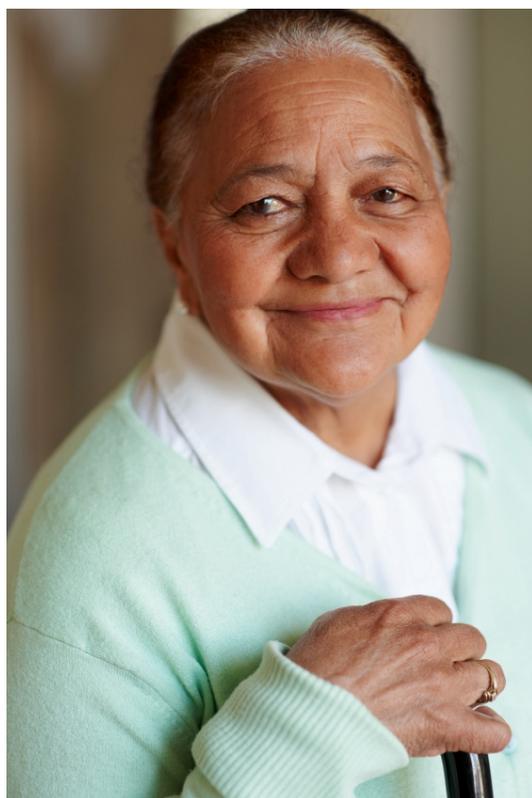


Improving Health Services For Older People In Hawke's Bay



STRATEGY 2011-2026

Contents

FOREWORD.....	2
1. INTRODUCTION	4
1.1 IMPETUS FOR CHANGE.....	4
1.2 INTEGRATION	6
1.3 SERVICE UTILISATION.....	9
1.4 OUR CHANGING POPULATION.....	11
1.5 IMPACT OF POPULATION CHANGE	13
2.1 EVIDENCE.....	17
2.2 INITIAL STAKEHOLDER ENGAGEMENT	18
2.3 CONSULTATION PROCESS.....	19
3. PROPOSED CHANGES.....	20
3.1 HIGH LEVEL OVERVIEW	20
3.2 CORE SERVICE COMPONENTS	21
3.3 CARE COORDINATION CENTRE.....	23
3.4 CARE CLUSTERS	24
3.5 CLINICAL NURSE SPECIALISTS - GERONTOLOGY.....	29
3.6 NURSE PRACTITIONERS	29
3.7 COMMUNITY GERIATRICIAN RESOURCE	30
3.8 INTERMEDIATE CARE SERVICES.....	31
4. ENABLERS	34
5. TERMINOLOGY	35

Foreword

In 2010/11 a wide range of health professionals, service providers and consumers were engaged in a process to develop a new way to deliver good quality, safe and sustainable services to meet the needs of the increasing number of older people in Hawke's Bay.

The model outlined in this document was been developed in line with the key principles of the government's *Better, Sooner, More Convenient*¹ initiative. Evidence of what really makes a difference in the lives of older people was drawn upon, along with evidence of what has worked to reduce the pressure on hospitals both in New Zealand and overseas.

Many older people – especially those who are intensive users of health and support services – have long term health conditions and support needs that require ongoing monitoring and follow-up. The model of care described here has been developed as a generic model which has the potential to be applied to other client groups with long term needs.

Key developments outlined in this paper include:

- The establishment of an Older Person's Health Service within Hawke's Bay DHB.
- The closer alignment of the over 65s team at Options Hawke's Bay with the DHB's Older Person's Health Services.
- The establishment of interdisciplinary Care Clusters aligned to General Practice groups to include a Care Manager, Allied Health and District Nursing.
- The development of Care Manager roles to undertake comprehensive assessment, care planning and service coordination for older patients with very complex needs.
- The development of Community Geriatrician resources.
- The resourcing of intermediate care services in community settings.
- The development of restorative home-based support services.

...piecemeal changes to older people's services are unlikely to make significant gains in the quality of life for our clients or achieve clinical and financial sustainability.

¹ *Better, Sooner, More Convenient* Primary Health Care is the Government's initiative to deliver a more personalised primary health care system that provides services closer to home and makes Kiwis healthier. This includes Integrated Family Health Centres, nurses acting as case managers for patients with chronic conditions, and shifting some secondary care services to primary care.

The Steering Group recognised at the outset of the planning process that piecemeal changes to older people's services were unlikely to make significant gains in the quality of life for our clients

or achieve clinical and financial sustainability. As such the developments discussed in this paper are not insignificant. However, changes will be made in an evolutionary, rather than revolutionary manner and the model may take several years to fully implement.

Changes will need to be carefully planned and implemented in stages, as finances and other resources allow. There is a window of opportunity to begin service developments before the increase in the number of adults aged over 85 years begins in earnest in 2013-2014.

It will be possible to redirect existing resources to fund some of the new services in 2011/12, but there will also be a need for further investment in coming years as the proportion of older people in the Hawke's Bay population grows.

This strategy document is not exhaustive and there is much detail still to be worked through at the implementation stage. Neither is it an immutable description – health services are ever evolving, and over the coming years, the model will be adjusted to include new practices and new evidence. However with the publication of this strategy the Hawke's Bay DHB, the wider health sector and the community have a big picture blueprint for how our services for older people will develop and confidence in how they will be delivered.



Andrew Lesperance

General Manager, Planning & Performance
Hawke's Bay District Health Board

1. Introduction

The Health of Older People's Services Improvement Project (HOPSI) aims to ensure that the needs of older people can be met by services which are clinically and financially sustainable in the face of a significant growth in the older population.

1.1 Impetus for Change

Hawke's Bay District Health Board (HBDHB) staff and other service providers (both contracted and voluntary) are in the most part providing good services to older people. However, their efforts are not well supported by the systems in which they operate, which are often fragmented and poorly coordinated. Funding and contracting arrangements are complicated and cause services to be delivered in silos which do not provide the flexibility to tailor services to the needs of individuals. Older people and their families report being overwhelmed by the complexity of the system and some just 'give up' trying to get the assistance to which they may be entitled because it becomes too difficult. Anecdotal evidence suggests that too often older people are struggling along in isolation and don't come to the attention of health and social services until they have a crisis.



***Hawke's Bay
DHB needs to act
now to meet the
increasing needs
of its older
population.***

The following issues have been raised by service providers, advocates and service users:

- Patients and their carers find navigating the multiplicity of providers and funding streams confusing and frustrating.
- Poor communication between service providers leads to delays in assessment and service provision.
- Lack of service coordination – both across different providers and across different teams with the hospital can lead to patients “falling between the gaps”, especially when transitioning between levels of care.
- Many services are still working in an acute, episodic model which does not adequately meet the needs of older people who have long term health and disability issues and does not provide an opportunity for early intervention.
- Patients with support needs report being refused services ‘on a technicality’ due to contractual boundary issues between providers.

- Some referrers are uncertain about what services are available, so send multiple referrals in the hope that one “will get through”.

- Lack of “patient centred” approach – some older people report feeling talked down to and patronised by some health professionals and not feeling like they have a voice.
- Continuing issues around patient discharge processes and correspondence with primary care, especially for patients being discharged home.
- Inconsistent follow-up in primary care for people discharged from hospital.
- Concerns about the quality of care provided by Home Based Support Services and oversight of in-home workers (home helps).
- Clients being subjected to multiple assessments by multiple agencies and being asked the same questions repeatedly.
- Concerns about the level of support Registered Nurses receive in residential care.
- Lack of physician/geriatrician resources to support primary care to manage patients more effectively in the community.
- Lack of common information and data systems to support coordinated care planning and delivery.

Hawke's Bay Hospital and other local health services are already experiencing significant pressure from several directions and this will be compounded by the increasing numbers of older people requiring services.

The workforce itself is ageing and Hawke's Bay is competing in an international market for clinical staff. Vote Health has almost doubled since 2000, but given the expected nominal Gross Domestic Product (GDP) growth in the short to medium term this level of increasing expenditure is unlikely to continue. Patient and family expectations of health services are increasing and this is likely to accelerate as the baby boomers reach older age. The trend towards urbanisation continues, with the Hastings and Napier populations increasing, whilst the rural centres are set to decline. The number of people with chronic conditions is increasing, and with it the level of complexity of health needs both in the community and secondary service settings. Traditional social structures are changing, with more older people living without family nearby, leading to a decrease in informal care and more reliance on both privately funded and government funded support services.

