

## Appendix 3

### Planning health and disability support services for older people over the next 20 years – a brief literature review

A resource paper for the Canterbury District Health Board's Older People's Health Services Strategy Project, April 2005

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#### Executive summary

Canterbury District Health Board faces a challenging time in coming decades, as it tries to meet the needs of an ageing population in a context of limited resources. We will need to use resources as effectively as possible, with a strong focus on preventing illness and disability occurring or worsening.

This is a brief resource document for DHB staff with the task of deciding how to use the health dollar to make best use of resources and meet the needs of Canterbury's older population.

Services for older people have been envisaged as a series of safety nets that could catch and cradle our older folk, helping them maintain their health and independence. For each of these safety nets we have summarised what is known about effective interventions, according to a brief review overseas and New Zealand literature.

Major themes that have emerged:

- The importance of physical activity, social networks, housing and diet in keeping people fit and healthy.
- The importance of effective primary care, with case management of chronic disease and use of COSEs to help people get the services they need.
- Easy access to disability support services to help people stay independent.
- Streamlining the patient journey into, through and out of hospital – using acute hospital beds only for acute patients.
- Making sure there are adequate post-discharge services.
- Making sure there are adequate longterm care services, both home-based and residential.
- Strong links between geriatric specialist teams and the rest of the health and disability support sector.
- Support for residential facilities to help residents stay as well and fit as possible.
- A stronger rehabilitation focus in all services.
- An extension of the palliative care philosophy to all end-of-life settings.
- More informed choice for older people at the end of life.

## 1. Background

This paper summarises some of the literature and local experience regarding ways of planning and configuring services for older people to meet the rising demand from an ageing population in a context of constrained resources.

Much of the overseas evidence comes from the studies summarised in Canterbury DHB's review of the health of older people,<sup>1</sup> as well as from the work of three long-standing policy research centres and of the UK NHS Modernisation Agency:

- UK's Personal Social Service Research Unit (PSSRU) based in 3 universities – 3 decades of detailed policy research on long-term care: [www.pssru.ac.uk](http://www.pssru.ac.uk)
- Canada's multi-centre national study of the cost-effectiveness of home-care [www.homecarestudy.com](http://www.homecarestudy.com)
- Manitoba Centre for Health Policy [www.umanitoba.ca/centres/mchp/reports.htm](http://www.umanitoba.ca/centres/mchp/reports.htm)
- NHS Modernisation Agency: [www.modern.nhs.uk](http://www.modern.nhs.uk)

## 2. The context

The evidence for most of this section is summarised and referenced in Canterbury DHB's review of older people's need for services.<sup>2</sup>

### A growing need for services

- The number of Canterbury residents aged 65+ years is expected to increase by 68% between 2001 and 2021 (from 57,222 to 96,250), with the largest increase coming in the 'young-old' 65-75 year age group.
- Older people are living longer, with better health and less disability than before.
- However some subgroups (eg low income people, Maori) have higher than average rates of chronic illness, starting earlier in middle age. This group will grow in size in the next two decades.
- Assuming the overall prevalence of chronic illnesses remains stable, the rise in the number of older people by itself will increase the number of cases of stroke, heart disease, cancer, arthritis, dementia and other chronic and disabling conditions.
- Overseas projections suggest that the need for acute hospital beds will rise more slowly than the need for disability support services.<sup>3</sup>

### A shift towards community-based care

- Inpatient admissions and average length of stay in acute hospitals per head of 65+ population have dropped in recent decades, mostly due to an increasing use of day surgery. The shortening of average length of stay for inpatient admissions may now have reached its limit.<sup>4</sup>
- The rate of entry to residential care and the average length of residential stay have probably levelled out or reduced per head of 65+ year old population, if New Zealand is following overseas trends. People are entering residential care at a later stage and are correspondingly more severely disabled than previously.<sup>5</sup>
- The use of home-based support services (both short-term and long-term) per head of population has risen in New Zealand as elsewhere. There is evidence that the

use of home-based services has become more intensive, with a smaller proportion of people receiving a greater volume of services.<sup>6</sup>

### **Limited funding**

- Canterbury DHB’s overall funding is constrained by the national Population Based Funding Formula and will gradually drop in terms of dollars per head of population until national equity is reached.

