Title
Differentiated models of care for over 65’s

Type of Referral
× New technology/service/model of care/programme

□ Significant service expansion

□ Existing service review (e.g., area of lower value for reduction or disinvestment)

Description
This referral proposes that the National Health Committee considers an integrated, system wide approach to the provision of aged care into the future, with an emphasis on community based care through a range of multiple, innovative models, which provide differentiated pathways to care for population groups over 65 with differential needs.

The proposal is deliberately broad and far reaching. The concepts and imperatives expressed are nothing new. They have been stated in multiple forums, reports and research literature.

The problem to be addressed is an obvious one. New Zealand has an ageing population. Our community based and residential provision for care of people over 65 is already stretched to capacity. All the demographic and statistical evidence points to a “tidal wave” of need that is threatening to overwhelm us and take our systems of provision beyond breaking point.

Many reports have been written, and multiple bodies and groups formed at national level to try and address the looming crisis in aged care. Yet those efforts are fragmented, hampered by competing interests and imperatives, resource hungry, and duplicate focus on issues without being able to provide system wide solutions.

The lack of an integrated approach across the country means that every DHB is currently creating their own approach to community based services. By contrast, residential service provision is considered at a national level. This creates an additional challenge when trying to integrate residential and community based approaches through the continuum of care and new innovations. The lack of integration of primary care into this mix further adds to the lack of coordination and fragmentation. This creates huge systemic inefficiencies that our health system can already ill afford, and will be even less able to afford as future population demands increase.

A fully systemic, integrated, national approach is required: one that will break out of the constraints of existing care models, trajectories and structures, and refocus scarce resources towards the increasing needs in ways that dramatically reduce the cost overall to the system. This inevitably requires investment being skewed towards preventive, primary care approaches and away from the resource hungry vortex of acute, medicalised, institutional care. Ultimately, a series of models for differentiated population groups are required that integrate primary care, community based support, intermittent secondary care and residential care are needed to achieve efficiency and sustainability in the system. The need for a differential approach for dementia in particular is urgently required, given the increase in numbers already placing severe demands on the system.

In terms of care models, we have the problem of “one size fits all” approaches being hugely
inefficient, because such approaches are not appropriate to effectively address client needs. So for example, a system that pays for housework to be done for and older person with a mobility problem, but does not pay for a socially isolated older person to go to a club is not structured correctly. A package of care and support services for a frail elderly person who is not cognitively impaired needs to look quite different to support a person with dementia – not only will the client’s needs be very different, but the support required for the primary carer(s) of the older person will also be different in type and scale. Another example is that the existing system may not provide eligibility for an older person who has significant health/mobility issues any help with housework, but via a disability allowance someone under 65 with a disability allowance can get gardening done and windows cleaned. Right now, we have a system that is far too rigid to provide the best combinations of service and support to meet differential needs.

A system wide approach of differential care models, in very simplistic terms, will say: “for x population group of over 65’s (for example, clients in various stages of dementia); what combinations of services, supports and settings need to be developed to sustain these clients in maximum quality of life, in place, in social connectedness and wellness, for as long as possible?”

Some examples
Below are some examples of the types of initiatives developed by various Presbyterian Support regions that would fit the proposed differential models of care. Additional examples of a commercially sensitive nature are set out in the appropriate section of the template.

Case example 1: Enhanced Model of Home Care
Sharing regional innovation that responds to client need is central to Presbyterian Support’s strategic goal of quality results for people and communities. One such innovation from Presbyterian Support Northern is a bulk funded case-mix model of home support, in partnership with the Auckland DHB and three other providers.

Open and transparent sharing between providers of previously guarded, commercially sensitive business intelligence is a key point of difference in this approach. It has enabled a new way of contracting that benefits both the clients and the organisations involved.

The Enhanced Model of Home Care focuses on achieving streamlined access for service users, a strengths based delivery model that promotes independence, flexible packages of funding and a comprehensive suite of assessment tools.

Enhanced Home Based Support Services assists older people to achieve quality, cost-effective outcomes, thus supporting them to live as independently as possible.

The four providers and the Auckland DHB specialist team have worked together with Auckland University to develop the service specifications. High levels of trust and collaboration, with the focus on client outcomes rather than the interests of each party, has been key to the success of this model.

Other DHBs are now considering implementing parts of the model. Our other Presbyterian Support regions look forward to working collaboratively with them to achieve similar success in other parts of the country. (PSNZ Annual Report 2010/11, p.11)
Case example 2: Home-based Support Case Study

Joyce - Safe at Home

When Joyce Lloyd came out of hospital after a hip replacement, she was frightened that she would be put into a rest home.