Hawke's Bay DHB needs to act now to meet the increasing needs of its older population. Clinical and financial sustainability of services for the elderly will not be achieved simply by trying to do what is currently done more cheaply or efficiently. Alternative ways of delivering care are required to ensure that the needs of older people are met and resources (staff, time, equipment, money) are used most effectively. New models of care are required that will make

more effective use of available health professionals expertise and capacity and which will empower more patients to better care for their own health. Piecemeal changes are unlikely to be effective and an all of sector approach - which builds an integrated model of care across the primary, community and secondary services continuum - is required.

1.2 Integration

Over the past decade, achieving service integration or integrated care has become the goal of many health and social services across the developed world. But what is integration? And what are the elements that are required to build an integrated service?

In 2001 the Ministry of Health released the Health of Older People Strategy. In this document, an integrated continuum of care is described as one where:

'an older person is able to access needed services at the right time, in the right place and from the right provider. Providers work closely together, and, where appropriate, with families, whanau and carers....Key elements of the integrated approach are:

- *services are older-person focused* se
- *the wellness model is promoted* th
- *services are co-ordinated and responsive to needs* se
- *families, whanau and carer needs are also considered, where appropriate* fa
- *there is information sharing and a smooth transition between services* th
- *managing and funding arrangements support integration'* pl

Lloyd and Wait in 2005 identified that Integrated Care means different things to different stakeholders.

*'To the **user**, it means a process of care that is seamless, smooth, and easy to navigate.*

*To the **frontline provider**, it means working with professionals from different fields and co-coordinating tasks and services across traditional professional boundaries.*

*To the **manager**, it means merging or co-coordinating organisational targets and performance measures, and managing and directing an enlarged and professionally diverse staff.*

*To the **policymaker**, it means merging budgets, and undertaking policy evaluations which recognise that interventions in one domain may have*

*repercussions on those in other domains, and thus should be evaluated as part of a broader care package.'*²

The World Health Organisation described integration as such:

'Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to

*improve services in relation to access, quality, user satisfaction and efficiency.'*³

And;

*'The organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money.'*⁴

Finally, Leichsenring discusses the need for integration not only within parts of one organisation providing care, but across multiple service settings.⁵

Integrated older person's health services in Hawke's Bay should have the following features:

- Seamless and easy to navigate for the client.
- Responsive to the needs of the client.
- Provide continuity of care over time for high needs patients.
- Health professionals from different disciplines working together to provide joined-up services.
- Clinical staff, administrators and managers across the public, NGO and private sectors work as a team to provide care with a common purpose (vertical and horizontal integration).
- Strong communication and information systems across providers to support quality service delivery and reduce duplication.
- Consistent and efficient referral processes between services.

² Lloyd J, Wait S. *Integrated Care. A guide for policymakers*. London: International Longevity Centre and the Alliance for Health & The Future, 2006.

³ Gröne, O & Garcia-Barbero, M (2002): *Trends in Integrated Care – Reflections on Conceptual Issues*. World Health Organization, Copenhagen, 2002, EUR/02/5037864

⁴ Waddington, C et al. *Technical Brief No. 1, Integrated Health Services – What and Why?*, World Health Organisation (2008)

⁵ Leichsenring, K (2004) *Developing integrated health and social care services for older persons in Europe*. International Journal of Integrated Care – Vol. 4, 3 September 2004

Co-locating services in a common building does not necessarily result in integration. If communication is poor, and the health workers continue to work in isolation from each other, then navigating the system has not become any easier from the service users perspective, although the service may appear integrated from the provider perspective.⁶

In Hawke's Bay, the total integration of older person's health services under one senior manager or organisational structure is not practical given the mix of service providers in the

public, private and community domains. The roles of different stakeholders in Hawke's Bay in achieving integration can be seen as:

- **Hawke's Bay DHB** as a funder should take a strategic overview of how and where services for older people should be delivered. The DHB should ensure that funding decisions are based on sustainable principles and do not motivate or reward silo service delivery.
- **Senior managers** within service providers (DHB, private and NGO) should place a high priority on working with other organisations and teams to provide the best outcomes for shared clients and should actively promote this ethos to their staff.
- **Health professionals, workers and administrators** should be part of teams that work together across the boundaries of their individual organisations and professional groups to provide seamless, joined up, efficient services to clients.

Waddington, for the World Health Organization, details the three main lessons that emerge from the literature about successfully developing integrated health services:

- a) Supporting integrated services does not mean that everything has to be integrated into one package, or necessarily delivered in one place. It does mean arranging services so that they are not disjointed and are easy for the user to navigate.
- b) Integration isn't a cure for inadequate resources.
- c) There are many more examples of policies in favour of integrated services than there are of actual implementation; developing such service required a full-scale "hearts and minds" commitment.

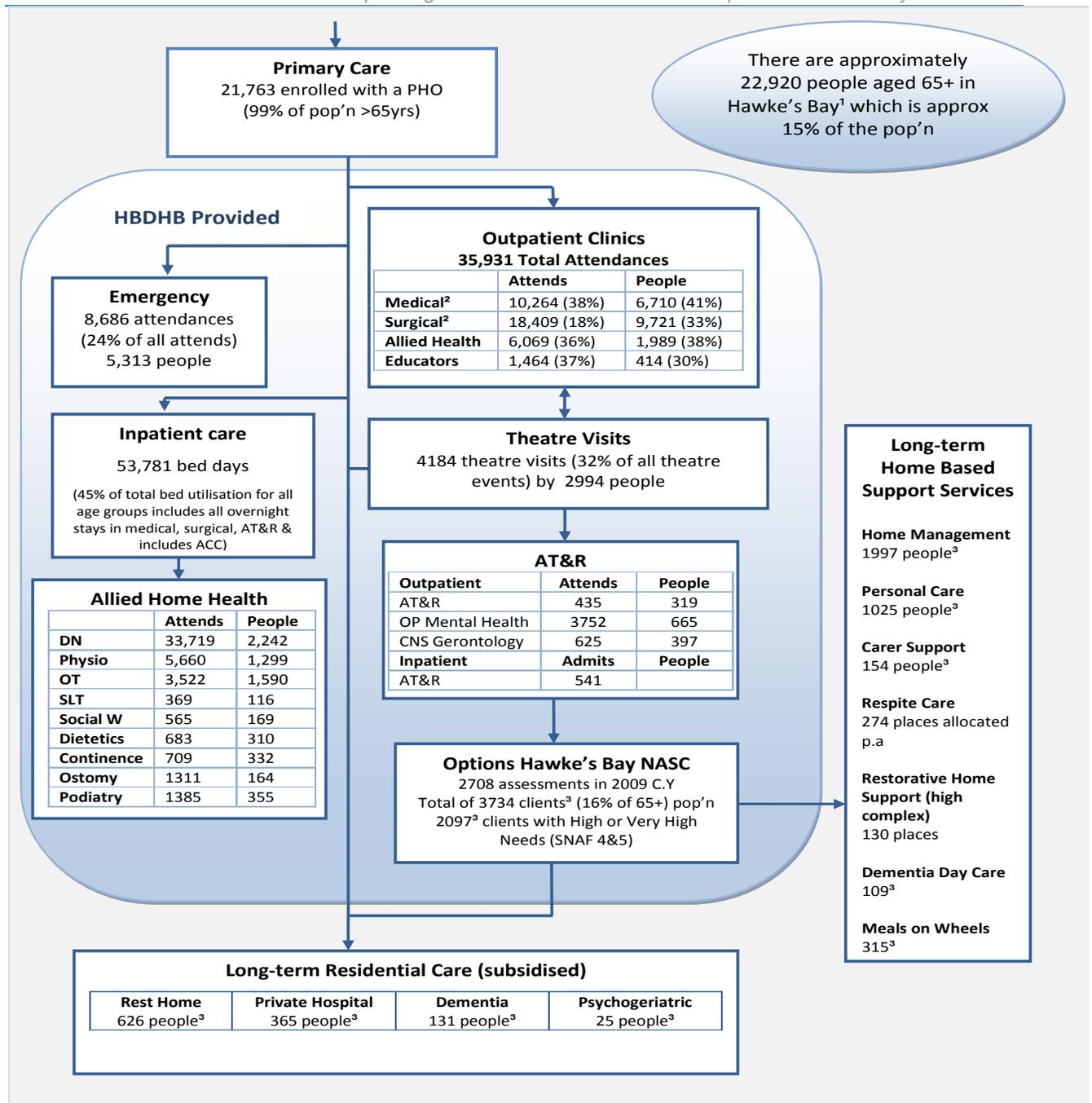
Given that social, cultural and economic factors are the main determinants of health there needs to be a means for health services to link with other services (voluntary, local government, housing, social development, spiritual) who are available to support older people. Intersectoral integration is difficult to achieve, and will require both a top down approach - where the environment for working intersectorally is created and championed at a senior management level across sectors - and a bottom up approach whereby locally, health professionals and

⁶ Lloyd & Wait 2006.

administrators build working relationships with ACC & WINZ case managers, volunteer coordinators, housing officers and the like to facilitate better outcomes for shared clients.