## **3. Older persons’ services as a series of Safety Nets**

Services for older people can be seen as a set of safety nets that help to prevent or slow down the progression or intensity of illness or disability as a person ages.

We have used the ‘safety net’ concept as a way of focusing attention on possible ‘top-of-the-cliff’ interventions that would reduce the need for services, rather than just continuing to expand existing ‘ambulances-at-the-bottom’ services.

We recognise that ‘ambulances-at-the-bottom’ will also continue to be needed.

<b>Safety Net 1: Helping people stay healthy and fit</b>
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Evidence for the effectiveness of interventions in the following areas has been collated in Canterbury DHB’s review of older people’s need for services.<sup>7</sup>

### **Housing**

- Warm, secure, affordable.
- Removing financial barriers to going back home from residential care

### **Social networks**

- Transport services, mobility schemes, driver licensing initiatives ...
- Supportive housing arrangements of various types
- Befriending, social clubs and other measures to minimise social isolation.

### **Physical activity**

- Support for exercise classes, balancing activities, recreation, Tai Chi ...

### **Continence education**

- Pelvic exercise and bladder training techniques.

### **Good diet**

- Supporting awareness and activity towards maintaining a good diet.

### **Smoking cessation**

### **Information, advocacy and protection from abuse**

## **Safety Net 2: Effective primary care and disability support – catching problems before they worsen**

**Easy access to affordable and effective primary care**<sup>8</sup> (general practice, allied health, pharmacy, dentists, optometrists, counsellors ... )

- Low enough fees/prices.
- Availability of GPs and other professionals (eg rural areas).
- Acceptability, use of Maori and other community workers etc.

**Screening for disease** eg hypertension, mammography, diabetes, eye checks, depression...<sup>9</sup>

**Early interventions** – flu vaccine, green prescriptions ...<sup>10</sup>

**Case management of chronic disease**<sup>11</sup>

- Using specialist nurses and other health professionals in primary care, such as diabetes and asthma educators, physios etc. Changing how primary care is funded to give an incentive for these workers to be based in local health centres.
- Support for patient self-care – support groups and organisations, patient information, education and awareness
- Medication management and review – pharmacists in the primary care team.
- Using COSEs/key workers to assess & coordinate services
- See the interesting US/UK discussion of the concept of ‘chronic disease management’ and how it plays out in different health systems (clinical protocols, greater use of nurse practitioners)<sup>12</sup>

**Supporting GPs to keep patients out of acute hospital**

- Monitoring the rate of avoidable admissions that could be reduced by better primary care (eg diabetic complications).<sup>13</sup> A New Zealand study found that 10% hospital admissions may be ‘avoided’ with more effective primary care.<sup>14</sup>
- Quick response teams, dinner bed & breakfast schemes/step-up beds etc
- Timely access to diagnostic tests and specialist advice without having to refer people for hospital admission.<sup>15</sup>

**Quick, flexible. rehab-focussed response to long-term disability need**<sup>16</sup>

- Assessment, housing modifications, equipment, mobility schemes, home based support services ...

**Adequate recognition and support for carers**<sup>17</sup>

- Respite care, day care and carer relief services.
- Information, advocacy and support groups and organisations ...

## **Maintaining long-term home support services to low needs people**

- There is good UK & Canadian evidence that providing longterm home support to people with low needs reduces acute hospital costs:
  - The multi-centre Canadian study of home-care reported on a natural experiment where some geographic areas cut low-level long-term home-care while others did not. Hospital admission costs rose where cuts were made.<sup>18</sup>
  - A PSSRU study in UK looked at how increasing long-term home-care was able to speed up discharge from acute hospital for people who did not need an acute bed.<sup>19</sup>

## **Supportive housing arrangements** to prevent unnecessary moves to residential care.

- A PSSRU study of UK rest home residents found that private payers were less disabled but had more illness than publicly funded residents. Most private payers were not involved in the decision to move into care - it was made by relatives.<sup>20</sup>

<b>Safety Net No. 3    A smooth path in and out of specialist services</b>
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## **Streamlining the patient journey in, through & out of the acute hospital**

The UK National Health Service has put additional funding into ‘intermediate care’ for older people on condition that health authorities ensure that acute hospital beds are used only for acute patients.