Joyce was delighted to discover that she had the option of remaining in her own home with Enliven Positive Ageing Services. Enliven support workers come to Joyce’s home daily, to help with practical tasks such as helping her take her medication, running her through her exercise regime, taking her to get the mail and with general household tasks that Joyce is no longer able to do.

“Enliven has been absolutely wonderful to me. If it hadn’t been for them I would have been put into a home when I came out of hospital 18 months ago. But the alternative was I could stay in my own home under the care of Enliven and be surrounded by my own pictures and belongings. With their help, I have been able to maintain my independence.”

For many older people it is important to be in familiar surroundings that hold so many happy memories. With a little help from Enliven, many older people are able to remain in the homes that they have lived in with their families for years, giving them a sense of independence and control while feeling secure and supported. (https://northern.enliven.org.nz/case-studies/home-based-support)

INTRODUCTION TO HOMESHARE (An initiative of Presbyterian Support East Coast)

What is Homesharing?

Homesharing is an intergenerational scheme for pairing older householders, who could benefit from help in the home and companionship, with mature individuals prepared to lend a hand in return for free accommodation. It is based on principles of fostering independence, mutual benefit and reciprocity.

Homesharing is a concept first developed in a formal sense in North America in the 1970s. It was seen primarily as an approach to preventing older people from being placed in residential care prematurely or unnecessarily, and secondly as a means of providing affordable housing options for younger people. Homesharing began as an intergenerational programme but could clearly be a viable option for other groups with a need for support and companionship in their own homes such as people with a disability.

Formal intergenerational Homeshare programmes now operate in eight countries, with over 100 programmes in the United States and several in the United Kingdom. Whilst there have been several models of Homesharing, the basic underlying philosophy is the same – independence, personal growth and improved quality of life through reciprocal sharing of resources (Johnson & McAdam 2000).

This is the first Homeshare programme in New Zealand. This service has been developed by Presbyterian Support East Coast’s Enliven Positive Ageing service and draws on a wide range of overseas literature.

Key terms used in describing Homesharing include:

‘Homesharing’ is the term used to signify an arrangement whereby an older person provides accommodation in their home to a mature adult or adults, in exchange for help in the home and companionship, the purpose of the arrangement being to build up a reciprocal relationship.
whereby the independence and quality of life of the older person is enhanced, and accommodation options and the quality of life of the mature adult(s) are increased.

“Householder” is the term used for the older person who offers free accommodation in their own home in exchange for a certain number of hours per week of specified assistance and companionship.

“Homesharer” is the term used to refer to the mature adult who receives the free accommodation in exchange for the specified assistance.

“The introduction” refers to the meeting arranged by the programme staff where a fully assessed potential householder and Homesharer spend some time getting to know one another and assessing mutual compatibility.

“The match” refers to the living arrangement between the householder and the Homesharer. It is underpinned by a formal written agreement signed by the two parties.

“Match monitoring” refers to the support offered by the Homeshare programme to the participants in the match to assist them in establishing their mutual roles in the household, resolving any disagreements, and renegotiating or dissolving the match at the expiry of the formal agreement.

The benefits of Homesharing are numerous. This type of housing option has advantages for individual householders and Homesharers as well as for the community at large.

Householder benefits
Many older people can benefit from Homesharing in the following ways:

- **Maintenance of independence**
  Homesharing assists older people to remain in their own homes and helps them to maintain a sense of independence and autonomy. With the presence of a Homesharer and the assistance they offer, many older people can reduce their demands on family or friends for assistance and can continue living life in their own home with a feeling of dignity and self-reliance.

- **Feelings of safety and security**
  Having someone to share the house can reduce the householder’s fears about personal safety and security, especially at night.

- **Improved physical and emotional health**
  Sharing a house, meals and some hours of companionship can have a marked impact on older people’s health. Lower stress levels and less anxiety, more regular meal times, better diet, more peaceful sleep, assistance with tasks at home, prompting about taking medication, all contribute to better physical and emotional health.

- **Pets**
  Homesharing can enable many older people to keep a much loved pet that they can no longer manage to look after without assistance. Animals can be an important ingredient in older people’s wellbeing and sense of safety and security.