1.3 Service Utilisation

Figure 1 below shows the service usage by people aged over 65 in the 2009 calendar year.



¹Source HBDHB Health Status Review 2010

²Includes both appointments to see nurses and medical staff appointments

³Current clients at 30/07/2010

Figure 1 Service Utilisation By Over 65's in 2009

In 2009:

- 99% of all older people were enrolled with a Primary Health Organisation (PHO) in Hawke's Bay.

- Nearly 1 in 4 of our older population attended the Hawke's Bay Hospital Emergency Department.
- People aged over 65 accounted for 45% of all acute inpatient bed days.
- Only 5% of older people lived in aged residential care which was subsidised by the DHB, which means that the vast majority were living independently with varying degrees of familial and state provided support in the community.
- Around 4,000 older people (17%) were receiving services at any point during the year from the DHBs Needs Assessment and Service Coordination (NASC) agency, Options Hawke's Bay.

1.4 Our Changing Population

New Zealand's population is changing. Today people aged over 65 account for approximately 37% of current health service funding and as the number of older people grows steeply in the next 15 years, this will increase to approximately 50% of the total national public health spend⁷.

Today there are approximately 22,900 people in Hawke's Bay who are over 65 years old. This is approximately 15% of the total population. Of those, around 2,860 are over 85 years (1.8% of the total HB population) and it is this older adult population which is an intensive user of health and disability support services, especially in the last year or two of life.

In 15 years time, there will be approximately 35,940 people in our area aged 65+ and 4,780 people aged 85+. *The number of people aged over 85 will increase by 67% by 2026.*

The exact growth in demand is difficult to predict given that many older people will be healthier at older ages. However, we do know that nearly 40% of people aged over 65 years in Hawke's Bay today have one chronic condition such as diabetes, cardiovascular disease, renal disease or cancer. 34% of those aged 75+ have two or more chronic conditions.

Today people aged over 65 account for approximately 37% of current health service funding ... in the next 15 years, this will increase to approx. 50% of the total national public health spend.

Therefore we can be certain that the nature of the health services will need to shift toward an emphasis on long-term conditions and toward increased complexity as patients with multiple co-morbidities will require longer stays in hospital and more complex care in the community⁸.

⁷National Health Board, Aug 2010. *Trends in Service Design and New Models of Care: A Review*

1.4.1 The Older Maori Population

The Maori population in Hawke's Bay has a young age structure and the number of Maori aged over 65 years is relatively small, with around 8.5% (1,955) of all people aged over 65 in Hawke's Bay identifying as Maori, whereas Maori represent around 25% of the Hawke's Bay population across all age groups.⁹ However, the number of Maori aged over 65 will more than double by 2026 and for Maori, the greatest percentage population growth will be in the over 65 age group. In real terms, this will mean an increase of around 2,300 Maori aged over 65.

From the 1950s to the 1980s there was an increase in life expectancy at birth for both Maori and non-Maori. However, during the 1980s and 1990s, Maori life expectancy increased only slightly, while non-Maori life expectancy increased steadily. This led to a widening disparity in life expectancy during this period.

Maori experience an earlier onset of age-related disease and impairment. For example, Maori women aged 45 years and over have a significantly higher rate of impairment caused by disease/illness than non-Maori, similar to the profile expected for the non-Maori 65 and over age group. Maori have a shorter life expectancy than non-Maori and therefore fewer Maori survive to old age.

Health service providers and funders may wrongly assume that older Maori will be taken care of by their whanau but more and more frequently, family are not living near-by or do not have the relationship or resources to provide ongoing care.

In terms of national policy, funding and service eligibility, older persons are usually defined as those who are over 65 years old. Using the 65th birthday as a proxy for determining level of health and support need is somewhat arbitrary for all people in the population given that age alone is not necessarily a determinant of health or frailty. For Maori, who carry a heavier burden of age related disease at a younger age than the majority Caucasian population, the implication is that health and disability support service funding criteria based on age (e.g., eligibility restricted to those aged 65 years and over) would discriminate against Maori.

Anecdotal reports indicate that Maori receive inequitable access to community support services for older people. Options Hawke's Bay funds disability support services for older people and has the

flexibility to fund services for people who are under 65 who are "close in interest" to the over 65s i.e. those people who are not yet 65, but have disability support needs due to age related impairment. Service user data from 2009/2010 suggests that the number of Maori clients

receiving services funded by Options Hawke's Bay is greater than the proportion of Maori in both the under and over 65 age group as a whole. At first glance this would appear to indicate that Maori are able to access these services (day care, respite, household management,

⁸ National Health Board, Aug 2010. *Trends in Service Design and New Models of Care: A Review*

⁹ Hawke's Bay DHB 2010, *Health Status Review*

personal cares) at least as well as non-Maori. However it is not clear whether Maori are being allocated as many hours of care as non-Maori or whether the numbers accessing services are appropriate once the higher levels of disease burden and socio-economic deprivation are considered. This requires further investigation.

Older Maori report poor access to disability support services, and cost as a barrier to access to medical services. Maori health service providers report that for many of their clients, the cost of visiting a General Practitioner has a real impact on the ability of kaumatua and kuia to stay healthy and that many who do visit the GP do not really understand what the GP is telling them, but feel too proud or whakama (shy/embarrassed) to say so. It may be that the health language is not understood, or that the short appointment times and the knowledge that the doctor is busy mean that the older person does not feel able to ask questions. It is reported that many older Maori are not taking prescribed medication properly – or at all in some cases – because they do not really understand what the medicines are for. This is a significant issue both for the patient who may experience worsening health and quality of life, and for the system which is funding pharmaceuticals which are wasted and then funding more intensive health services as the patient becomes more unwell.

Kaupapa Maori residential care options are limited in Hawke's Bay. Maori who are no longer able to live independently may resist entering a mainstream age care facility due to a perception that the food, surroundings and general culture of rest homes are not familiar or welcoming. Health service providers and funders may wrongly assume that older Maori will be taken care of by their whanau but more and more frequently, family are not living near-by or do not have the relationship or resources to provide ongoing care. How to make aged residential care services more attractive to Maori clients will require further attention as the number of older Maori increases.

1.5 Impact of Population Change

Analysis shows that if we continue to do what we are doing today, demand for services will increase to the point where the District Health Board's financial and clinical sustainability will be under threat.

In February 2011 Health Workforce New Zealand released its report 'Workforce for the Care of Older People' to review the needs of older people, the way in which services are provided today and to propose how services might be different in the future. This review predicts a 100% rise in the needs of older people by 2026 with only a projected 30% funding increase to meet those needs.¹⁰

¹⁰ *Health Workforce NZ, Aged Care Workforce Review, 2011. <http://www.healthworkforce.govt.nz/our-work/workforce-service-reviews/aged-care>*

Table 1 below shows the utilisation of some services by older people in Hawke's Bay in 2009, and projects the potential demands over the next 10 years if we continue to deliver services as we currently do¹¹.

Service	2009 Pop. 22,920 (actual)	2015 Pop. 26,840 (projected)	2021 Pop. 31,530 (projected)
Emergency Dept. attendances per day	24	28	32
Outpatient appointments (Medical/Surgical/Nursing/Allied Health/Educators)	35,931	42,076	49,429
Theatre visits	4,148	4,857	5,706
Inpatient Bed Days (Incl. Medical, Surgical, ATR & ACC)	53,781	62,979	74,096
Options Hawke's Bay Clients (total)	3,734	4,373	5,137
Options Hawke's Bay Clients – High Needs	2,097	2,456	2,885
Rest home residents (DHB subsidised)	626	733	861
Hospital Level Care residents (DHB subsidised)	365	427	502
Older Persons Mental Health Svc. visits	3,752	4,394	5,161
Clinical Nurse Specialist Gerontology Visits	625	732	860

Table 1: Projected Service Utilisation by Over 65 Age Group

¹¹ Note: these projections are conservative as they are based on the raw increase in the number of over 65s and do not take account of the increased proportion of older people who will be 85+. Given that the over 85s are particularly intensive service users, it is possible that these figures underestimate the increases we can expect to see in service utilisation.

