46	10	21.74%
M45.02	Neurology	1st	27	10	37.04%
M45.03		Subsequent	14	5	35.71%
M50.02	Oncology	1st	46	21	45.65%
M50.03		Subsequent	340	164	48.24%
M65.02	Respiratory	1st	15	6	40.00%
M65.03		Subsequent	18	11	61.11%
M70.02	Rheumatology	1st	11	4	36.36%
M70.03		Subsequent	31	5	16.13%
TOTAL FOR MEDICAL SPECIALTIES			3,099	1,294	41.76%

Appendix A. HOW IT COULD WORK - EXAMPLES

Example 1 – referral from GP

Mrs Brown is 85, finding it hard to look after herself or her house because of increasing disability or illness and goes to the GP for help. This may be a short-term problem (a bad bout of flu) or long-term (arthritis, heart failure).

The GP deals with the medical side of it and faxes/emails a referral to the Centre for the support she needs (district nursing, personal care, home help, carer support, respite care, equipment etc).

Simple needs – if her needs are simple (eg for minimal long term home help, short-term personal care) the GP/practice nurse will probably use the Centre’s standard assessment tool and send in a completed low-needs assessment to Centre, with a request for a routine low needs package. Or the GP may make a general recommendation but leave it up to the Centre to arrange for her needs to be assessed.

The Centre will:

- Check Mrs Brown is eligible (ie retain the various funding buckets in the meantime), check that the assessment tool is completed OK, sign-off the standard funding and fax/email her referral to a home support/district nursing provider.
- If an assessment hasn’t been done, the Centre will either do this assessment or fax/email an appropriate provider (eg district nurse, home support agency) to do one on behalf of the GP.

Complex needs - if the GP (or whoever does the assessment) notes that Mrs Brown may have more complex problems (eg possible need for toilet seat, non-compliance with medication, incontinence, beginnings of dementia, depression caused by social isolation etc) that could worsen but which would respond to early intervention, the Centre will (as well as arranging the simple package):

- Refer her to more specialist assessment (eg AT&R unit, OT, continence adviser etc), and coordinate these assessments.
- Act as or find a ‘key worker’ to coordinate services and stay in long-term touch with her. The Centre could take this role, or it could be taken by another primary-based professional (eg practice nurse, district nurse, OT) – whoever has most close contact. Even if the Centre worker is not her key worker, they will have Mrs B on their database and know who is managing her care for the next time she needs services.

The Centre’s register of clients will start to match the registers of high-risk/chronically ill patients that many GPs/PHOs are developing.

Example 2 – straightforward referral from hospital

Mr Smith is a healthy 67 year old when a sudden heart attack puts him in hospital. The hospital ward staff assess him for post-discharge services (district nurse, personal care, home help, OT/PT assessment for equipment and maybe home-based rehab.). Ward staff use a standard assessment tool, and fax/email this to the Centre.

The Centre worker signs off the standard straightforward package of post-discharge care for cardiac patients and refers him to the various providers, including his GP. Mr Smith comes onto the Centre’s books and may be allocated a Centre worker but otherwise has no contact with Centre. If he appears at hospital again or on his GP’s high-risk chronically ill register,

the Centre will get more involved in coordinating his care and making sure he is referred for specialist assessment (eg AT&R rehab) if needed.

Example 3 – frail elderly person referred from AT&R

Mrs Lee is 87, has had a sudden stroke, has limited mobility from arthritis and is now unable to look after herself at home any more. She comes acutely into ED department, spends some time in a medical bed, then is transferred to AT&R service for assessment and rehabilitation. AT&R staff assess her as needing rest home level care. The social worker is involved because this is major change for Mrs Lee and her family.

AT&R staff involve the Centre in Mrs Lee's transfer of care planning at an early stage while she is in AT&R and the Centre allocates a staff member to her. This person pulls together the specialist assessments (eg geriatrician assessment for rest home care, OT etc) and coordinates her care plan for the community, liaising with GP, rest homes, continence adviser, AT&R outreach team etc.