- **Maintaining community involvement**
  Improved physical and emotional health, and some assistance given by the Homesharer in terms of transport, meal preparation or household tasks, means that many householders can maintain their involvement with friends and family and with the community around them.

Homesharer benefits
Homesharers too may experience many benefits, including:
Financial savings
Homesharing means Homesharers can make significant cost savings on rent and can often live in good quality accommodation at minimal cost. This may be an important benefit for Homesharers living on a low income such as students, and many people find it provides an ideal opportunity to save for a major financial commitment in the future such as house purchase, or overseas travel.

Safety and security
Many people find they feel safer sharing with an older person rather than living alone or sharing with other single adults in a shared house. Young students from overseas or from rural New Zealand can find cities quite daunting. Living in a home like environment with a mature person can make all the difference to feelings of safety, wellbeing and even mental health.

Companionship and homelike environment
Many Homesharers prefer to share with an older person citing reduced loneliness or homesickness and a sense of wellbeing from living in a home-like environment with a concerned householder. Others find they benefit from assistance with work or study requirements from an older knowledgeable person, and a stable home life conducive to work and study. In many cases Homesharers develop warm ties of friendship with the householder and with the householder’s family.

Adaptation to New Zealand society
Overseas students or recent arrivals often find that living with a New Zealand citizen assists them to adapt to our culture and society and improves their English language skills with the support of a local resident.

Community service
Some Homesharers feel that by undertaking the role of Homesharer they are making a contribution to the wellbeing of the community as well as gaining personally from living with an older New Zealander. This can give many people a tremendous sense of personal satisfaction.

Community benefits
Homesharing also brings benefits for the community at large, including:

- **Cost efficient affordable housing**
  By using current housing stock to greater capacity, Homesharing expands the number of affordable housing units for both younger and older citizens.

- **Prevention of premature institutionalisation**
  By facilitating prolonged independent living arrangements, Homesharing can prevent premature institutionalisation and reduce the demand and the cost to the community for more formal supports such as in-home care services and supported residential accommodation.

- **Community stabilisation and cohesion**
  By reducing the incidence and impact of isolation, depression and loneliness in our community, and building ties and mutual support between the generations, Homesharing makes an important contribution to community stability and cohesion. Social capital of this type is now recognised as an important community benefit.

Examples of innovations from Presbyterian Support upper South Island

**Innovation**
In 2008 PSUSI celebrated 100 years of working with the community. Our organisation has been a leader in innovative service development which in relation to older people has more recently
included:

- **Restorative Home Support** - As outlined, Presbyterian Support organisations across New Zealand led the way in the development and implementation of this service model. Enliven HomeCare services in Nelson and Marlborough led the sector in transitioning to the Restorative Home Support model.

- **HomeShare** - In 2005 PSUSI put effort and energy into developing an alternative style of day activity programme, initially to cater for isolated elders living in rural communities. Through our increasing reach into smaller towns in Mid Canterbury we recognised there was a gap around day support services in these communities which at worst could lead to elders either shifting away from their home towns to bigger centres or going into permanent residential care. We responded by developing a model we call HomeShare. Trained and paid hosts open their homes to older people and provide a day activity programme. Catering for 2-4 clients for the day (usually 9.30am-3pm), hosts provide a programme of activity, morning and afternoon teas and a cooked lunch-time meal. A health professional and the wider Enliven services team support the programme. Recruitment and training of suitable hosts is a critical to its ongoing success. While HomeShare is a relatively new development we are now in our 3rd year of operation in Mid Canterbury and our second year in North Canterbury. HomeShare forms a useful alternative to traditional day programmes and can be easily tailored to suit elders with mild to moderate dementia.

We currently operate HomeShare services in rural Canterbury and will open two in Greymouth under contract to the West Coast DHB in November.

- **Harakeke Club** - We have been one of the first social services organisations in NZ to recognise the special nature and benefits of day activity programmes for older people with memory loss that run outside the residential care setting. Our own research to develop a model of community care for people with dementia and their carers took place over 2.5 years from 1986. This research supported a day centre especially geared and designed to cater for people with dementia. We developed a day centre within our own Harakeke Home and in 1994 a dementia-specific stand-alone day centre was built behind the residential home. The original stand-alone service in Riccarton was named "Harakeke Club" and is still located there 14 years later.

A second Harakeke Club centre was established in Linwood, Christchurch in 2007. Our Nelson Harakeke Club was developed nine years ago (previously called Immanuel House) and is now running from the purpose-built regional service centre in Stoke.