These figures should be cause for concern. Table 1 shows that the pressure placed on the secondary service will be immense over the next ten years, with a potential 21,000 extra inpatient bed days (55-60 new hospital beds) required by 2021.

An extra 270 outpatient appointments per week may be necessary to meet demands. The DHB might be required to spend an *extra* \$12 million in rest homes and private hospitals alone by 2021. Without significant changes to the way in which services are provided and increased emphasis on self management and maintain health and regaining function, the threshold for intervention will need to increase and people will need to be more sick or functionally impaired in order to receive services. This will have significant implications for the quality of life of older people and their families, for health agencies and professionals, for the funder and for the Government.

The DHB has a window of opportunity between now and 2013 – when the number of people in the over 85 age group will begin to increase steeply – to establish a new model of care which will better meet the needs of its older population.

In order to relieve some of the pressure in the hospital, health services should be provided in the community wherever it is clinically safe and appropriate to do so. This should be achieved by improving the support for people with complex health needs in the community, linking the primary and secondary services effectively and developing a district wide emphasis on restorative or re-ablement services which will focus on helping older people 'to do' tasks rather than 'doing to or for' them. The community services should be complemented by the establishment of sub-acute or intermediate care services to provide clinicians with a flexible resource that can aid early discharge provide convalescent care or prevent admission to secondary services. This will require a change in current clinical practice so that effective working relationships can be established between Community Geriatricians, General Practitioners and, in time, Nurse Practitioners to manage access to and oversight of the sub-acute service.

The DHB has a window of opportunity ... to establish a new model of care which will better meet the needs of its older population.

2. PROJECT METHODOLOGY

The Project Manager was appointed to a draft Terms of Reference in mid-May 2010. The Steering Group was established to gain input from a range of stakeholders. The Steering Group members at 1 August 2011 were:

Andrew Lesperance	GM Planning & Performance HBDHB (Project Sponsor & Chair)
Tim Frendin	Clinical Director, Physician/Geriatrician HBDHB
Eldred Gilbert	Director of Nursing, Primary Care HBDHB
Elizabeth Dixon	General Practitioner, Clive Medical Centre
Derek Morrison	Chair, Health Care Providers Hawke's Bay (Residential Care)
Lorna Cowan	General Manager, Enliven
Mary Wills	Senior Portfolio Manager, Older Person's Health, HBDHB
Sarah Mulcahy	Acting Chief Executive, Health Hawke's Bay
Tracee Te Huia	Director Maori Health HBDHB
Allison Stevenson	Service Manager, Health Services HBDHB

Over the past 5 years a number of planning/research projects have been undertaken to try to address the issues facing services for older people in Hawke's Bay. These include:

Document	Published
HBDHB Strategic Plan 2006-2010	2006
District Annual Plan 2009/10	2009
Journey to 2015	2007
Ageing in Hawke's Bay	2005
Falls Prevention Project Report	2008
Hastings District Council – Positive Ageing Strategy	2007
“Don't Call Me Dear” Presbyterian Support East Coast	2007
Tu Mai – Maori Health Strategy 2007-2012	2007

Table 2. Planning documents

The documents were reviewed and common themes and recommendations were identified.

The Terms of Reference were refined by the Steering Group following the review of the above documents and three high level priorities were selected for the project. These were:

- establishing a single point of entry/centralised referral process for older adults requiring community based services
- implementing a model of care that will meet the needs for older people who require long term care and support
- increasing opportunities for the specialist secondary health services to support primary care and other community based service providers

2.1 Evidence

The literature was reviewed. There is a solid base of evidence to demonstrate that effective, integrated services for older people include the following components:

- A single point of entry – to enable a fairer allocation of resources¹², using standard access criteria to enable people to be triaged and referred to the most appropriate service.¹³
- Comprehensive geriatric assessment processes.^{14&15}
- Case management/care coordination/care management for elderly 'at risk' patients – to manage service integration and coordination¹⁶, provide oversight and identify when patients are at risk of further functional decline^{17&18}.

¹² Wainwright T. *Home Care Thoughts from Abroad*. NZHTA 2003

¹³ Johri M, Beland F, Bergman H. *International experiments in integrated care for the elderly: A synthesis of the evidence*. International Journal of geriatric psychiatry, 2003, 18:222-235

¹⁴ NZ Guidelines Group. *Assessment Processes For Older People*, 2003

¹⁵ Parsons M et al. *The Tauranga Older Person Assessment Trial (TOPCAT)*. Ministry of Health, 2007

¹⁶ Act L. *Case Management for At Risk Elderly Patients: A Review*. Asian Journal of Gerontology & Geriatrics Vol .1 No 3 December 2006

¹⁷ Bernabei et al. *Randomised trial of impact of model of integrated care and case management for older people living in the community*. BMJ ; 316:48 May 1998

¹⁸ Parsons M, Kerse N et al., *ASPIRE (Assessment of Services Promoting Independence and Recovery in Elders)*. 2006, The University of Auckland

- Specialist multidisciplinary/interdisciplinary teams of health practitioners with advanced competence in physical and psychiatric conditions, disease processes in older people and specialist interventions to treat, rehabilitate or maximise the older person's functional capacity¹⁹.
- Intermediate care services that have a clear function (admission prevention and/or post acute care), incorporate comprehensive multi-disciplinary assessment, have an enablement process, offer time limited services and involve multi-agency working.²⁰

How we put the service components together is really up to us to decide, based on what will work best in Hawke's Bay for our local population.

There is also evidence to demonstrate that where Gerontology Nurse Practitioners co-manage complex older patients with a Geriatrician, quality of patient care improves,²¹ and that Nurse Practitioners can make a substantial contribution in aged care settings where they can work across service boundaries and take a clinical leadership role.²²

Whilst the evidence for the features of an effective, integrated service for older people is compelling, the literature provides little guidance about how to structure a continuum to achieve the best results. How we put the service components together is really up to us to decide, based on what will work best in Hawke's Bay for our local population.

2.2 Initial Stakeholder Engagement

The Project Manager met with a large number of stakeholders during the initial planning phases. The engagement process included one-to-one meetings, focus groups and reference group meetings. The focus groups brought together people from across the sector with experience and expertise in older person's health services. The focus group discussions made an important contribution to the development of the draft model of care by providing information on the more practical implications of potential service changes.

¹⁹ Bernabei et al. *Randomised trial of impact of model of integrated care and case management for older people living in the community*. BMJ ; 316:48 May 1998

²⁰ British Geriatric Society, *Intermediate Care: Guidance for Commissioners and Providers of Health and Social Care, Best Practice Guide*; 2008

²¹ Ganz et al. *Nurse Practitioner Comanagement for Patients in an American Geriatric Practice*, American Journal of Managed Care, 2010

²² Arbon et al. *Reporting a research project on the potential of aged care Nurse Practitioners in the Australian Capital Territory*, Journal of Clinical Nursing, 2008

2.3 Consultation Process

Consultation took place between 11 April 2011 and 30 May 2011. The consultation document was distributed to service providers contracted by the Hawke's Bay DHB, to every general practitioner and other stakeholders by mail, and was placed on the Hawke's Bay DHB website. Copies were sent to every public library in Hawke's Bay and Media Releases notified local press that the consultation was underway. Each Public Meeting was advertised 3 times in the local newspapers, on the HBDHB website and through the libraries.

The proposed service model was presented at 7 public meetings and at a large number of other meetings with service providers and interest groups on request. An evening forum was held for general practitioners to discuss the proposed service changes with the project team and with the Chief Medical Officers of Health.

The format for most of the meetings was similar; the Project Manager presented the proposed new model of care and used a case study as an example of how the change in services might affect an older person with complex health and social support needs. The attendees were invited to ask questions and respond to the proposal. The GP consultation meeting also included a panel discussion.