Mrs Lee remains on the Centre's database as a complex case. The Centre worker allocated to her may be her 'key worker' – if not, they make sure that she has a key worker and keep her on the active caseload long-term.

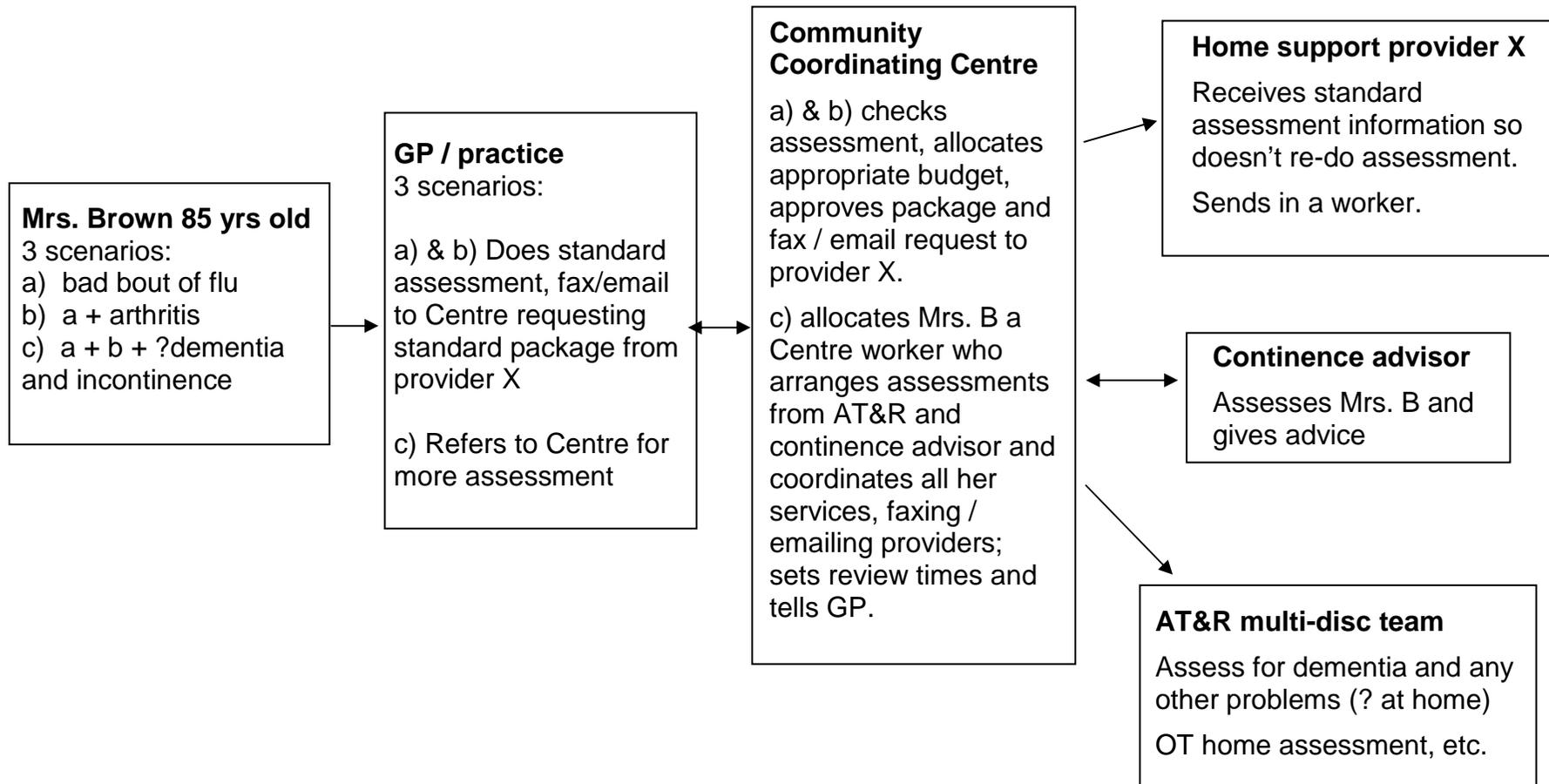
Example 4 – younger person needing long-term palliative care