Clients are transported to and from the centres via our own Minibus transport and enjoy morning and afternoon tea and a main meal at lunchtime. Outings and exercise programmes are incorporated into the days with an emphasis on activity and friendship within a safe and supportive environment.

We employ a range of staff including Occupational Therapists, Registered Nurses and Diversional Therapists to oversee the programmes. They are supported by trained assistants and volunteers. We have a close association with the regional Alzheimer’s Societies, especially in terms of caregiver education, supporting their field workers and recruiting and training volunteers. Additionally all our day activity programmes fit within the broader range of Enliven Services provided by PSUSI. This enables our clients service plans and their care to be integrated when they are using more than one of our services.

In the last financial year we had a total of 8790 client attendances at our Harakeke Clubs and catered for 261 individual clients.

- **Training for the Enliven workforce** - PSUSI in conjunction with other Presbyterian Support organisations across New Zealand has led sector training for Support Workers with the development of the first specific restorative model training programme, "Facilitating Independence Training" (FITS), PSNZ. This programme has subsequently been incorporated into the Careerforce National Certificate training at Level III.

- **Falls Prevention** – PSUSI was one of the first providers of modified Tai Chi programmes for
older people beginning this service in Nelson over 10 years ago with rapid expansion to Christchurch and then two years ago to Marlborough.

- **Canterbury SupportLink pilot** – PSUSI is currently piloting under contract to the CDHB, an integrated community support programme for people with dementia. The CDHB’s acceptance of our proposal recognised our more than 20 years of successful experience and expertise in community support with this client group through day programmes and social work support as well as our success in an innovative Community Support contract.

<table>
<thead>
<tr>
<th>Area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category:</strong> model/pathway of care</td>
</tr>
</tbody>
</table>

**Condition, disease and/or disability type:** range of conditions affecting over 65 year olds, grouped into differential models of response, including, but not limited to: cognitive impairments, including dementia related illnesses and those with cognitive impairments caused by alcohol and drug abuse, and other mental health issues; chronic conditions; frailty and mobility issues related to ageing

**Service specialty:** care for older persons in community and residential settings, but with systemic preference towards ageing in place wherever possible and for as long as possible and practicable

<table>
<thead>
<tr>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Group/Clinical Indication(s):</strong> persons over the age of 65 living in New Zealand, differentiated into sub groups as per the categories outlined above under condition type</td>
</tr>
</tbody>
</table>

People aged 65 and over make up a large and growing proportion of New Zealand’s population. At the time of the 2001 Census of Population and Dwellings, they numbered 450,426 and made up around 12 percent of the total usually resident population. Over the next 25 years, the number of people aged 65 and over is projected to rise significantly to reach 924,400 by 2026. By that time, they will make up around 20 percent of the total usually resident population. This is projected to increase further to 25 percent in 2051. (Statistics New Zealand 2004)

**Future Demand:**
- The largest increases in the 65+ age group will occur in the decades ending in 2021 (increase of 223,000) and 2031 (increase of 276,000) when the large birth cohorts of the 1950s and 1960s move into this age group. (Statistics New Zealand – 2006)

Demand for facilities: By 2026, between 12,000 and 20,000 extra residents will require aged residential care. In the 20 years between 2006 and 2026 the New Zealand population is expected to grow by 20% (from 4.2 million to 5 million). The over 65 population, however, is estimated to increase by 84% (from 512,000 to 944,000).

- Supply of facilities: Sector bed numbers need to increase by 78% to 110% by 2026 to accommodate the projected increase in extra residents and to replace aging facilities.

- Costs and investment: Financial returns currently being generated for subsidised aged residential care operations are insufficient to support building new capacity and replacing
Aging stock. Approximately half of current stock is now over 20 years old.

- Workforce implications: The workforce employed in the aged residential care sector has doubled in the last 20 years to 33,000. Workforce demand is expected to increase between 50% and 75% (on an FTE basis) by 2026. The workforce is expected to adjust to demand through mechanisms such as remuneration and population growth.

  - Models of care: Four alternative service configuration scenarios were considered worthy of further consideration: improvement in the current approach, an enhancement of professional services in the community, an individualised funding approach and the development of low income community housing for the elderly. (Aged Residential Care Service Review, Grant Thornton- 2010)

**Estimated Current Demand or Size of Group:**

The number of New Zealanders aged 65 years and over has doubled over the last 50 years and is expected to more than double again over the next 50 years. At the 2001 Census of Population and Dwellings, New Zealand residents aged 65 years and over numbered over 450,000 and made up 12 percent of the total population, up from 9 percent in 1951.