An estimated 300 people attended meetings to see the proposed model of care presented and sixty four formal submissions were received. The submissions were collated and analysed and two documents "Improving Health Services for Older People in Hawke's Bay: A Summary of Submissions" and "Improving Health Services for Older People in Hawke's Bay: Response to Consultation Feedback" were produced. These documents were sent to all submitters who provided an address and are available on the Hawke's Bay District Health Board website or from the DHB on request.

The feedback to the model of care proposed in the consultation document was largely positive, and provided a mandate for the project to move from the strategy phase to the implementation phase.

3. PROPOSED CHANGES

The principles of the Older Person's Health Service should draw on best practice approaches and the common themes in the earlier planning documents discussed in Section 2 above;

- Services should maximise the ability of older people to live independently and age in place.
- Services should aim to maintain and restore good health and function.
- Patient information should be accessible to all health professionals working with the patient
- Services should be patient centred and engage patients in decision making.
- Patients should be encouraged and educated to manage their own health conditions as much as possible.
- Services should be well integrated and coordinated across the continuum of care
- The most complex patients will benefit from services delivered by an interdisciplinary team of health professionals with experience in geriatric assessment and rehabilitation.
- Clinicians should have access to safe, flexible community based sub-acute services as an alternative to acute hospital admission.

3.1 High Level Overview

Core components of the integrated Older Persons Health Service will include but not be restricted to:

- A Care Coordination Centre.
- Geographical interdisciplinary Care Clusters (aligned to specific general practices).
- Care Management for clients with very complex needs.
- Older Persons Mental Health Service.
- Specialised Gerontology Nursing Services – Clinical Nurse Specialists and Nurse Practitioners.
- Community Geriatrician resource.
- Orbit (Rapid Response Team).
- Intermediate care services to provide short term, flexible sub-acute alternatives to hospital admission.
- Restorative home based support services.

Patients with very complex health and social needs should have a Care Manager who can keep an overview of service delivery and provide coordination of the multiple service inputs.

3.2 Core Service Components

Figure 2 shows the detail of the Older Persons Care Coordination Centre and Older Person's Health Service. This diagram represents the working relationships in older persons' health services, rather than the organisational or management structure.

Health & Community Support Services for Older People

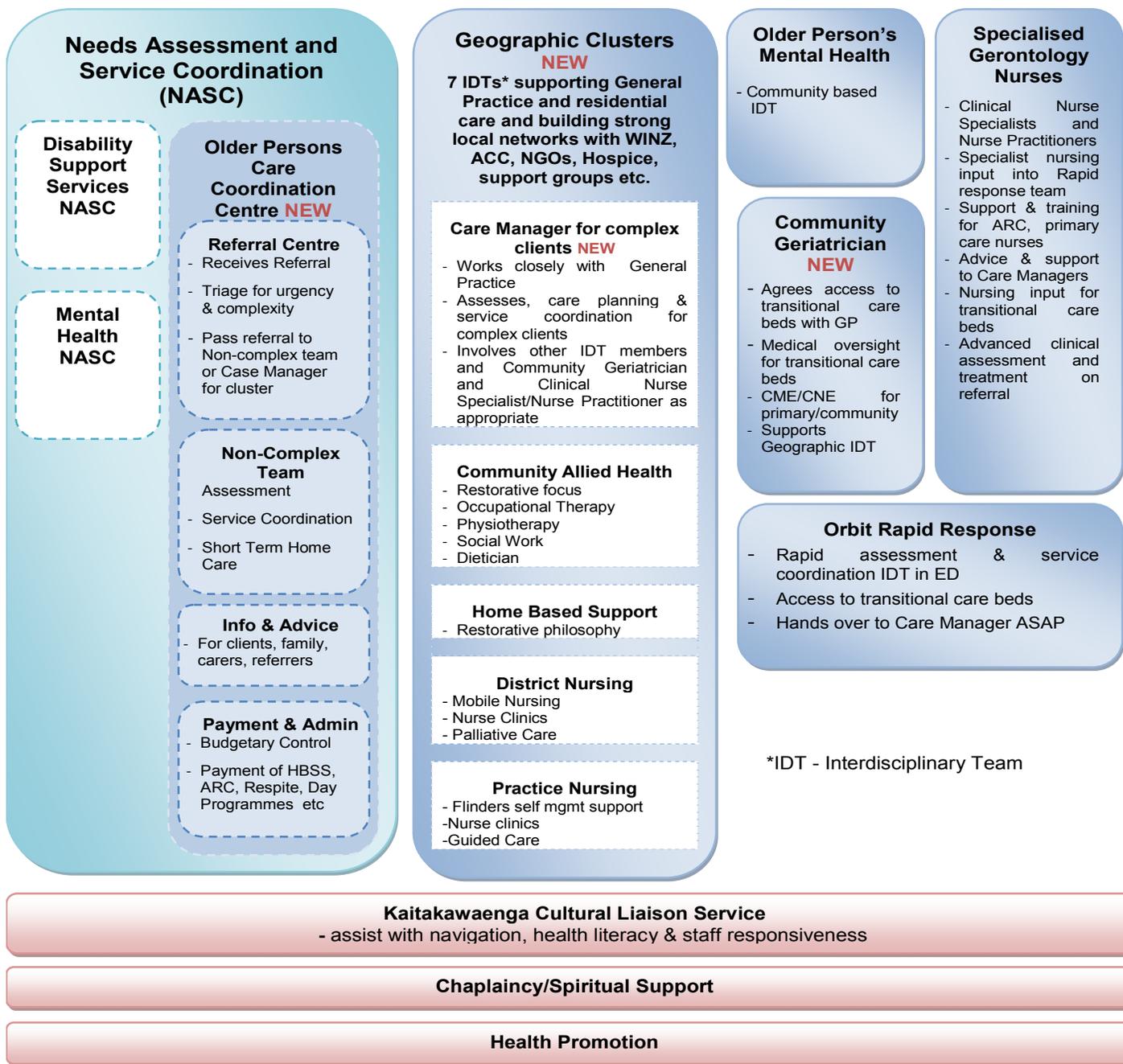


Figure 2 Health and Community Support Services for Older People

Currently the geriatricians/physicians have responsibilities across general medical (acute and outpatients), Assessment, Treatment and Rehabilitation (AT&R) and community geriatrics/home visits. Further work will need to take place to clarify the scope of the geriatrician/physician roles.

The Older Person's Mental Health Team is already working as well established multi-disciplinary team. It will be necessary to grow the FTE over time as the numbers of people living with dementia increase, but otherwise, significant changes to this team are not proposed as part of this strategy.

Orbit is an interdisciplinary rapid response team which has been recently established to identify older people who attend the Emergency Department due to a health or support crisis. Orbit provides a rapid assessment and service coordination function to either prevent admission to a ward, or to ensure that suitable supports are in place when the older person returns to their usual residence. At the time of writing this is a relatively new service which is still being embedded with an expectation that this will grow and complement existing and additional services proposed in this strategic document.

Major changes to the way in which current services are to be delivered in the future are discussed in more detail below.

3.3 Care Coordination Centre

The Older Person's Needs Assessment and Service Coordination (NASC) agency, part of Options Hawke's Bay, will remain part of the whole of life NASC. Leaving the NASC whole and evolving it to a Care Coordination Centre will provide the future potential for the Care Coordination Centre to become a central referral point for all referrals made to the community based health service delivered by the DHB such as District Nursing, Allied Health, Nurse Educators.

There will be benefits from aligning the Older Person's NASC more closely with the Older Person's Health Service. This will promote better integration of the community support services with clinical services, which will result in better communication, better discharge planning, the provision of more timely and appropriate services and more clinical oversight for the NASC.

The Care Coordination Centre for Older People (CCCOP) will provide a single point of contact for people requiring access to or information about community based services support services (short and long term home based support, residential care, day programmes, carer support and respite care, NGOs, voluntary organisations, support groups etc.).

The Care Coordination Centre will triage referrals using a standardised screening tool to determine the urgency of the referral, eligibility of the person referred to receive services, and the likely level of complexity of the client's needs.

Leaving the NASC whole and evolving it to a Care Coordination Centre will also provide the future potential for [it] to become a central referral point for all referrals made to the community based health service delivered by the DHB.

For clients who are likely to have low needs, the Care Coordination Centre staff will assess the persons support requirements using the InterRai Contact Assessment and will arrange services accordingly through local providers.

Patients who have low level support needs, for example some home based support and/or personal cares or perhaps some respite care, will not notice a significant difference to the type of service they currently receive from Options Hawke's Bay. Their medical care will continue to be provided by their General Practice, and their main contact for support services will be with the Care Coordination Centre where staff will arrange home based support, day programmes and other community based support services for the client.