Ms Ngata is 54 and suffers from end-stage emphysema and heart failure, with uncertain life expectancy of 6 months to 2 years. She can no longer manage at home and needs a form of sheltered housing and some personal care. The hospital physician and social worker refer her to Centre for residential care/supported housing/intensive home care.

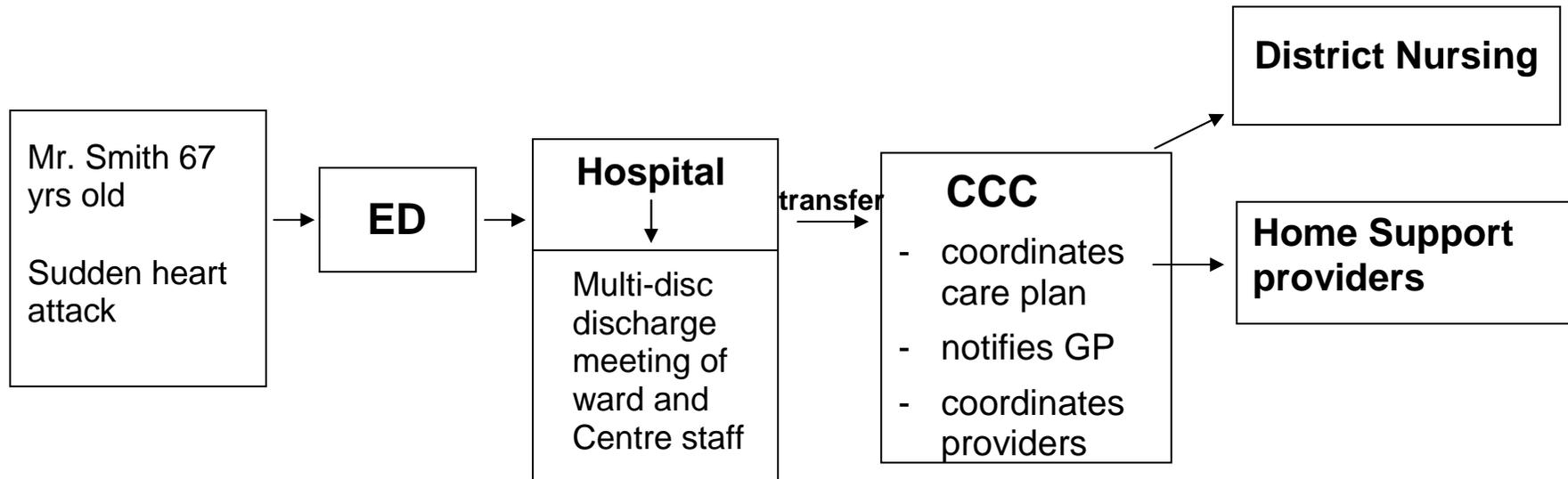
If the hospital staff have done a full assessment (using a standard assessment tool) and figured out what she needs/is available, they send a referral to the Centre who approves it. The Centre worker establishes who Ms Ngata's key worker is (eg hospital social worker, Centre worker, hospice, practice nurse/GP) and keeps Ms Ngata on the Centre caseload. The Centre worker can access/approve residential, home care, supported housing etc flexibly.

If the GP or hospital nurse makes this referral, the Centre worker would make sure Ms Ngata has a specialist medical/social work assessment.