Population projections indicate that the population aged 65 and over is expected to increase by around 100,000 over the current decade, to reach 566,000 by 2011. After 2011, the rate of increase is expected to accelerate, as the large baby-boom cohort begins to enter this age group. Between 2011 and 2021, the number of older people is expected to grow by about 200,000 and by a further 230,000 in the following 10 years. By 2051, there will be over 1.18 million people aged 65 years and over, an increase of around 166 percent since 2001. At that stage they will account for about one out of every four New Zealanders. (Statistics New Zealand 2004)

**Demography:**

Population ageing can be regarded as an intrinsic dimension of the ‘demographic transition’. That is, a transition from relatively high mortality and high fertility rates to relatively low mortality and low fertility rates.

The changing age structure of New Zealand’s population is inextricably linked with a projected decrease in births and a projected increase in deaths. Births exceeded deaths by about 30,000 in 2005 (June year), but deaths are projected to outnumber births from the early 2040s.

All ethnic groups will age. However, the broad Māori, Pacific and Asian populations are likely to remain younger than the broad European population because of ethnic differences in fertility, mortality and migration.

(Demographic Aspects of New Zealand’s Ageing Population – 2006)
Current Availability
Flexibility in options and amount of care available in community settings are lacking, and the shortage will worsen dramatically in coming years. A mix of public and private provision is inevitable, but policy settings should favour universal minimum standards of care provision rather than premium differentials that incentivise providers who are seeking to profit commercially from provision of services.

Proposed Service/Patient/Programme Pathway
Needs assessment should be client/family/whanau centred, rather than health system centred as it is at present. Family members should be actively engaged in, and inform the assessment process, particularly in the cases of clients with cognitive impairments. Flexible packages of care tailored to client need should be available, with a high degree of discretion on how funds are used to best support ageing in place for a particular individual, taking into account family and carer context.

Current or Alternative Intervention
The current mix of provision is increasingly skewed towards private provision, increasing differentials between standards of care for those who can afford to pay privately and those that cannot, and demand pressures in traditional and existing residential models of care skewing the resource demand to this end of the care spectrum.

Safety Information
N/a

Estimated Benefits
A system wide response to aged care provision in a differential care model basis will, if designed and implemented properly, will:

- Provide care pathways for over 65 population groups based on their differential needs ie dementia care appropriate; older frail appropriate; chronic condition management appropriate. Tailor packages of care to individual needs within these population groups, allowing for maximum innovation in meeting goals to maintain wellness, independence and social connectedness. The needs of carers and family supports will also be included as an essential part of the package
- Older people will be able to remain in their communities longer, and maintain quality of life, on multiple levels, for more of their life span
- This preventive, strengths based, flexible approach, which looks to clients goals and aims rather than categorises them in terms of their health problems or limitations, will drive a restorative rather than medicalised, institutionalised approach to aged care
- Cost savings from delaying and preventing entry into high cost, high need medical, residential and hospital care will make the overall costs of care for the increasing number of older people more sustainable and more equal into future years.

Estimated Costs
### Cost Effectiveness


### Service Configuration and Implementation Issues


### Ethical, Equity and Acceptability Issues


### Relevant Stakeholders

Non-government providers of aged care services, DHBs, Ministry of Health, aged care consumer groups eg Greypower, Alzheimer's New Zealand, IDEA Services and like population group bodies.

### Is there any other relevant information?

N/a

### Ranking (if submitting multiple referrals)

N/a – only one proposal submitted

### Referrer Contact Details

<table>
<thead>
<tr>
<th>Title</th>
<th>Mrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Katherine</td>
</tr>
<tr>
<td>Surname</td>
<td>Noble</td>
</tr>
<tr>
<td>Position</td>
<td>National Executive Officer</td>
</tr>
<tr>
<td>Organisation</td>
<td>Presbyterian Support New Zealand</td>
</tr>
</tbody>
</table>

### Endorsing/Sponsoring Organisation Contact Details

<table>
<thead>
<tr>
<th>Title</th>
<th>Presbyterian Support New Zealand</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Gillian</td>
</tr>
<tr>
<td>Surname</td>
<td>Bremner</td>
</tr>
<tr>
<td>Position</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Organisation</td>
<td>Presbyterian Support Otago</td>
</tr>
</tbody>
</table>

### Available Evidence and Assessment of Quality (including references to information stated above)