If a client is screened as being likely to have complex health and support needs they will be passed from the Care Coordination Centre to a Care Manager who works with the clients General Practice and is part of the Older Person's Health Team. In other DHBs, the presence of health issues such as a progressive neurological condition, or cognitive impairment, or difficulty in administering their own medicine means that clients are immediately screened as having complex needs and are offered a comprehensive needs assessment using the InterRai Minimum Dataset – Home Care (MDS-HC) tool.

Options Hawke's Bay currently receives around 4,000 referrals per year for the over 65 age group. Based on the experiences of other District Health Boards, it is expected that around 1,800 of those referrals would be people with very complex needs.

The Care Coordination Centre will be responsible for the administration and payment to disability support services (such as aged residential care, home based support, respite care, carer support) for all older people. Importantly, the Care Coordination Centre will be responsible for budgetary control for those services.

3.4 Care Clusters

For those older people with complex needs, requiring services from numerous health professionals and support services, the General Practice will remain as primary health service provider. However, the General Practice and family/whanau will be joined by a Care Cluster to support the client.

Care Clusters are interdisciplinary teams of health and support services, and each team will provide services to the high needs/high complexity older people who are living in the locality of the cluster. Seven Care Clusters will be established throughout Hawke's Bay aligned to the General Practices in a particular area. Over time, if the government's vision of Integrated Family Health Centres (IFHC) – that is, consolidated groupings of primary care providers who are able to deliver a wide range of health services to an enrolled population – is realised, it is possible that some of these teams may be co-located in the IFHCs. However, for the foreseeable future it is expected that those staff who are currently employed by the HBDHB will remain employed by the DHB.

It is proposed that each Care Cluster includes the following:

- Care Manager
- Physiotherapy
- Occupational Therapy
- Community Geriatrician (as required)
- District Nursing
- Practice Nurses
- General Practitioner

Also aligned with each geographic Care Cluster will be:

- Restorative home based support service
- Community Pharmacist
- Social Worker
- Dietician
- Aged Residential Care Services
- Speech Language Therapy
- Hospice
- Kaitakawaenga – cultural liaison



...integrated care arrangements which include care management...can be successful in reducing hospital demand and increasing patient satisfaction.

For low FTE disciplines (such as Social Work, Dietician, Speech Language Therapist), it will be necessary for staff members to work with more than one Care Cluster.

As Care Clusters will work in specific geographic locations there will be increased opportunities for the Cluster team, and especially the Care Managers, to build working relationships with other agencies, support groups and hauora providers in that locale.

3.4.1 Care Management

Older people with complex needs, who have the potential to be intensive users of services, will be transferred by the Care Coordination Centre to a Care Manager who is responsible for conducting a comprehensive assessment of the client's needs using the interRAI MDS-HC assessment tool which has been designed to assess the medical, rehabilitation and support requirements of an older person. The software associated with the interRAI assessment indicates where further action for any specific problem may be required. The triggered responses are called Client Assessment Protocols (CAPS) which are then available as a starting point for further in-depth assessments and care plans. The Care Manager will undertake care planning in consultation with the client and will coordinate and connect the health and support services providing care. Regular review and follow-up is a key component of the role.

Studies in New Zealand and overseas show integrated care arrangements which include care management and coordination which span time, health care setting and disciplines and involves care planning and ongoing patient monitoring and follow-up can be successful in reducing hospital demand and increasing patient satisfaction.²³ & ²⁴ & ²⁵

This role will differ from a nursing case management model as the Care Manager role will be primarily focused on assessment and service coordination rather than delivering hands-on clinical treatment.

The Care Manager will develop strong relationships with the general practitioners within their cluster, and will provide the bridge between primary and secondary care for high needs patients.

The Care Manager will be a health professional with an Annual Practising Certificate. Central to successful care management is the ability for the individual to build strong relationships with the clients and their families/whanau, general practice staff and other agencies/service providers locally. This is necessary to enable good information sharing, the development of trust between the health professionals from different disciplines and a fast response time when the client has had a change in their health or support needs, with the aim of averting crises.

The Care Manager will 'follow' their clients into and out of hospital and will enable the discharge process to occur in a timely, safe and coordinated manner.

Initial estimates indicate that there will need to be at least 1 Care Manager for every 3,000 people aged over 65 years, which has been based on the client ratio used in the Coordination Of Services for the Elderly (COSE) service in Canterbury. With our current numbers of high needs clients this will require 7-8 Care Managers for Hawke's Bay, each with a case load of around 250 patients. Not all clients would be actively requiring input from the Care Manager at one time. There will need to be a pragmatic approach to managing patients who reside in one area, but are enrolled with a General Practice in another area. Allocating the best care cluster for these clients will need to be made on a case by case basis.

COSE was subject to a randomised controlled trial as part of the ASPIRE research, and was found to reduce entry to residential care by 43% in Canterbury when compared with the usual NASC service.

²³ Parsons, M., Kerse, N. et al, *ASPIRE*. 2006, The University of Auckland

²⁴ Bird S, Korowski W, et al. *Integrated care facilitation for older patients with complex health care needs reduces hospital demand*. 2007, Australian Health Care Review.

²⁵ Bernabi, op.cit

3.4.2 Interdisciplinary Team

Evidence shows that having strong links between specialist interdisciplinary teams (IDTs) and primary care based care managers reduces admissions in chronically ill older people.²⁶ & ²⁷

Working with the Care Manager as part of the Care Cluster will be community physiotherapists and occupational therapists and district nurses who will support the older patients with complex needs in their Care Cluster. They will be engaged on behalf of the patient by the Care Manager on an "as needed" basis to perform specialised assessments and deliver interventions with a strong focus on rehabilitation to maintain/regain independence. The cluster will involve the Older Person's Mental Health Team, Community Geriatrician resource and other health professionals (dietetics, social work, pharmacist and Clinical Nurse Specialists and/or Nurse Practitioners) as required.

The interdisciplinary team will be mobile and the majority of their work will be conducted in the patient's home and the intermediate care beds. Hawke's Bay DHB already employs allied health staff and specialist District Nurses who actively deliver restorative and rehabilitative services to complex older clients as well as other people from all age ranges and level of need. In the future it is expected that they will continue to do this specialised work with older people but the individual health professionals will be aligned geographically to one Care Cluster and working as part of an interdisciplinary team for the complex older clients in their area. This will not necessitate a change in employer for these professionals who are currently employed by the DHB. There will be some operational issues to be addressed to facilitate this new way of working, but the efficiencies of communication and service delivery that should flow from having an interdisciplinary team working together on a daily basis is expected to improve satisfaction, care and outcomes for clients.

3.4.3 The role of Primary Care in the Clusters

For most older patients, even those with complex needs, general practice will continue be the lead clinical service provider most of the time. The Care Manager function will support general practice in this task by providing timely access to specialised geriatric physical, social and functional assessment, support and interventions with the aim of keeping those clients well and intervening to avert crises before they happen.

Evidence shows that having strong links between specialist interdisciplinary teams and primary care based care managers reduces admissions in chronically ill older people.

²⁶ Heaney, C., K. Lim, et al *Unassigned geriatric evaluation and management program: preventing sub acute hospital admissions*. 2002, Australian Health Review 25 (6).

²⁷ New Zealand Guidelines Group, *Best Practice Evidence Based Guideline: Assessment processes for Older People*. 2003

Health Hawke's Bay is training Practice Nurses in the Flinders self management model. Using a generic set of tools and processes, practice nurses will use Flinders to enable patients with long term conditions to care for their own health needs more effectively, with the patient becoming their own principal care giver. Whilst this might not be practical for all older people and especially those with dementia, there are a large number of people in the younger-older age group (c. 65-75 years) who have the ability and the resources to manage their own health very successfully if given some assistance and who will then carry those skills into older age.

The level of involvement of some General Practices may be higher than others. This will depend on variables such as the level of special interest a primary care team has in gerontology, the number of older people with complex needs enrolled with the practice, the density and proximity of aged residential care services and whether or not there are Intermediate Care beds located in the geographical area. Potential for GP with Special Interest (GPSI) or lead general practice arrangements will need to be explored in partnership with the Community Geriatrician and other senior medical and nursing staff.