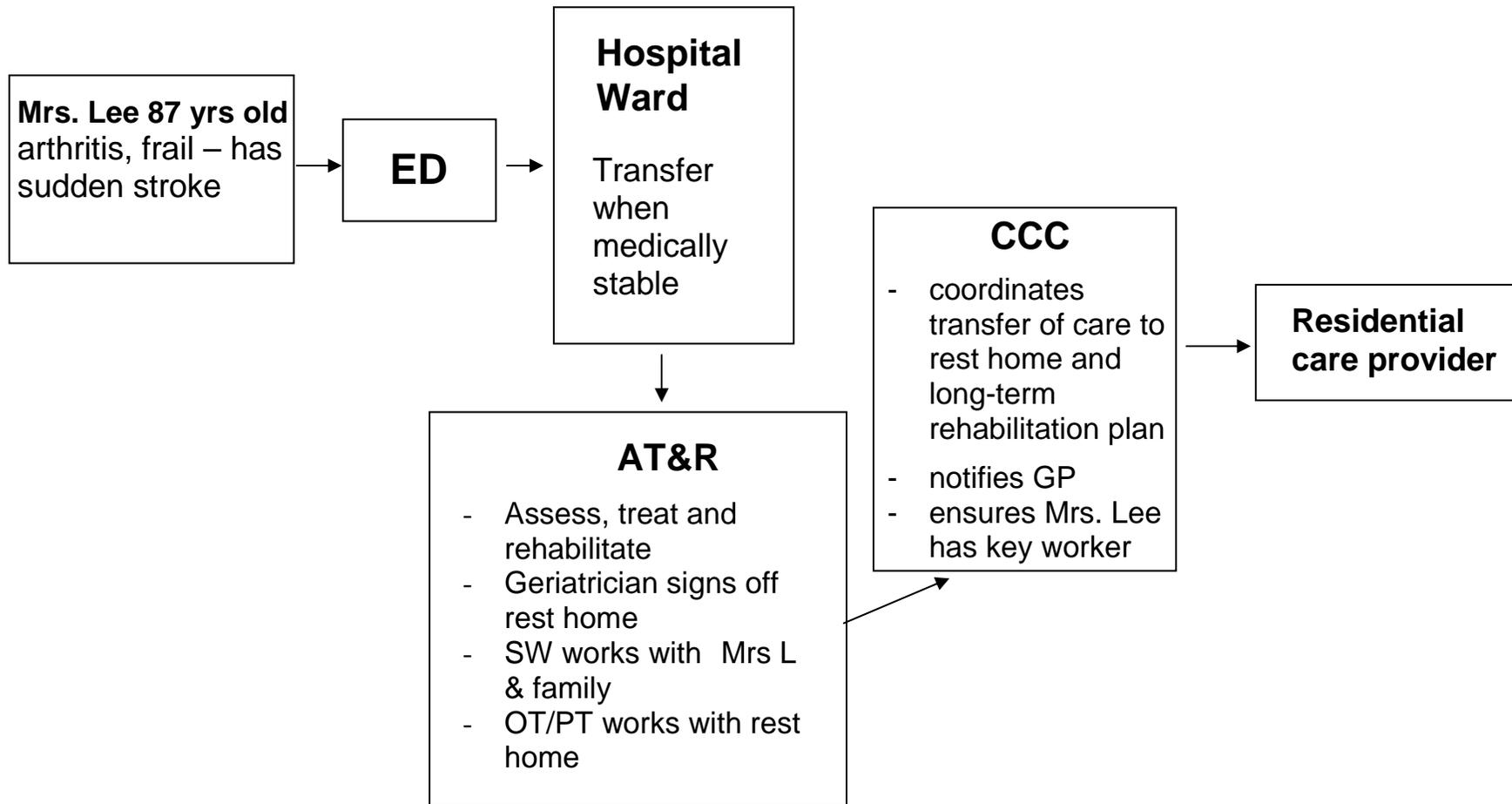
Example 1. Referral from Primary Care



Example 2. Straightforward referral from hospital



Example 3. Frail elderly person referred to and from AT&R



Example 4. Younger person needing long-term palliative care