A national 3-year NHS Change Agent Team has been set up to help health authorities reduce their rate of ‘delayed discharges’. They have a website ([www.modern.nhs.uk](http://www.modern.nhs.uk)) with some very readable documents, with links to practical local examples.<sup>21</sup>

They identified ‘10 high impact changes’ including:

- Day surgery as the norm, and greater use of outpatient services.
- Better access to diagnostic tests, for both hospital doctors and GPs.
- Reduce the variation in rates of admissions and length of stay (elective admissions are in fact more variable than acute admissions).
- Manage variation in the discharge process – reduce bottlenecks by reducing variation in care pathway. Process mapping to see where the bottlenecks are – figuring out how long the care pathway should ideally take and seeing where in reality it clogs up. Smooth out variation for the majority, don’t just focus on the ‘frequent flier’ extremes.
- Do follow-ups differently – more could be done by GP, and some could be patient-initiated.
- More use of care pathways/clinical guidelines to reduce variation in treatments – needs to be clinician-led.
- Reduce queues – more queues = more delay. Combined group clinics.
- Develop different staff roles to make best use of the most qualified – assistant practitioners and advanced practitioners.

A Manitoba projection of the need for acute beds by 2020 found the supply likely to be adequate, even at current length of stay/admission rate, so long as effective action was taken to ensure that only those needing acute beds were in them.<sup>22</sup>

## **Giving more priority to surgery that keeps people independent**

- Examples are cataract and hip replacement operations.

## **Analyse patient flow in the whole system**

- Not just within the hospital - see how many people are affected and where interventions can be made most productively. An excellent Australian article uses a diagram of patient flows to identify possible intervention points.<sup>23</sup>

## **Build up ‘intermediate/transitional care’ services<sup>24</sup>**

- ‘Intermediate care’ = not just beds but a spectrum of multi-disciplinary, strongly rehab-focussed services to enable people to be discharged from acute beds appropriately. Intermediate beds may be used for assessment, post-acute care, and for people while they sort out which residential facility to go to (if any).
- ‘Transitional care’ - Waikato DHB’s service specification for transitional care identifies 3 levels of care: 1) facility-based post-discharge care for the medically stable who will go home, 2) facility-based post-discharge care for the more medically frail who may not go back home, and 3) home-based admission prevention or post-discharge care for the medically stable. All levels have a strong rehab component, combined with medical/ nursing/home support input.<sup>25</sup>
- Slow-stream rehabilitation.
- Home-based rehabilitation.

## **Build capacity in home-based and residential services**

- Ensure there is adequate capacity in short-term home-based services, intermediate care, rapid response teams etc, so that the extra demand from faster discharge from hospital can be met without increasing the risk of relapse or re-admission. The UK government has put considerable additional \$\$ into these services.<sup>26</sup>
- Ensure there are adequate capacity in long-term services, both home-based and residential, to allow people to move out of acute beds to the most appropriate long-term care in a timely way:
  - A PSSRU projection of UK need for longterm services by 2031 found a need for a 50% I increase in home care hours and a 65% increase in residential beds.<sup>27</sup>
  - A Canadian projection of need for residential care beds came to a ratio of 110:1000 population aged 70+ years. The dropping rate of admission and average length of stay in residential care is counterbalanced by rise in population of older people.<sup>28</sup>
  - Long-term home-based services are cost-effective in reducing need for residential care in a population – there is much Canadian and UK evidence for this.<sup>29</sup>
  - It is critical that the long-term services workforce is adequately trained and resourced if they are to be effective in helping people maintain their health and independence as much as possible.<sup>30</sup>

## **Case coordination within and outside the hospital<sup>31</sup>**

- Liaison nurses/case coordinators/key workers - to smooth and speed the individual patient path in and out of hospital, to primary care and community services.