3.4.4 Restorative Home-Based Support Services

Home-based support services (HBSS) such as help with personal care and help with household chores can be critical to the continued health and well-being of older people. Assurance about the quality and adequacy of those services is important for the older people receiving them and for those who care about people receiving the services.

Traditional home-based support service tend towards a 'dependency' model which may give insufficient attention to an individual's potential or actual capacities, and as a consequence some older people may become entrenched in a 'sick role', characterised by an absence of self-motivation, and the view that because they are aged or unwell they must remain 'dependent' upon continuing support services²⁸. Home-based support services which emphasise task completion and doing 'as much as possible for the client', rather than doing activities with the client and encouraging independence can create a cycle of dependency and learned helplessness. This can result in decreased function and confidence and increase the likelihood of more services being offered.

Restorative home-based support services emphasise maintaining or improving functional capacity, goal setting, and increasing quality of life to enable the client to live as independently as possible. In 2002 Tinetti et al.,²⁹ found that individuals who received restorative home care showed greater improvement in their self-care, home management and mobility scores at discharge than did those receiving usual home care. These findings were confirmed in the ASPIRE research in New Zealand.

²⁸ McWilliam, et al. *Care delivery approaches and seniors' independence*. Canadian Journal of Ageing, (2000).

²⁹ Tinetti et al. *Evaluation of Restorative Care vs Usual Care for Older Adults*. Journal American Medical Association (2002).

In the future, home-based support services will be aligned with the care clusters and work with the care manager and interdisciplinary team to provide restorative services with an emphasis on “doing with” the client rather than “doing for”.

However, it is acknowledged that in some cases, maintaining or improving function is not likely to be possible, and flexibility should be retained in the system to meet the needs of those older people for whom restoration or maintenance is no longer possible.

3.5 Clinical Nurse Specialists - Gerontology

Clinical Nurse Specialists – Gerontology (CNS) are highly skilled nurses on a pathway to Nurse Practitioner status. Currently the Hawke's Bay DHB CNSs conduct a significant amount of geriatric assessment and care planning as well as treatment. Some of the assessment and care planning will transfer to the Care Manager for the patient's particular geographic Care Cluster.

The existing two Clinical Nurse Specialists - Gerontology will maintain their hands-on clinical roles as part of the Orbit Rapid Response Team operating in the emergency department, and their remit should be to ‘hand over’ the client to the relevant Care Manager as soon as practical. The Clinical Nurse Specialists may also have a responsibility to provide comprehensive clinical assessment and care for patients admitted to the intermediate care services and on referral from Care Clusters.

Key to utilising these professionals effectively will be to ensure that opportunities exist for them to upskill fellow nurses by working shoulder to shoulder with other nurses (for example Practice Nurses and Aged Residential Care Nurses) to assist those nurses to care for individual older people with complex health needs. As well as this the DHB will need to consider Gerontology Nurse Education roles in community/primary care.

3.6 Nurse Practitioners

Nurse Practitioners are expert nurses who have met Nursing Council requirements to assess, diagnose and manage health conditions within a specific area of practice. They practice both independently and in collaboration with other health professionals, and demonstrate leadership as consultants and educators. Hawke's Bay DHB does not currently employ any Gerontology Nurse Practitioners, but considers that the Clinical Nurse Specialist – Gerontology positions should act as the pathway to Nurse Practitioner status. It is expected that within a few years, Hawke's Bay will have at least one fully qualified Nurse Practitioner for Gerontology, and at that time it is likely that the Nurse Practitioner will take on a range of responsibilities including a dual role overseeing the growing Intermediate Care services alongside the Community Geriatricians.

General Practice feedback has suggested that training in gerontological assessment and care for Practice Nurses would be welcome. Nurse Practitioners may also have a role to play in working with registered nurses in the aged residential care sector to increase their knowledge and practice. This approach has proved successful at Waitemata DHB.

3.7 Community Geriatrician Resource

International benchmarking suggests that an appropriate level of geriatrician staffing for a population of 155,000 is 3.1 Full Time Equivalents (FTE)³⁰, allocated solely to geriatric medicine. The HBDHB is currently understaffed with physicians who are delivering hands on geriatric care. Although there are approximately 3.9 FTE geriatricians/physicians currently on staff, a significant proportion of their hours are dedicated to other responsibilities including acute general medical work and senior clinical management and governance roles within the DHB. This results in only around 1.8 FTE being available for the Assessment Treatment & Rehabilitation (AT&R) department and community geriatrics; significantly below the Royal College of Physicians recommendation.

Currently, three of the four geriatricians/physicians assume acute medical, AT&R and home visiting duties. The workload of the geriatrician/physicians is such that their acute medical responsibilities place significant demands on their day, and the level of urgency surrounding the acute work makes prioritising home or residential care visits a continual struggle. Given the low FTE dedicated to geriatric medicine and the general medical workload, it is proposed that a Community Geriatrician resource is developed within the Older Person's Health Services. The establishment of the new model of care will provide an opportunity to review the responsibilities of all the physicians/geriatricians. Further work is necessary to determine the structure of the geriatrician/physician roles and rotations, and to ensure that leave and other cover can be managed effectively.

The Community Geriatricians will have a significant role in providing and directing medical and rehabilitative care and oversight to older people in the new intermediate care beds.

Under the new model of care, combining physician roles in both hospital and community will be a major challenge for the physician/geriatricians and older person's service. Managing the workload across acute, AT&R and community safely, and protecting the community geriatrics resource from the demands of the hospital must be prioritized if the intermediate care services are to be effective and sustainable.

The Community Geriatrician resource will provide a bridge between primary and secondary (hospital) services through the AT&R department, but should preferably have no acute inpatient responsibilities. The community services must be embedded and protected – they will falter if physician resources are bound to respond to the needs of the acute secondary services.

The Community Geriatrician resource will have a significant role in providing and directing medical and rehabilitative care and oversight to older people in the new intermediate care beds. The Community Geriatrician will approve access to the intermediate care bed following discussion with the patients GP.

³⁰ Royal College of Physicians (London), *Consultant Physicians Working with Patients*. 2008

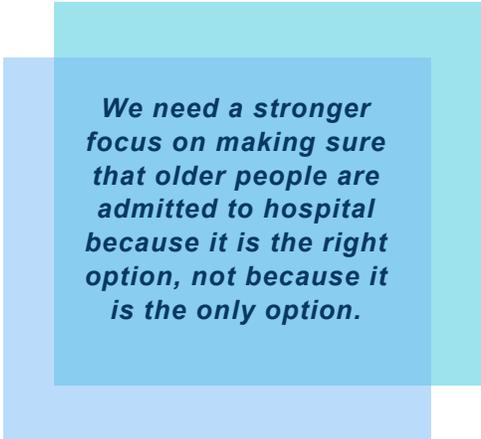
The Community Geriatrician resource will also provide oversight and advice to the Care Clusters and be available for home visits to clients and will have a role in providing training and Continuing Medical Education (CME) to the primary care sector.

3.8 Intermediate Care Services

The number of older people is increasing, especially in the over 85 age group who are more likely to be acute inpatient service users than their younger counterparts. Already the Hawke's Bay Hospital inpatient services are under pressure and are coping with demand by trying to manage down the Length of Stay in hospital. Some GPs have concerns that some older people are being discharged following an acute admission before they are really well enough to go home, or before suitable supports are in place.

The rapid increase in the older older population means that before long, HBDHB's ability to manage the bed capacity in the hospital by reducing Length of Stay will be overtaken by the growth in demand as both the number of older people, and the burden of disease they experience, increase. The DHB will need to purchase new beds to meet that demand. The question for the DHB is whether to invest in more beds at the hospital, or purchases capacity in the community.

We need a stronger focus on making sure that older people are admitted to hospital because it is the right option, not because it is the only option – and to do that we need to resource alternative methods of service delivery. In line with the DHB vision to have more patient care delivered in the community, and to meet the Minister's expectations of providing the Right Care in the Right Place at the Right Time, it is proposed that the DHB contracts for capacity in the community to provide flexible intermediate care options for clinicians and patients.



We need a stronger focus on making sure that older people are admitted to hospital because it is the right option, not because it is the only option.

Intermediate care is a generic term that covers a range of services that help prevent unnecessary admission to hospital, or help facilitate early discharge. Other names to describe these types of services include sub-acute beds, transitional care, and step down services, convalescent care and hospital-at-home.