- Better discharge planning – single coordinator and multi-disciplinary teams. An interface team in ED to direct people to transition beds or community if necessary.

### **Stronger links between geriatric/rehab and general medical services, ED and primary care**

- Identifying the long-stayers in acute hospital. A Manitoba study found that 5% of 65+ year olds use 80% all 65+ yr beddays.<sup>32</sup> Many are cognitively impaired and many have had falls. Delays in getting tests, consultations and homecare increase hospital length of stay and likelihood of readmission.<sup>33</sup>
- Merging general medicine & geriatric wards – the reconfiguration process in one Australian tertiary hospital reduced general medicine & geriatric beds and replaced them with a merged ward and a community geriatric team. Resulted in fewer acute beddays, falls, re-admissions or entries to residential care.<sup>34</sup>
- Stronger link of geriatric specialist multi-disciplinary team and primary-based case managers to reduce admission and readmissions of chronically ill people.<sup>35</sup>
- A stronger rehabilitation focus to all services.

### **More active primary management of ‘frequent fliers’**

- Identify ‘frequent fliers’ and make sure they are case managed by community/primary-based key workers able to access the services of multi-disciplinary teams. (With the aim of reducing crises, better medication management, earlier detection & treatment, thereby preventing next year’s intake of frequent fliers.)<sup>36</sup>

### **Single assessment and access point for longterm care**

- Single assessment process, with shared information and patient records.<sup>37</sup>
- The Canadian national study of cost-effectiveness of home care constantly reinforces the importance of a single gate-keeping point for long-term care.<sup>38</sup>

### **Care pathways and protocols**

- Especially for conditions likely to result in disability & longterm care (eg stroke, dementia & confusion, falls & hip fracture, incontinence). Needs to cover staff in all sectors – primary, hospital, community, residential.<sup>39</sup>

### **Good communication and IT**

- Clinical information (including lab tests, radiology and other diagnostic results) shared electronically among hospital wards, primary care, district nursing and allied health, home care agencies, residential facilities etc (with appropriate privacy safeguards).<sup>40</sup>

#### **Safety Net 4: Slowing the progression of deteriorating health or dependence**

##### **Intensive home-based services to enable people to stay at home**

- Intensive home support (such as the Community First scheme) can be a cost-effective substitute for residential care for a proportion of frail older people.<sup>41</sup>

##### **More support for residential providers**

- Greater support for residential care staff from specialist geriatric services and community nursing and allied health to help them maintain residents at their optimum level of functioning, thus reducing inpatient admissions and entry to higher level care. This includes continence training, active medication/rehab reviews, allied health support, wound care, stomal care etc.
- US Evercare project – GP/nurse practitioner active management of rest home residents resulting in fewer hospital admissions.<sup>42</sup>

#### **Safety Net 5: Appropriate care at the end of life**

##### **Extend palliative/hospice philosophy & training<sup>43</sup>**

- The ‘palliative approach’ tends to be limited to hospice services and cancer patients, a slightly younger group than the average dying person.
- Extend training to staff in other end-of-life settings so that acute hospital and residential facility staff, district nurses, GPs, home-care workers etc take a more ‘palliative approach’ to managing end-of-life care.
- Ensure greater knowledge among health workers and public about a palliative approach to non-cancer conditions (eg heart failure).

##### **More informed choice at end of life**

- Ensure older people have good information about the pros & cons of acute medical or surgical interventions at very end of life.
- Encourage people to make ‘living wills’, and also to make decisions about enduring power of attorney before situations arise where these will be needed.
- Easier access to non-acute beds, home-based care and other services for end-of-life care

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## References and notes

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- <sup>25</sup> The service specification can be found in the contracts between Waikato DHB and providers such as Moana House. This is accessible to DHB staff via the contract database (HIN).
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