Intermediate care is a mainstay of the developments in the care of the aged in the UK and is Standard 3 of the National Service Framework for Older People.³¹ The rationale is:

“Currently too many people are admitted to hospital for want of community based services that would better meet their needs.”

³¹ Department of Health (UK), 2007 *National Service Framework for Older People*

Clinicians have advised that this is also the case here in Hawke's Bay. Pressure is placed on the acute inpatient services by the admission or delayed discharge of older people do not necessarily require the level of care that a regional hospital provides, but are too unwell to remain at or return home. Many older people do not wish to be in hospital unless it is absolutely necessary and intermediate care can improve the patient satisfaction.

The cornerstone of these services will be sub-acute beds that will most likely be purchased from one or more of the aged residential care facilities that already provide hospital level care services. These will provide a flexible resource for the care of older people who are too unwell to remain at home, but who do not require hospital admission. The beds will be supplemented by hospital-at-home arrangements for those who are well enough to remain safely at home but who require an enhanced level of medical and nursing oversight for a period until they regain their health. As with the intermediate care beds the hospital at home services will be delivered by the care cluster for the patient's locality along with the community geriatricians and senior nurses. However, given the low staffing numbers, it will be necessary to balance need, preferences, travelling distances and resources carefully when making decisions whether to offer an intermediate care bed, or in home arrangements.

The intermediate care services will also be used for convalescent care, and will act as a step-down to facilitate the timely discharge from an acute ward once the worst of the patient's illness has passed and until they are well enough to return home.



The philosophy of the intermediate care services must be restorative and offer an AT&R-type multi-disciplinary rehabilitation model.

Access to the beds and hospital in the home services will be agreed between the Community Geriatricians and Nurse Practitioners (in time) and the patient's GP. The Community Geriatricians providing the medical oversight in partnership with the patients GP wherever possible. There may be the potential to develop General Practitioner with Special Interest in Gerontology roles in Hawke's Bay, and these positions could be instrumental in managing the medical oversight of patients in intermediate care services. The intermediate care services would be integrated with Coordinated Primary Options programme already offered by Health Hawke's Bay.

The philosophy of the intermediate care services must be restorative and offer an Assessment Treatment & Rehabilitation (AT&R) type multi-disciplinary rehabilitation model. Intermediate care services should:

- Be targeted at people who would otherwise face unnecessarily prolonged hospital stays or avoidable admission to acute in-patient care or long term residential care.
- Be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active treatment and rehabilitation.
- Be designed to maximise independence and to enable patients/users to remain or resume living at home.

- Involve short-term interventions, typically lasting no longer than 6 weeks and frequently as little as 1-2 weeks or less³².
- Be responsive to Maori.

The Community Geriatrician and General Practice will be supported by the Care Cluster for the locality to provide an inter-disciplinary team approach and will be augmented by Clinical Nurse Specialists and Nurse Practitioners as these roles develop.

Evidence from established intermediate care beds in the UK suggests that for a population of the size of Hawke's Bay, between 12 and 60 intermediate care beds might be required, depending on the average length of stay.³³ Benchmarking with Australian services shows that we may need 30 beds in Hawke's Bay. Accurately quantifying the number of beds required is not possible at this time, so given that the intermediate care beds will need to be fully funded (rather than purchased on a fee for service basis) and that it will take time for the service to become established and fully utilised, it is recommended that up to ten beds are funded in the first year.

³² Department of Health (UK), 2007 *National Service Framework for Older People*

³³ British Geriatric Society, *Developing Intermediate Care to Support Reform and Emergency Care Services*. October 2003

4. ENABLERS

Leadership

Leadership is needed at both clinical and senior management levels to champion the vision for the new service model and to encourage those affected by the changes to participate in problem-solving.

Funding

The DHB will have to fund services for the increasing number of older adults with complex health and support needs in Hawke's Bay over the next few years. The DHB has committed to funding a planned, evidence based approach to delivering patient care and managing secondary demand; instead of adopting a 'wait and see' approach which would be unplanned and reactive. The implementation of the new model may take 2-3 years to be fully realised and options for reallocating funding from other services will need to be considered.

Workforce Development

For the model to be fully realised, new ways of working will need to be developed, and increases in staffing numbers will be required to meet the needs of an increased number of older people with complex health and support needs. Some of the teams discussed in this document (e.g. Allied Health, District Nursing, Older Person's Mental Health) are already under significant caseload pressure. A workforce development plan should identify training requirements and project the increases in FTE that will be required over the coming years, and to identify the potential to develop new roles such as GP with Special Interest (GPSI), Nurse Practitioner and cross professional roles such as Rehabilitation Therapists.

Information systems

The availability of the most up to date health information and care plan to all parties involved with the care of the patient is a crucial enabler.

Clinical pathways

Robust clinical pathways will be required to standardise referral and care processes, reduce variability and improve outcomes.

Commitment

To ensure a successful transition to the new way of working it will be necessary to secure a high level of buy-in at all levels within the DHB and in the wider service provider and stakeholder networks.

5. TERMINOLOGY

The following table provides an explanation of some terms and phrases as they are used in the context of this Strategy.

Term	Explanation
Acute care	Short term treatment for an injury, episode of illness or urgent medical condition. It is characteristically episodic or 'one-off' in nature.
AT&R	Assessment, Treatment and Rehabilitation. The rehabilitation inpatient service at Hawke's Bay Hospital.
Care Cluster	An interdisciplinary team which works with older clients, General Practices, Rest Homes and other social and health service providers in a specific geographic area.
Care Manager	A registered health professional responsible for comprehensive assessment, care planning and service coordination for older people with very complex needs.
Chronic Care	Ongoing care for long-term or recurring condition(s) that can have a significant impact on a person's life, such as cardiovascular disease, diabetes, cancer, arthritis, depression.
Clinical Nurse Specialist – Gerontology	Specialised nurse with advanced knowledge and skills in the assessment and clinical care of older people gained through experience and postgraduate education.
Community Geriatrician	Physician who specialises in older person's medicine and works predominantly in homes and community settings, rather than in a hospital.
Co-morbidities	The simultaneous presence of 2 or diseases or morbidities in the same person.
Comprehensive Geriatric Assessment	A multidimensional inter-disciplinary diagnostic process focused on determining an older person's medical, psychological and functional capabilities, in order to develop a coordinated and integrated plan for treatment.
Continuum of Care	A comprehensive arrangement of health services spanning all levels of intensity including health promotion, primary/community services, intermediate care,

	institutional/long term care and specialist health care.
Discharge	The physical and administrative process of transferring a client back to their usual residence following an inpatient event.
FTE	Full Time Equivalent (employee). 1 FTE = 40 hours per week.
GPSI	GP with Special Interest.
Home Based Support Services	Home help services (household tasks and personal cares).
Inpatient Care	Medical treatment that is provided in a hospital, and requires at least one overnight stay.
Interdisciplinary Team	A team of health professionals from different disciplines who work together to care for patients with multiple needs.
Intermediate Care	Flexible services which offer clinicians and clients an alternative to secondary hospital admission by providing sub-acute services from a community setting or in the client's home. See page 28.
interRAI	Multi-faceted web based tool used to assess the medical, social and functional support needs of older people.
Model of Care	Describes the way in which health services are configured to meet the needs of a specific group in the population such as 'older persons', 'Maori', 'diabetics' etc.
NASC	Needs Assessment and Service Coordination agency. Another name for Options Hawke's Bay.
NGO	Non-government organisation.
Nurse Practitioner	Legal title for an expert nurse who has completed advanced education and training in a specific area. NPs have met Nursing Council of New Zealand requirements to assess, diagnose and manage health conditions.
Options Hawke's Bay	A team within HBDHB responsible for needs assessment and service coordination.
Primary Care	Professional health care received in the community, usually from a GP or practice nurse.
Primary Health Organisation	PHOs are the local structures for delivering and co-ordinating primary health care services. PHOs bring

together GPs, nurses and other health professionals in the community to serve the needs of their enrolled populations. Most GPs belong to a PHO. The PHO for Hawke's Bay is Health Hawke's Bay.

Residential Care/Aged Residential Care

Continuing care facilities, including rest homes, private hospitals, residential dementia services and retirement villages.

Restorative Care

Health and support services that aim to maintain or restore a client's independence and prevent loss of functional ability.

Secondary Care

Health services provided by practitioners who generally do not have first contact with a client. This includes, for example, specialist services within a hospital setting
